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The Roads to a Healthy Future (ROADS II) Project

Final Project Report

August 1, 2008-July 31, 2014

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August 1, 2008—July 31, 2014

Prepared by:

FHI 360/ROADS II Project

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Acronyms and Abbreviations

AB	Abstinence and Be Faithful
ABC	Abstinence, Be faithful, (use) Condoms
ANC	Antenatal Care
ART	Antiretroviral Therapy
ATGWU	Amalgamated Transport and General Workers Union
CBD	Community-Based Distributors
CHWs	Community Health Workers
CSW	Commercial Sex Worker
FP	Family Planning
GBV	Gender-Based Violence
HBC	Home-Based Care
HTC	Home Testing and Counseling
IUD	Intrauterine Device
LWA	Leader with Associate
MARPs	Most-At-Risk-Populations
MCH	Maternal Child Health
MNH	Maternal Neonatal Health
MVC	Most Vulnerable Children
RH	Reproductive Health
OP	Other Prevention
OVC	Orphan and Vulnerable Children
PE	Peer Educator
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
SBA	Skilled Birth Attendants
SDM	Standard Days Method
SRC	*SafeTStop* Resource Centers
SDM	Standard Days Method
SDP	Service Delivery Points
TBA	Traditional Birth Attendant
TOT	Training of Trainers

Executive Summary

The Roads to a Healthy Future (ROADS II) Project was a five-year Leader With Associate (LWA) award funded by the U.S. Agency for International Development (USAID)/East Africa (EA) and bilateral USAID missions. The Award was issued on September 15, 2008 with a period of performance starting August 1, 2008 through July 31, 2013 at a total estimated amount of $ 109,000,000. However, during the life of the project, the Award received 10 modifications which extended the end date to July 31, 2014 and with the high level of buy-in by Missions, revised the project's total estimated amount to $ 200,000,000.

The Project focused specifically on vulnerable communities along regional transport corridors in East, Central and Southern Africa, including border towns historically underserved with health and development programming. ROADS II, the follow-on to the successful Regional Outreach Addressing AIDS through Development Strategies (ROADS I) Project, went beyond HIV prevention, care and support, to address family planning/reproductive health (FP/RH), maternal, newborn and child health (MNCH), nutrition, malaria, and health systems strengthening.

The Project's goal was a *Healthier Population in the East Africa Region Achieved through African Leadership.* The expected results were: effective programs in HIV/AIDS and health implemented that increase the number of people served with prevention, care, treatment and support services; promising practices/new approaches promoted to improve outcomes in health and HIV/AIDS; and African capacity to respond to key health and HIV/AIDS issues increased.

Over the five years of implementation, the Project largely met or exceeded its targets across the program areas and interventions, both for the mobile populations it has served and the interacting local community members.

