# Cordaid and **health and well-being**

# Cordaid Aids Award

**Amsterdam, December 2009. Presentation of the second Cordaid AIDS Award by Marijke Wijnroks, the Dutch Ministry of Foreign Affairs' AIDS ambassador. The Cordaid Aids Award 2009 highlighted home care. The winners were Nacwola, a Ugandan network organisation by and for women, and South Africa's Moira Boshoff. Cordaid was particularly struck by Nacwola's human rights-based approach. Ten thousand HIV-positive women contributed to building up this network organisation, which is working to reach HIV and AIDS patients in the remotest parts of Uganda. Nacwola was awarded the € 15,000 prize. Moira Boshoff, who five years ago founded her Care Ministry based in her diocese, was awarded the € 5,000 prize in the best individual category. The volunteers of her organisation are now reaching some five hundred adults and four hundred orphans every month with psychosocial care.**

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CORDAID

René Grotenhuis, director of Cordaid:

# "Development is emancipation"

**Development aid on the way out? Not if Cordaid director René Grotenhuis has anything to say about it. "I see Cordaid as an important actor in social change. We actively participate in global communities of change."**

This new perspective breaks with the old model, under which Cordaid's most important function was to provide financial aid to the poor. Migration problems, climate change, scarcity of resources and the food crisis are not problems of the South but of the world as a whole. We too have a lot of changes to make. Cordaid sees its role as a part of global movements in these areas, all of which, says Grotenhuis, are directly linked to poverty. "Money remains an important means of setting off these global changes. In these communities of change, the richest shoulders bear the heaviest financial burdens - it's a simple doctrine of fairness. Which means that the financing function remains part of what Cordaid does, but the responsibilities and the choices are being shifted more and more to our partner organisations. People living on the fringes of society have to have their voices heard; they have to have a say in the discussions and the decision-making affecting their lives. And one way of achieving that is to create more south-south relationships."

Movements of social change are not something restricted to civil society even though it takes citizens to make things happen. Cordaid actively seeks connections with the business sector, professionals and political players. Worldwide responsibilities call for worldwide knowledge exchange, and for Cordaid, that means spreading knowledge and experiences, not only abroad, but also in the Netherlands. "Cordaid has not only financial resources, but an extensive network to contribute," says Grotenhuis. "But it is our partner organisations that are in the best position to map the needs of vulnerable people and marginalised groups."

"It's about developing social stakeholding, among our base in the Netherlands and our partners worldwide. These are people who connect with us, who feel a shared sense of ownership, who tell us where we can do better, and who are proud of what we are achieving.
I also like to point out that the concept of global communities of change is very compatible with the Catholic idea that through compassion for your fellow man, you become a better person."

Examples of communities of change can be found in the work being done in Cordaid's sectors Health and well-being, Entrepreneurship, Participation and Emergency Aid & Reconstruction. In Africa, home-based care organisations are using the Cordaid network to exchange knowledge and experience with groups in other parts of the world, like Mexico. In its Climate Adaptation and Disaster Risk Reduction programme, Cordaid is supporting local partners in ten countries on improving readiness for natural disasters like droughts, floods, hurricanes and earthquakes. Partners in the Horn of Africa, for example, are using this programme to exchange experiences on potential adaptations and collaborate on joint lobbying strategies to get governmental authorities involved in setting up precautionary measures.

*René Grotenhuis*

"By connecting other institutions like research institutions to these kinds of programmes, the process can be further enhanced. But the sense of ownership is crucial, and that means making sure that decisions are made together whenever and wherever possible."

**On the ground**

The idea of communities of change is based on the assumption that people can draw a connection between their own experiences and those of people in other countries. This can be difficult, especially in conflict areas; sometimes the brutality and suffering emerging from each new conflict seems unprecedented. But there are patterns of power, exclusion and marginalisation that can be found everywhere, and this is where Cordaid tries to make connections. Working in fragile states and societies is part and parcel of Cordaid's work. Cordaid has a long history of emergency aid and conflict management in unstable areas. "It's in our organisation's DNA," says Grotenhuis. "In conflict areas, churches play an important role. This is a network that is sometimes one of the few things, or the only thing, that people can build on." Cordaid also identifies and addresses the needs and obstacles faced by migrants and refugees from countries such as Sudan, Angola and Afghanistan in maintaining an active connection with their home countries.