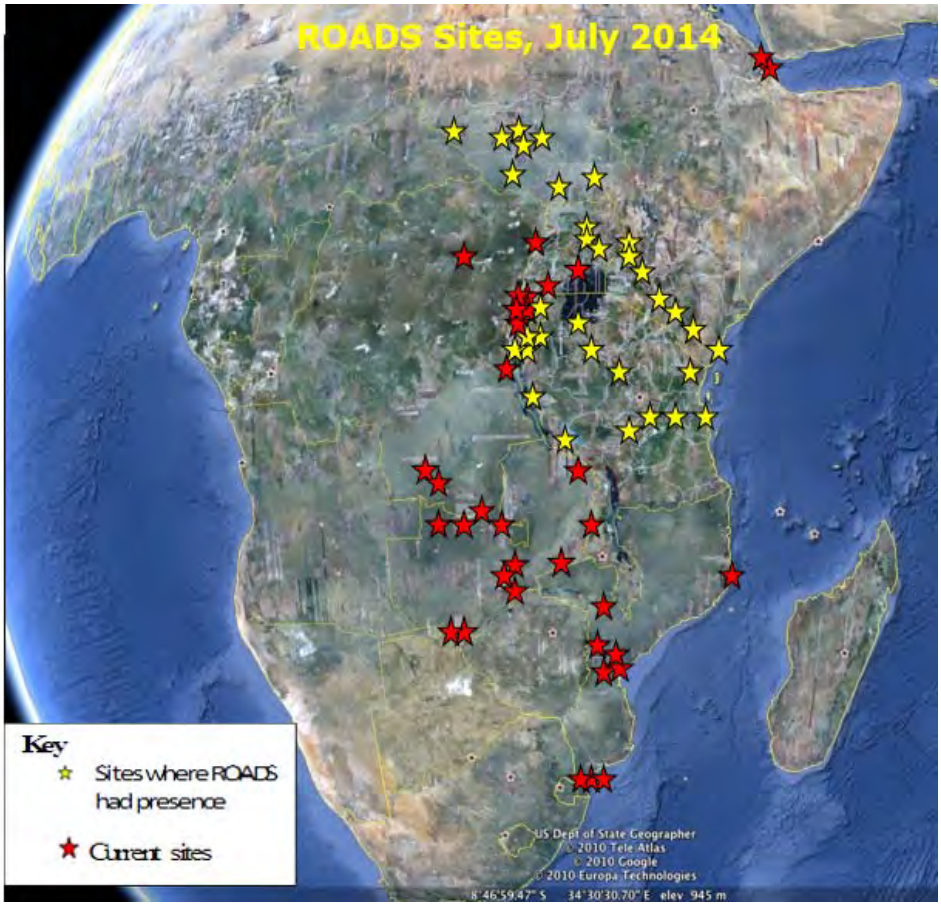
ROADS also added new interventions to its original programmatic purview, thus extending the range of health and development services provided, including gender-based violence (GBV) prevention, alcohol abuse counseling and support groups, nutritional support to families and individuals through the innovative design and training provision of community gardens and bio-intensive gardens. ROADS provided economic strengthening through the creation, training, and support of local Group Savings and Loan Associations (GSLAs), a key development model that strengthens the economic resilience of communities, families, and individuals, with savings enabling greater access to health services.

A key innovation by the Project was the Cluster Model. The use of this model has contributed to an improved quality of life of the cluster members individually and at an organizational level. Through this approach, ROADS provided a unique model of development, which builds capacities at the grassroots level through horizontal and vertical learning processes, utilizing immediate social networks that previously were informal, and strengthening organizational and leadership skills to implement what formerly were ad hoc responses by communities to address their needs. Moreover, the cluster model has proven successful in mobilizing communities sustainably.

Towards the end of the Project, an evaluation was conducted by a team of external consultants. Some of the key findings from the evaluation report indicate the Project addressed the following rationales:

- **Public Health:** ROADS target groups are at the highest risk of HIV infection and for onward transmission of HIV/STIs nationally and internationally.
- **Human Rights:** ROADS target groups remain underserved by all health services, and these groups are generally socially marginalized and stigmatized.
- **Global Health Initiative (GHI):** The ROADS approach supports the GHI approach, encompassing HIV/sexually transmitted infections (STI), Tuberculosis (TB), malaria, MNCH, sexual and reproductive health (SRH) and FP as an integrated program under one umbrella, which has adaptable intervention priorities based on the programmatic flexibility to address the local needs, as well as build local ownership by communities and a more intensive focus on capacity building and sustainability.
- **Sustainable Development:** ROADS uses a holistic development framework for programming including economic strengthening, which is increasingly recognized as essential to overcome the inferior health conditions and socioeconomic vulnerabilities in sub-Saharan African countries.
- **Gender:** ROADS takes a gendered approach to its interventions, including gender equity, increasing access to essential services for women and men and increasing individual and community understanding of the related socio-cultural issues, including GBV, alcohol and substance use, and other behaviors that increase individual and community vulnerability to ill-health and socio-economic dissolution.
- **Structural Change:** ROADS strengthens existing community structures, including community based organizations (CBOs) and local associations, to build and maintain social networks to support health, economic development, food security, and healthy behavioral and social norms as well as enforce laws and provide legal support, where needed. The lack of addressing relevant structural obstacles and issues remains a major impediment to increasing HIV prevention practices and gender equality, and decreasing poverty in sub-Saharan Africa.
- **Globalization:** That ROADS II Project has increased its focus on food supply and nutritional support through a variety of initiatives, such as the bio-intensive individual and community gardens, highlights its flexibility as an initiative capable of encompassing a wider array of development options in partnership with other entities—governments, non-governmental and community organizations, nationally and regionally.
- **Humanitarian:** In several of the ROADS countries, the number of refugees, and other mobile populations using transport corridors, is increasing. Future corridor initiatives also should recognize the current or potential need, where relevant, to create linkages with or incorporate humanitarian-focused programming into the overall response and intervention mix to be able to have a greater impact on the communities served.