Cordaid considers the connection between migration and development aid a critical one in achieving its goals. Cordaid defines the concept of sustainability as not only an ecological question, but a social one as well. Of course, support for fair trade is an important part of this, but for Cordaid, it doesn't end there. In many cases, the poorest pay the price in the pursuit of natural resources. In Chad, people are being driven off their lands for the pursuit of oil resources; in Ghana, water supplies are under severe threat from mining operations.

"Development aid is a focal point where social, economic, political, cultural and religious aspects come together," says Grotenhuis. "The longer I work in the field of development, the more I realise that the root cause of poverty is exclusion, and that development is really a process of emancipation." He points out that the major emancipation movements, such as the labour movement or the women's movement, were always centred around marginalised people who were themselves the driving force behind the movement but who also needed sympathisers in other segments of society. "That's why I see development aid as support for a process that is in the hands of people who are being excluded. And, what's more, we in the northern hemisphere have to get beyond our self-satisfied attitude and start asking ourselves about our own processes of development. Because our lifestyle is untenable. It's about time we convince the political sector and the public that global issues are also northern issues. That we are all responsible, and that we can't solve anything without each other's knowledge, experience and inspiration."

This brochure presents some examples of what Cordaid is doing in the field of health and well-being - how organisations at the community level are dedicating their efforts not only to care, but prevention, and how advocacy organisations are creating sustainable improvements. Because the problems of the south are closely interwoven with those of the north, we hope that these examples inspire a new look at development aid. A look that will inspire solidarity.

***Minga Hospital, Petauke district (Zambia)***
*The people of Petauke (population: 82,000) come here for deliveries, information and education on HIV and AIDS ,hospital and outpatient treatment . The patients and their family members often prepare their meals just outside the hospital.*

# Safe motherhood

**Chilipa, Malawi. In Malawi, Cordaid is supporting the College of Medicine's Safe Motherhood programme. One of the driving forces behind this programme is Mary Sibandi, shown here leading a discussion with the Chilipa women's group. Much of the medical knowledge concerning reproductive issues is based on traditional mores rather than medical science. And some of these traditions can be dangerous. For example, traditionally the first child must be delivered in the presence of the husband's sisters. If the birth does not go smoothly, they see this as a sign that the woman has been unfaithful; the child evidently does not want to belong to the family. Now, thanks to the Safe Motherhood programme, the sisters-in-law come to the hospital, so they can see that with some medical help, the child does indeed want to be born. The importance of this step cannot be understated. Because many women bear their first child at a very early age, the woman's pelvis is often not fully grown, which makes it difficult for the child to pass through the birth canal. The complications and risks this entails are common and extremely dangerous.**

**Mary's work in Chilipa began after a conversation with one such young woman. Mary was so moved by the woman's situation, she felt had to do something for her. The woman in question is now 27 years old, and has had seven pregnancies. But because of complications with each one, she remains childless.
Mary managed to see to it that she has recovered from the damage left by these pregnancies. But many women in the village proved to be suffering from similar problems. They have now received care as well, and today travel as a group to other villages to educate other women first-hand and warn them about pregnancy-related risks.**

HEALTH AND WELL-BEING

Monique Lagro, Health and Well-Being sector manager:

# “A lot can happen at the community level”

**Cordaid's goal is to improve the health and socio-economic situation of poor and vulnerable groups, including women. An important part of that is reinforcing healthcare systems and structures, from patient organisations to worker’s unions and from self-help groups to lobbying organisations.**

“Our priority is to strengthen the demand side, like patient organisations and midwife groups,” says Sector Manager Monique Lagro. “We try to get sufficient numbers of motivated midwives into the remotest areas, in order to reduce the maternal mortality rate. This requires us to use limited resources as efficiently as possible. One way to do this is by implementing a performance-based financing system, or PBF. We also need to increase focus on documentation and publishing. In both the global north and the south, we actively involve knowledge institutions in improving healthcare, so we can ultimately understand which approaches work best at the community level.”