ROADS II Project Sites Since 2005



Maps showing ROADS sites in 2006 and in 2014. Since inception, ROADS worked in 70 sites in 11 countries along transport corridors in East, Central and Southern Africa.

Section 1: Introduction and Context

ROADS II was operational in the following countries in East, Central and Southern Africa: Burundi, Djibouti, Kenya, Mozambique, Rwanda, Tanzania, Uganda, Democratic Republic of Congo (DRC) and Zambia. Countries with previous ROADS programming included: South Sudan and Ethiopia. Despite encouraging signs in the fight against AIDS in East and Central Africa, HIV continues to spread rapidly in many of the region's poorest communities. This is particularly true in hotspot communities along major transport corridors, where HIV prevalence is often twice as high as national estimates and essential health services are weak or non-existent.[1] The combination of poverty, concentration of mobile truck drivers and other transient workers, hazardous sexual networking, and a dearth of quality health services create an environment of elevated risk. These communities are complex environments:

They are frequented by a significant number of truck drivers-150-300 per day[2] in many corridor communities-who spend long periods away from their families and health providers. The drivers, who are two to three times more likely to be HIV-positive[3] than the general population, often exhibit heavy alcohol consumption, abusive behavior and low levels of condom use.[4] They often find themselves at odds with host community members, who see them as scapegoats for social ills found within[5].

In addition to transport workers, many men, women and children in hotspot communities are also mobile as a result of forced migration from conflict and violence[6] or in search of livelihood opportunities. While working outside their own country or community, women and children are particularly vulnerable to trafficking.

Concurrent sexual partnerships are a norm for both men and women. Many women, up to 80 percent in some of the communities where ROADS works, befriend truck drivers and other men in their communities for gifts, companionship and/or financial support[7]. For mobile men, these relationships form their social network on the road. The relationships are complex, bringing both reward and risk, including HIV and gender-based violence (GBV). GBV is endemic in many of these communities, inhibiting many women from accessing FP/RH and HIV services.

The towns are home to large numbers of PLHIV who succumb more rapidly to AIDS due to poverty, poor nutrition and limited access to health services. AIDS-affected households are often food insecure even in "breadbasket" areas such as Western Province, Kenya, and the Southern Highlands of Tanzania.[8] Another major barrier to HIV and other health services is distance to health facilities. In ROADS sites, it is not uncommon for the nearest health center or district hospital to be 25-50 kilometers from the town center. Many people are too poor to afford transport, where it exists. Higher mortality and morbidity lead to increased numbers of vulnerable children including orphans, who lack access to immunization, nutrition, growth monitoring and other services.

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[1] *Roads to a Healthy Future* RFA.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Morrison N. Chester and Alan Ferguson. 2005. Hot spot Mapping of the Northern Corridor Transport Route: Mombasa-Kampala. University of Manitoba and University of Nairobi.
[8] *Roads to a Healthy Future* RFA.

Unemployment is a spiraling problem in towns along regional transport corridors. In some cases up to 70 percent of the population is unemployed or chronically under-employed (Universities of Nairobi and Manitoba, 2004). In such environments, alcohol abuse is endemic, often leading to physical and sexual abuse of women and children.

1.1 Building on ROADS I Foundations

ROADS II was a follow-on Project to the Regional Outreach Addressing AIDS through Development Strategies (ROADS I) a five-year USAID project (September 1, 2005 – December 31, 2010). The Project built on ROADS I's successes considering the comprehensiveness of the program that recognized the need of organizing strong prevention measures combined with treatment and care and support with in-built sustainability – both organizational and financial. In addition, the Project addressed several key recommendations identified during ROADS I's external mid-term evaluation conducted in January 2005 which included the following:

Key Mid-Term Recommendation	ROADS II's Response
Expand country-level and liaison staff	• ROADS expanded its staff from 58 in 2008 to 184 in 2012, decentralizing key functions to fully staffed country teams (technical, program, finance) linked through the regional platform • ROADS Country Managers liaised regularly with USAID AORs and other USG staff and partners (monthly and quarterly meetings, site visits, etc.) • ROADS integrated itself into a range of national planning bodies, including ministry of health, ministry of transport, ministry of gender and PEPFAR TWGs
Strengthen project M&E system	• ROADS strengthened country M&E structures and systems. Each ROADS country office had dedicated M&E Officers and selected countries had Data Managers based at the sites to provide regular and immediate support to local IPs or based at the country office to maintain databases and collect information for national and regional reporting • ROADS strengthened IP M&E systems through training of staff and deployment of Data Management staff in selected countries • The project developed a regional integrated database replacing multiple formats previously used. The database met the data needs of the complex, multi-faceted project yet was easy to use at the IP level. ROADS populated the database with service statistics to better correlate inputs and outcomes • ROADS revised project M&E plans and developed country-specific PMPs responding to ROADS I recommendations and emerging data needs. This included revision of tools and development of new tools and guidelines • ROADS strengthened its data quality assurance mechanism through development of a participatory data quality assessment checklist and guide used periodically to assess the quality of data at the IP level. IP

	skills in data quality assessment were strengthened for routine data quality assessments during implementation • ROADS' research agenda was strengthened significantly. The project conducted behavioral monitoring surveys (BMS) in selected countries to: 1) provide a baseline to estimate project contribution to observed outcomes; and 2) provide site-level outcome data for use by all stakeholders ROADS strengthened its site and technical assessment tools and conducted qualitative and quantitative studies to inform programming.
Explore and negotiate partnerships with regional bodies and other donors	• ROADS continued working with the East, Central and Southern Africa Health Community (ECSA-HC) • ROADS was enlisted by USAID/Southern Africa to participate in a Southern Africa Development Community (SADC) donor meeting to share project approaches in transport corridor programming (September 2011) • ROADS participated in East African Community (EAC) Regional HIV and AIDS Partnership Forums (2009-2011, 2014), and is a member of the EAC Task Force to develop a regional strategy for transport corridor programming • ROADS continues to receive UNICEF funding in Djibouti for youth-focused programming in PK 12 and Balbala • The project continues collaborating with the private sector, including Dubai Ports World (Djibouti) and General Motors (Kenya)
Clarify the applicability of the LifeWorks approach in multiple contexts beyond Kenya	• Strategic review of LifeWorks in FY 2009 led to adaptation of the OHA Economic Strengthening pathway approach to working with HIV-affected households, based on: i) strengthening internal savings & loans; ii) maximizing household production; and iii) preparing for commercial readiness. The revised approach was successfully implemented in Rwanda, Tanzania and Zambia.
Formalize the branded ROADS package for easy adoption and franchising along the corridors	• The Kenya Ministry of Transport adopted *SafeTStop* branding and replicated it along key roads and highways in the country • Dubai Ports World is establishing a *SafeTStop* Community Center in Djibouti, with plans to expand an adapted model to Mozambique and Senegal
Improve targeting of risk and vulnerable groups, particularly young women	• Under ROADS I, youth clusters reached significant numbers of young people, but not necessarily those most at risk. Under ROADS II, the project made concerted effort to identify and reach most-at-risk young people, particularly younger, highly vulnerable female sex workers (Burundi, Djibouti, Mozambique, Rwanda and Tanzania) • Adapting strategies from Avahan/India, ROADS II Rwanda increased the number of "hidden" FSW reached with prevention, care and support services from 596 in 2009 to 2,310 by in 2014.
Hold regional dissemination for sharing and input from Missions and partners	• ROADS organized two (2010 and 2011) Agreement Officer Representative (AOR) meetings to bring together USAID counterparts from across the region to discuss lessons learned, best practices and new horizons.