A lot has changed in recent decades. In the past, western doctors were frequently sent out into these remote areas. Now, NGOs in north and south understand that this approach does not “fix” the ongoing shortage of healthcare personnel. Healthcare means more than just curative care. Prevention is essential. “At the community level, there is a lot to be gained from mobilising community organisations, like women’s groups,” says Lagro. Catholic hospitals are in a difficult situation. As long as contraceptives, birth control and family planning remain taboo, Catholic institutions risk being cut off from funding where healthcare is financed from sources such as PBF. Lagro points out the paradox of the situation. On the one hand, church institutions continue to fail to make contraceptives available, but yet always stand ready to provide healthcare services, even without governmental financial support. We saw this happening, for example, in the years of turmoil in the Democratic Republic of Congo. “We can also be proud of the church's large-scale home care programmes in Zambia, Congo and Malawi. The church has been able to mobilise a lot of volunteers to care for patients and their children. With the arrival of AIDS inhibitors, the demand has shifted from death counselling to looking for employment for the HIV-positive. There is also a need for sex education, and this is not something the church is cut out for: they have always been better on the care side than getting into discussions on sexual education to make girls and women more empowered in dealing with men. We have now entered into the dialogue with the church on HIV and AIDS in seven different countries. We demand that the church give out honest information and not peddle myths. That they don’t stigmatise. With the church, we are developing a curriculum for church leaders that includes HIV and AIDS prevention, sexuality, women's rights and stigmatisation. The church

*Monique Lagro*

has a huge role to play in healthcare. We have to keep working with a player this significant, even if that is a balancing act sometimes."

**Bonding**

It is in fact the lower healthcare personnel that need to be attracted to remote areas, as is being done in places like Zambia, says Lagro. "The challenge is to find motivated personnel, so that fewer mothers will die in childbirth. Then we try to build communities of change around them, like nursing unions." Cordaid wants to increase the influence patients and health personnel can have on policy development. In that way the quality of care can improve along with the working conditions of the personnel involved. But we also take a critical look at the role of Dutch and European healthcare institutions, which are drawing personnel out of places like Zambia." Cordaid is doing this in partnership with Wemos.

Improving healthcare does not always have to be a complicated process. In Malawi, the maternal mortality rate (a very good indicator for the quality of healthcare in general) is being reduced by making use of the social control by the villagers themselves. "When you go in and scale up local initiatives, it's very important to know what does and doesn't work," says Lagro. "And we also need good examples in order to be able to lobby better. My conviction is that at the community level, a lot can happen with relatively little money, but we do have to have the evidence to back it up."

Health, exclusion and poverty go hand in hand. Social protection (by the government or a social organisation) is a good instrument for combating exclusion. It's about helping vulnerable groups such as children, older people and people with a disability, to be stronger. Older people have become a key group to support: in many cases, they are surviving their adult children (often AIDS victims) and have a huge role as caregivers for the grandchildren.

But they need financial support to do this, which is why Cordaid is lobbying to set up pension systems in developing countries. Because parents cannot take on all the care themselves, Cordaid is making efforts to improve care structures in the community.

A lot depends on sharing and bundling knowledge and experiences and in making contacts between people. The Cordaid Aids Award, promoting ecclesiastical leadership in the approach to AIDS and home care, is a good example. "There was a great response to this award," Lagro recalls. "You can put a lot in motion even with just a little money. The proposals we received are examples of bottom-up initiatives, where people are holding their church to account on critical issues. Next, Cordaid will be awarding a similar prize for reproductive health issues."
The goal is also to anchor specific diseases, such as HIV and AIDS, in the general healthcare system, because separate programmes can detract from existing healthcare systems by drawing away already scarce personnel.

Maternal mortality is one Millennium Goal which is still far off. "We have to put knowledge institutions, NGOs, the business world, the pharmaceutical industry, and the political sector together. We need a community of change to break down the walls between the NGOs and the knowledge world."

# Bicycle ambulance

**Katema, Malawi. One reason that women in Malawi do not give birth in a health centre or hospital is a lack of transportation. Transporting a woman who is about to give birth is usually put off until the last possible moment. In the past, women in labour were frequently carried to the hospital by their husbands, in some cases with the man simply hoisting her over his shoulders. Couple that with delivery complications and blood loss, and walking miles to the hospital becomes a life-threatening undertaking.**

**This is why the Safe Motherhood programme in Malawi is helping participating villages obtain a bicycle ambulance. The villagers pool savings to acquire the bicycle and are collectively responsible for its management and maintenance. And the arrival of the bicycle becomes an opportune moment to explain why it is needed and what it is to be used for. It is important for pregnant women to seek medical care as early as possible, especially when complications can be expected. This way, complications can be helped before they become life-threatening due to lack of time. Bicycle ambulances have dramatically increased the chances of women in need receiving medical care in time.**

CASE 1

# Zambia: Shortage of healthcare personnel is intractable problem

**WHAT**
Structural approach to personnel shortage in Zambia.

**WHY**
To improve healthcare.

**HOW**
By influencing policy.

**Zambia struggles with a severe shortage of medical personnel. Partnership and lobbying appear to be the key to improvement.**

One factor is the large number of AIDS victims among healthcare personnel. Additionally, many Zambian doctors and nurses emigrate in search of better working conditions. And investment in training still falls far short of what is needed. Lastly, a great deal of donor funding goes towards fighting specific diseases, such as HIV and AIDS, and this actually draws sorely needed healthcare personnel away from the general healthcare sector.