	• ROADS organized cross-country exchange visits to accelerate shared learning • Community partners attended ROADS regional meetings and were supported by the project to attend donor forums (e.g., Busia, Kenya IP presented at the PEPFAR Southern and Eastern Africa Technical Consultation on Alcohol and HIV Prevention, April 2011) • ROADS continued to support the African Network for Strategic Communication in Health and Development (AfriComNet) in organizing and convening practicums on key HIV and AIDS topics (three FHI 360 staff are Board members) • ROADS developed features for dissemination through USAID and FHI 360 channels (e.g., *SafeTStop* exhibition in US Embassy, Nairobi, Kenya, May 2012), dissemination of ROADS II Evaluation in Washington DC, Dec 2012. • ROADS presented abstracts at national and international forums. It won Best Abstract from RBC-CNLS Rwanda for abstract on "Socio-Economic Impact and Socio-Support" June 2011 and exhibited a poster "Capacity Strengthening for CBOs" during International AIDS Society (IAS) conference in 2012
Negotiate with government, regional and donor programs to provide continuity of ART for truckers	• ROADS II negotiated with Reach Out Mbuya, a CDC/Uganda clinical partner, to provide ART re-supply at the *SafeTStop* Resource Center in Mbuya-Kinawattaka, Kampala for truckers in collaboration with ATGWU (implementing partner).
Document cost aspects of the model to enhance replicability	• ROADS closely tracked programming costs including costs of establishing and supporting clusters. • ROADS with technical assistance from an FHI 360 health economist developed a cost-tracking system for specific services supported by the project. This became an important tool used to develop FHI 360's PEPFAR expenditure reporting.

1.2 Overview of Project

ROADS II's vision was to leave communities stronger. The Project's philosophy was to lay a small footprint so that communities can develop and manage African-led and African-owned responses to health and development needs, innovate as necessary, and sustain these responses over the long-term. The Project envisioned continued full and active participation of all segments of community life. By placing the community as a whole at the center of design and implementation-rather than ceding these responsibilities to a few larger implementing agencies, FHI 360 ensured that ROADS II went beyond a project with a fixed shelf life to an engine for sustainable development.

1.3 Goal, Objectives and Expected Results

Goal: The Project's goal was a "Healthier population in the East Africa Region Achieved through African Leadership."

Objectives:

- Extend HIV and broader health services to underserved, most-at-risk mobile and community populations along the ECSA transport corridors and waterways.
- Build the capacity of indigenous partners to design, implement and manage programming of their own design over the long term, in line with the GHI.
- Identify, test and diffuse innovations throughout sub-Saharan Africa.

Expected results were:

- Effective programs in HIV/AIDS and health implemented that increase the number of people served with prevention, care, treatment and support services.
- Promising practices/new approaches promoted to improve outcomes in health and HIV/AIDS.
- African capacity to respond to key health and HIV/AIDS issues increased.

1.4 Project Partners

ROADS II was implemented with support and collaboration of different partners. The team was composed of FHI 360, Development Alternatives Inc. (DAI), Howard University (HU)/ Pharmaceutical Care and Continuing Education (PACE) Center, the Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (JHU/CCP), Jhpiego, North Star Alliance (formerly North Star Foundation), PATH, Solidarity Center and Voice for Humanity (VFH). In addition, the Project worked with local, regional and international organizations partners. These include over 530 indigenous volunteer groups, institutions addressing technical areas (e.g., MIFUMI in Uganda for GBV), private businesses and corporations (e.g., General Motors East Africa, Dubai Ports World), faith-based organizations, the East, Central and Southern Africa (ECSA) Health Community, the African Network for Strategic Communications in Health and Development (AfriComNet) and multilateral institutions such as the Joint United Nations Programme on HIV/AIDS (UNAIDS).

1.5 Strategic Approach

ROADS programming was implemented under six *SafeTStop* pillars, which encapsulate the Project's development approach as follows:

- Create a safe environment for people to talk openly about HIV and other health issues, and promote health seeking behavior;
- Safeguard health through increased use of quality HIV and other health services;
- Enhance economic and food security as a prevention/care and community sustainability strategy;
- Reduce alcohol/substance abuse as barriers to health seeking behavior;
- Improved access to safety nets for most vulnerable families and children;
- Safeguard women and children from violence and sexual exploitation.

Section 2: Beneficiaries/Target Groups

The Project worked with mobile populations and host communities along the transport corridors. These included the following:

- Sex workers

- Men who have Sex with Men (MSM)
- Out-of-school youth
- Low-income women (LIW)
- Truckers and their assistants
- Fishing population
- Taxi drivers including motorcyclists (*boda boda)*
- Orphans and most vulnerable children (OVC)
- People living with HIV (PLHIV)

Section 3: Results

3.1 COMPONENT 1

3.1.1 Pillar 1: Create a safe environment for people to talk openly about HIV and other health issues, and promote health seeking behavior

The Project promoted healthy behaviors through community 'cluster' organizations, which capitalize on routine interpersonal communication through trusted networks, as distinct from other models that utilize sporadic interaction and one-off special events. The cluster model, a ROADS innovation, involved the full range of indigenous volunteer groups who contribute to their community. With technical assistance from ROADS they identified needs, planned and implemented together, drawing on many of their own resources (e.g., thousands of hours of volunteer time, community facilities) and using donor funding as a catalyst, not a mainstay.