In partnership with development organisation Wemos (specialist in healthcare policy influencing), Cordaid is working towards supporting nurse's trade union ZUNO. At Cordaid's initiative, ZUNO has united with other social organisations under the banner of a health forum. Church organisations, training/educational institutions, patient organisations and slum-dwellers are now collaborating on policy development. ZUNO was recently recognised as a negotiating party for the Zambian government in the search for solutions for the personnel shortage. "That's a big step forward," says Cordaid's Johan van Rixtel. "Policy is still being decided by officials. It's very important that nursing professionals, who know the field best, get a say." Their voice has to lead to governmental authorities addressing the personnel crisis.

### United we stand

"ZUNO had to struggle for years to get recognised as an interest group," says Van Rixtel. "Getting the fragmented social organisations in Zambia together proved to be extremely important. From that point on, there were more options for taking on problems." For example, patient organisations and slum-dwellers, working with local public administrators, succeeded in getting the message across that HIV patients can use land to grow food. For these people, medication is of little help without a source of healthy food.

*Ndola, Zambia*
*With Cordaid support, the Saint Theresa Hospital has developed a policy for attracting new personnel and providing professional medical training.*

Cordaid is working to make jobs in rural hospitals more attractive to healthcare personnel, with things like better housing, continuing education and retraining, better availability of medicines and materials, and education for children of personnel. There are now 80 more doctors working in rural areas. The same effect has not yet been seen in nursing personnel, who earn too little and are often forced to take a second job. Additionally, many have a tendency to not show up for work. "More than anything else, I've learned to look for the right mix, and not focus on one thing to improve, like stimulus measures to retain personnel," says Van Rixtel. "We have to take up the whole package."

Cordaid supports not only lobbying for more healthcare personnel in Zambia, but is also attempting to influence Dutch healthcare institutions so as to prevent them from being a drain on the few Zambian healthcare personnel there are. The aging of the population will also put pressure on the Dutch healthcare sector. Cordaid is supporting Wemos, both financially and substantively, in the development of a code of conduct.

Van Rixtel thinks it is important to get beyond the fragmented projects pursued so far. "There has to be more cohesion between the things that Dutch development organisations are doing in the south," he says. "In Zambia, we are coordinating the major initiatives better." Slowly, healthcare is improving. "We have to try to take these improvements to other countries, like Ghana, Tanzania and Uganda."

CASE 2

# Burundi and Rwanda: Harvesting the fruits of results

**WHAT**
Rewarding performance in the medical care sector.

**WHY**
To create a better healthcare sector.

**HOW**
Innovative financing system and lobbying.

**Performance-based financing makes healthcare organisations accountable for their performance. Cordaid is working with this system in five countries, including Burundi.**

The healthcare sector is extremely weak in the fragile state of Burundi, where materials, drugs, funding and motivated personnel are all in short supply. One strong point is that healthcare is free for pregnant women and children younger than age five. The problem, however, is that the national government fails to reimburse these expenses, or pays them so late, that hospital continuity is threatened. This is where Cordaid has introduced performance-based financing (PBF). “Health centres provide services, for which we pay, monthly, based on results,” says Cordaid’s Piet Vroeg. “That money is used to supplement salaries, attract new personnel and keep up medicine stocks.” Each month, the number of services provided is calculated, and the reliability of the data is checked by random sampling among the patients. The quality of the services is evaluated quarterly.

**Best foot forward**
This improves the quantity and quality of the healthcare. The system is transparent, with a good price/quality ratio. “The added value of the initiative is with the health centres,” says Vroeg. “They have a great deal of freedom in how they spend money, they feel responsible. It promotes enterprise and efficiency.”
Catholic health centres have an opportunity to improve their services. To be eligible for PBF, they have to offer HIV prevention and family planning. Centres that decline to provide these services are able to outsource them to other healthcentres in order to meet the requirements for PBF.

Cordaid launched PBF in Rwanda in 2002 and expanded the system into Burundi, the Democratic Republic of Congo, Cameroon, Tanzania and Zambia. Burundi was able to benefit from the lessons learned in Rwanda.

“In Rwanda, we felt that the task of the national government was to scale up the example that we had introduced locally. Unfortunately, in the process we lost some of the principles: in Rwanda, public bodies, rather than social organisations, do the monitoring. The goal is for government and social organisations to work together, to monitor the care as closely as possible.” There is an underlying organisation that tracks the care by asking patients whether they received the service, how much they paid, and whether they are satisfied. “Initially, fraud was rampant in many forms, such as reporting non-existent patients. The monitoring system reduced the fraud to one per cent within six months.” Unlike in Rwanda, in Burundi Cordaid is involved in scaling up PBF to the national level. Three years after it was launched, half the country is now using the financing system.

**The ups and downs**
Vroeg has a few concerns. “One question is how long a performance-based system has a stimulus effect.” Another risk is that health centres may begin concentrating on specific diseases. “We prevent this by spreading the subsidy over 25 services, with a focus on malaria and mother-infant mortality.” In Rwanda, much more funding was going to fighting AIDS than to general healthcare. Later, this situation was rectified to a certain degree. Home care for AIDS patients is an integral component of preventing too much cost pressure on the health centres.

The challenge in Burundi is ensuring that social organisations are involved on the purchase side. “For example, they have to have be able to give input to the national commission responsible for drafting the list of national priorities and the corresponding subsidies,” Vroeg says. “Because it's the social organisation that knows the needs at the local level.”

CASE 3

# Malawi: Safe motherhood

**WHAT**
Proper assessment of the risks faced by pregnant women.

**WHY**
Reducing maternal mortality.

**HOW**
By working with villagers and village leaders directly wherever possible.

**Malawi has one of the highest mother/infant mortality rates in the world because it has a significant shortage of midwives. Women cannot always reach a hospital in time, in part because the risks in their pregnancy have not been adequately assessed. This situation is the most dramatic in rural areas.**

The College of Medicine in Malawi is working to improve maternity care in rural areas. Training of midwives, village leaders and villagers, health education for young people, bicycle ambulances, and involving men by giving them a greater role are just a few aspects of the College of Medicine's work in this area.

**Care structure at village level**
In Muslim villages, normally the woman's uncle will decide whether or not she will go to the hospital. Slowly but surely, these traditions have to change. Each village now has a health committee composed of residents, local authorities, teachers, tribal leaders, midwives and traditional medicine men. Monitoring of maternal mortality plays an important role. When a woman dies in childbirth, the villagers ask questions: why did this happen, and why didn't she get help in time? Is an unwilling husband or a traditional medicine man to blame for not referring the woman to medical attention? How can this be prevented in the future? It's about social control, backed by sanctions. Cordaid's José Utrera explains: "The tribal chiefs have endorsed this approach. Safe childbirth has become a responsibility of the community. At the heart of the activities is women's empowerment. The villagers are becoming more responsible. That's what makes this a sustainable solution."
Whole village communities are being trained ("trained birth attendants") to monitor pregnant women and refer them in a timely manner where required. In these isolated villages, which are only accessible by poor roads, the bicycle ambulance has proven to be a solution. "We don't just give these away," explains Utrera. "The whole village collects money to buy, and to maintain, the ambulance." The next step is to create a solution for the personnel shortage. One new factor is that university students now have to do a placement in a rural area in the final year of their study. Efforts are also being made to boost their motivation, so they stay in these isolated areas longer and tackle the local problems together with the local communities.

**Maternal mortality: a community problem**
Since the start of the programme in 2004, maternal mortality has dropped by 85%. "Documenting this is important for demonstrating to policymakers that the approach is successful, so the idea of a care structure at the village level can be adopted elsewhere," says Utrera. The University of Groningen is involved as a knowledge institution, and is providing training on qualitative research in the district. The ultimate goal is to make the approach even more effective and to scientifically substantiate the results.

HIV prevention is closely linked to maternal and infant care. Here, too, the programme works closely with tribal leaders, who became convinced of the importance of prevention after months of intensive dialogue. Boys and girls participating in initiation rituals are now getting HIV prevention counselling.