Since inception in October 2005, the cluster model increased the number of community volunteers participating in HIV programming in transport corridor communities. By 2014, ROADS was working with 110 clusters including 1,445 community groups and 121,020 individual members, against a baseline of 24 clusters, 237 groups and 25,394 members in 2006. Through community mobilization and outreach (e.g., peer education, counseling, magnet theater) these volunteers—the vast majority participating in a donor-funded program for the first time—have generated significant uptake of services supported by other USG partners.

Since 2005, ROADS worked with 110 clusters including 1,445 community groups and 121,020 community members.

During the Project implementation, the community clusters harnessed their networks to promote strengthened FP/RH, malaria, MNCH and TB services, while continuing to address HIV/AIDS, alcohol abuse, GBV and other salient issues. The clusters' linkages with public and private providers, including pharmacists/drug shop operators were also strengthened. In addition, strategic communication skills of community volunteers and health providers were strengthened to effectively promote the different services.

To ensure this worked, roles were shared among the following strategic partners: PATH took the lead in *SafeTStop* branding and capacity building for community mobilization and outreach; Solidarity Center and VFH spearheaded ROADS' efforts to mobilize and educate truck drivers at *SafeTStop* Resource Centers; North Star Alliance managed primary health care and HIV related health services at the

Resource/Wellness Centers; HU/PACE Center was responsible for strengthening pharmaceutical care capacity across the region and JHU/CCP was responsible for developing/adapting materials, messages and campaigns to promote essential health services and health-seeking behaviors. Jhpiego was the clinical service partner. DAI supported FHI360's economic strengthening component under ROADS II.

3.1.1.1 Community mobilization and outreach. ROADS staff at the sites worked with communities and partners to integrate discussions of broader health services into their ongoing HIV activities. This was done through peer educators trained to promote health messages and promote the full menu of services among hard-to-reach populations (such as sex workers) and vulnerable audiences. This included correcting misinformation about long-term FP methods, and promoting greater uptake of HIV testing and counseling (HTC) and antenatal care (ANC) services. In several ROADS sites, community mobilization and outreach also addressed alcohol abuse, GBV and good nutritional practices especially among undernourished children. In others, the project varied and adopted ways to reach the intended audiences. In Djibouti for instance, implementing partners and their member associations conducted community mobilization through Magnet Theater, musical shows and movie projections. This was geared towards increasing awareness of HIV risk and prevention among project target groups, promote adoption of personal risk management in regard to HIV/AIDS and promote HTC. ROADS also participated in community, national and global events such as World AIDS Day to sensitize communities on different issues.

3.1.1.2. Bridging mobile audiences and transport corridor communities. ROADS network of S*afeTStop* Resource Centers was the locus of strategic communication for truck drivers visiting hotspot communities. On-site, full-time coordinators and peer educators affiliated with local transport unions and associations discussed health issues with the drivers who visited each of the Project's alcohol-free centers daily for information, services and relaxation.

SafeTStop Resource Center in Tanzania

In Djibouti for instance, it is estimated that 1,300 trucks daily go through PK 12, the main truck stop crossing the Djibouti-Ethiopian border. The number of average days a truck spends in Djibouti is also estimated at five days. The total estimated mobile population at PK12 per night is approximately 4,200 individuals. ROADS worked with transport unions and associations to recruit and train peer educators, who discussed health issues with truckers visiting the *SafeTstop* Resource Center. These included HIV prevention, HTC promotion, condom distribution, and diagnosis and treatment of sexually transmitted infections.

Similar services were also offered in Burundi, Kenya, Mozambique, Rwanda, Tanzania and Uganda. In Uganda's Mbuya-Kinawattaka, the Resource Centers also provided free toilet and laundry facilities and a prayer room for use by Muslim truck drivers.