Maternal mortality is one of the biggest and most stubborn problems in Africa. "If you want to tackle maternal mortality, you have to change the position of women," says Utrera. "Maternal mortality is not a women's problem, but a community problem. Traditions are not set in stone; they can change. It's so important to do projects like this in Africa; you don't see this type of approach here much."

***Phambaya, Malawi***
*In Malawi, Cordaid is supporting the College of Medicine's Safe Motherhood Programme. This programme is using tools like bicycle ambulances to reduce maternal and infant mortality in remote, rural areas such as the village of Phambaya.*

CASE 4

# India: Promoting family-based child care

**WHAT**
Reuniting children with their families and communities.

**WHY**
To improve the children's emotional and social development and to strengthen families.

**HOW**
Software-based linking of children's organisations' information with the children's telephone helpline.

**In India, as in most of the rest of the world, some eighty per cent of children living in orphanages are not actually orphans, but have at least one living parent. These are children whose families have placed them in an institution because they themselves are too poor to care for them, runaways, missing children and victims of child trafficking. And what these children really need is to grow up in a family, preferably their own family.**

"Orphanages are often divided strictly into age and gender groups," explains Cordaid's Julie Love, "so brothers and sisters are frequently separated. But the most important thing is that so many of these children don't even belong in an orphanage." And of course, orphanages are expensive.

Cordaid has been supporting the Navajeevan Bala Bhavan organisation in India since 2005. Navajeevan Bala Bhavan has succeeded in reuniting some 10,000 children with their parents. "Often, we see children earning their first diploma before they are willing to go back," says Love. "Just bringing a child back is often not enough. The situation of the child and the family has to change. There are also children who are hundreds of miles from home." Carefully monitoring of how the returned children are doing is important, because runaways are seen as a family scandal.

In partnership with UNICEF India, Cordaid is supporting the Young At Risk Forum in setting up the Homelink software system, designed to exchange information on missing and found children with relevant parties, like some eighty children's organisations and the children's telephone helpline. The database is also a tool for combating child labour and child trafficking. Finally, it is a resource for research and policy influencing - for example, it can be used to check whether a given area has more missing children than other areas. "With this type of evidence in hand, organisations can start talking to the authorities, which until now have been hard to convince," says Love. "Cordaid's goal is to ultimately help channel the government funding that is now going to orphanages, to support poor families like single-parent households and also poor foster families instead." The aim is that the software will also be used by the police to locate missing children.
In 2008, of the 1,380,000 children listed in the database as missing, 31,000 were able to be traced and reunited with their families. Police in a number of Indian states have now adopted the Homelink system.

### Sharing experiences

Cordaid is an active member of The Better Care Network (BCN) The Netherlands. This group of organisations and experts works to raise awareness and influence policy towards family strengthening and improving the quality of care for children by making more family based care available. It does this by linking the experiences of child organisations in the Netherlands and abroad. BCN is working in the Netherlands, for example by informing technical colleges and universities of the effect of internships in orphanages abroad. Many students are interested in working in an orphanage. "But they come and go, and this takes its toll on the children," says Cordaid's Alinda Bosch. BCN shows how things can be done better." BCN is doing something similar with the private sector initiative in the Netherlands. After coming home, travellers often want to do "something good themselves, preferably for children," and one frequent response is to set up an orphanage. "BCN talks with them about why that might not be the best idea," says Bosch. "They try to reign in people's enthusiasm, and come up with a small-scale alternative for an orphanage that may better suit the children's needs. Our motto is 'get the aid to the child."

*In Moradabad (Northern India), Cordaid is working with the Association for Stimulating Know How (ASK). ASK stands up for the rights of the child, and gives alternative education to children who have had to perform long hours of child labour and are not able to move into the official education programme.*

CASE 5

# Tanzania and Uganda: The power of older people

**WHAT**
Strengthening organisations for older people.

**WHY**
To help older people gain security in their lives.

**HOW**
Through self-help groups and special interest organisations.

**When people think of vulnerable groups, they generally think of children and people with a disability. But older people are also a fast-growing vulnerable group: By 2050, some 10 per cent of the population of sub-Saharan Africa will be over the age of 60. Cordaid supports organisations for older people in countries like Uganda and Tanzania.**

Social connections change: young people and job-seekers leave; many young adults are dying of AIDS; older people remain, and are left out by the once reliable health system. In many cases, they are alone, but buredened with the care of orphaned grandchildren.

Cordaid has been supporting organisations for older people in Uganda and Tanzania for a number of years. The key to this support is forming self-help groups with small, local NGOs and helping older people gain a sense of security. Older people are organising so they can be stronger together, help each other, and take on income-generating activities (often community-based). Like chicken farming, or theatre productions, in which they can convey their message and earn something in the process. Of course, it's not just about earning extra money, but even more importantly, about finding social support. Older people want to stay in the community, stay useful. They want to matter.

"Alone, older people are very vulnerable," explains Cordaid's Alinda Bosch, "certainly in view of their personal suffering and the poverty. But when older people band together, they are strong, and they have proven to be able to win back the respect of the community. The problem is that there are still so few organisations for older people that are not only strong at the village level, but can bridge the gap to the national level and, through national organisations, lobby for policy changes." Such sorely-needed changes are things like a guaranteed minimum pension and a minimum stipend for necessary care of grandchildren. Cordaid is also supporting organisations that help older people with legal support, such as when an older woman is left alone after the death of her husband and is at risk of losing her land. Or illiterate women saddled with the care of their grandchildren and who are threatened with eviction from their homes.

The challenge is to enable a strong structure of organisations of and for older people to develop - things like self-help groups, organisations for older people at the village level, and interest groups that can lobby the government for the right of self-sufficiency for older people. "Cordaid is supporting the creation of these structures," says Bosch.

***Kampala, Uganda***
*Since the death of her own children, this woman has been saddled with the care of her grandchildren. She can go to partner organisation Uganda Reach the Aged Association (URAA) for aid for her grandchildren and for help in obtaining a personal income.*

***Kaberamaido, Uganda***
*An older woman in front of her house in a Kaberamaido refugee camp. Partner organisation Transcultural Psychosocial Organisation (TPO Uganda) works in the camp. One of the group's focus areas is preventing violence against women.*

**Recognising rights**
Cordaid supports national lobby for the rights of and better services for older people and as a Dutch partner of the Help Age International network, also supports the worldwide federation of organisations for older people. Help Age International lobbies for social retirement facilities for older people and for recognition of the rights of older people.

"It's not easy to get attention for the basic human rights of older people," says Bosch. "Sometimes, aid for older people meets with a critical response, as if it is charity. But this is a basic right to care, protection and socio-economic security. Research shows that older people are very careful with even the smallest of pensions. They spend the money on their day-to-day needs, on their families; school uniforms and meals for their grandchildren."

CASE 6

# Papua, Indonesia: New task for Catholic clinics

**WHAT**
Working towards preventive healthcare.

**WHY**
To leverage the strong potential of the church (goodwill base in the village communities).

**HOW**
Promoting cooperation between Catholic clinics and the government, mobilising the church-based foundation for health education.

**The importance of the Catholic Church in healthcare in Papua is declining. Is there still a role for the church, and does it make any sense to continue to invest in it? Yes, says Cordaid's Ernest Schoffelen. "Thanks to its deep roots in society, the church reaches people that no one else can reach. This offers huge potential for preventive healthcare."**

For a long time, Cordaid contributed to improving the curative care offered by Catholic clinics run by convents in rural Indonesia. Once, these clinics were the only place patients could turn to. Now, there are government hospitals everywhere, and they offer free services to the poor. As the number of sisters declines, many Catholic care centres have too few personnel and dwindling numbers of patients.

**Renewed**

Looking at how to improve the care these institutions can offer, we opted for a different approach. Their focus should shift from curative care to prevention. Not through hospitals, but through the parish structure of the church. "In Papua, the church has built up more trust with the village communities than any other group," says Schoffelen. "That's their added value."

This approach is a departure from the old way of thinking, which placed its central focus on curative care. Now, the work being done through the parishes is about preventing disease. And this reaches more people than curative care. "Parish workers are not healthcare workers," says Schoffelen. "That's why we still work with a simple package of educational material about health, just giving the most important messages about vaccination, diarrhoea, safe childbirth, maternal care and birth control." Ideally, a particular subject should be discussed each month, whether that happens in a sermon in church or in Bible study group. An encouraging sign is that one of the dioceses has adopted "health" as a primary theme for its annual meeting.

One limiting factor, says Schoffelen, is that there are still too many walls within the structure of the ecclesiastical institutions. "Health commissions focus only on curative care providers and have little interest in cooperation with parish workers, and this partnership doesn't appeal very much to the parish side, either. Health commissions, pastoral and educative commissions are still not talking to each other nearly enough." Although it is unfamiliair, parish workers in Papua are enthusiastic about the new approach. They know the field, they are curious and they very much want to be a factor in improving behaviour.

***Merauke, Papua (Indonesia)***
*Josephina brings her child to a village health centre for a check-up. She has been encouraged to do this by her church group.*

CASE 7

# DR Congo: Dialogue with the church on HIV and AIDS prevention

**WHAT**
Dialogue with the church on HIV and AIDS prevention.

**WHY**
To reduce the number of infections.

**HOW**
By getting the voice of communities in the diocese heard.

**In the Democratic Republic of Congo (DRC), Cordaid has been doing something long thought impossible: talking to the church about HIV and AIDS. How is that dialogue going?**

The number of HIV and AIDS infections in the DRC is a major problem, and the government has a fairly limited role in the healthcare sector. The Catholic Church, by contrast, has a very prominent role in access to medicines and healthcare. But the reality of HIV and AIDS and prevention is denied within the higher levels of the church. Patients are stigmatised, discriminated against and ostracised. The implicit message is that "they get what they deserve." Cordaid wants to work towards cultural change within the church and strengthen its role in dealing with HIV and AIDS. AIDS is not a sin, but a medical sickness. Prevention, sexuality and treatment with AIDS inhibitors all have to be talked about.

Caritas Congo, with Cordaid support, is working as an umbrella organisation to reach all diocese and church partners with AIDS prevention activities. The objective: breaking through the taboos. Starting with the diocese. Every diocese has now produced an action plan to strengthen its role in the fight against AIDS. These plans are then elevated to the provincial and national level, where they are incorporated into a national action plan for the church. The subject of HIV and AIDS is now integrated into the activities of the diocese wherever possible. This includes patient monitoring, psycho-social care, death counselling and employment. Cordaid has entered into a contract with a telephone company under which AIDS patients manage telephone booths in order to earn an income. Prevention is open for discussion - at least, in terms of postponing sexual contacts. But not contraception, at least, not yet. This is at odds with the reality in which Congolese are marrying at around age 40 on average, because only then can they afford a dowry.
"Starting with the basis, the diocese, works," says Cordaid's Remco van der Veen. "The closer to the situation on the ground, the better sense you get of the reality. The information from the diocese is then elevated to the next level. It is essential to involve people at all levels, because then the action plans are supported by all. The bishops have now given their blessing to the work being done by Caritas and Cordaid."

**Cordaid Aids Award**
Cordaid has set up a prize for the religious organisation doing the most in the fight against AIDS. In 2008, the first Cordaid AIDS Award was presented to the Fikelela AIDS project in Cape Town, South Africa. To challenge the church to reduce he stigma of AIDS, the project developed a hallmark to be attached to the church door, a sign to signify that "this church is HIV and AIDS-friendly." The hallmark shows that the entire church community is willing to give real help to HIV and AIDS victims. That help can vary from working land to home care, and from mental healthcare to orphan care. Two bishops had themselves publicly tested, and many followed their example. "The hallmark gives patients security; it assures them that they can rely on the promise of their church," says Van der Veen.

The winners of the Cordaid AIDS Award 2009 were Nacwola, a Ugandan network organisation, and South Africa's Moira Boshoff (see also the inside cover of this brochure).

The submissions for the award present a broad range of initiatives, from education of traditional medicine men to an educational theatre production. All initiatives have the object of preventing new infections, caring for orphans and supporting informal caregivers.

The church has an important role to play in women's equality. Progress is being made, but only in baby steps. Recently, one such baby step came in the form of a statement from the Vatican acknowledging the specific contribution of women and promoting their participation "at appropriate levels."

***Kinshasa, DR Congo***
*Congolese bishops receive a presentation on fighting AIDS.*

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Cordaid is a Dutch development aid organisation which endeavours passionately to turn the tide in the battle against injustice and poverty. We believe in social and economic justice for everyone. Along with this, we trust in the power of individuals to build their own future. Together with our local partner organisations, we encourage and help underprivileged people to do just this. Our hope is that in this way they will gain a better life and a valuable place in society.

Cordaid is active in Africa, Asia, and Latin America, and focuses on the following spheres of activity: emergency aid and reconstruction, health and well-being, entrepreneurship and economic independence, participation and strengthening the position of minorities.

*You can find more information about these spheres of activity in the following four brochures:*

Cordaid and **health and well-being**

Cordaid and **emergency aid and reconstruction**

Cordaid and **participation**

Cordaid and **entrepreneurship**