Another tool used was the "Sauti" MP3 device that ROADS distributed during ROADS I to drivers at Resource Centers in Kenya, Rwanda and Uganda, as well as through clusters for use at the community level. The easy-to-use audio devices included several hours of health-related content, which truck drivers and turn boys could listen to with their peers while on the road. With the end of the Associate Awards in Kenya and Uganda, support to unions declined and in Rwanda, ROADS stopped working with the union due to financial mismanagement. As a result, the mechanism for distribution and coordination of the devices could not be implemented. To facilitate sustainability, the lesson learned was on the need to expand coordination mechanisms for reaching transport workers rather than solely relying on trucker unions.

3.1.1.3. Deepening reach through immediate social networks. ROADS II strengthened and expanded the *immediate social network (ISN)* approach, an approach pioneered under ROADS I to maximize the quality and frequency of interaction among trusted individuals. Under this approach, ROADS broadened "peer" to include not only people in an educator's age cohort, but also those older or younger with whom s/he has a trusted relationship (e.g., family members, neighbors, customers). Through these networks, peer educators promoted healthy behaviors such as consistent use of insecticide treated bednets (ITNs) especially for children and pregnant women, immunization, increased uptake of ANC services, and referral for TB screening.

Using this approach, ROADS developed a distinct social networking strategy to identify "hidden" sex workers in *SafeTStop* sites, based on the Indian Avahan model and link them with other health services. This approach was used in Djibouti, Rwanda and Tanzania. Sex workers were identified and trained as peer educators. Thereafter, the trained sex workers, who acted as leaders, mobilized their peers from their hot spots. They formed a group of 10 and a peer educator was responsible to support her peers by delivering health education messages through small group discussions, and one-on-one peer support. They also promoted consistent condom use and demonstrated their correct use, and promoted adoption of other HIV risk reduction behaviors. In Djibouti, the identified sex workers formed Sister-to-Sister groups. Due to stigma, sex workers in Djibouti sometimes were unable to pick condoms from health facilities. ROADS II used this ISN approach to distribute the government-free condoms to them through peer educators.

3.1.1.4. *SafeTStop* branding. To promote the concept that an entire community, rather than just a Resource center, is a *SafeTStop,* and to clearly identify strengthened service networks, ROADS designed and adapted *SafeTStop* branding for low-literacy audiences in site-specific languages. This included wall branding and signage featured at pharmacies/drug shops, health facilities, bars and lodges, and other outlets participating in the program. Prior to production, all the materials were pre-tested in national and local languages (French, English, Arabic, Kiswahili, Amharic, Portuguese etc.) with truckers and host communities for message comprehension, recognition, visual appeal and call for action.

To promote the expanded menu of services, ROADS built upon this established regional branding campaign-visually distinct and clearly recognizable along the transport corridors to evoke discussion, trial and acceptance of healthy behaviors. ROADS existing campaign included images that resonate with both mobile populations and local communities; for example, the stoplight image that appears on the resource centers is identical to a traffic light image that appears in truck driver training manuals from around the region.

3.1.1.5 Message development to promote essential health services. According to the health priorities of each country, JHU/CCP supported the roll-out of improved FP/RH, malaria, MCH and TB services by creating an inventory of messages, materials and campaigns used to promote these services around the region. They adapted and reproduced them in select *SafeTStop* communities, reinforcing client education and counseling provided at the facility and community levels.

One of the posters developed in Kenya

ROADS offered technical support to Kenya, DRC, Djibouti, Mozambique and Tanzania to develop behavior-specific HIV prevention messages. Through an innovative community messaging process, messages were harvested from targeted focus groups (female sex workers, truckers, youth, OVC, artisanal miners, fisher folk, PLHIV and community men and women), and were developed in collaboration with governments and other stakeholders.

The process involved rapid assessments at communities, which informed creative workshops with target audience, governments and other stakeholders. Messages were drafted and pre-tested, reviewed and submitted for approval by respective authorities at the Ministry of Health. These were later used to contextualize messages and material production. In Kenya, among the messages and posters produced included messaging on anal sex (first ever), condom use, alcohol and substance use. The posters were successfully uploaded onto the National AIDS and STIs Control Program (NASCOP) website for use by national implementing partners and print materials were distributed along the Northern transport corridor. Based on local needs assessments and identified priorities, key themes varied across countries. For example, in Djibouti, the messages addressed female sex workers (FSWs) and consistent condom use, female sex workers and drugs, ART adherence, and stigma and discrimination against PLHIV by health personnel. In DRC, the key themes focused on condom use for FSWs and artisanal miners, GBV and alcohol use.

The messages were incorporated in peer education trainings and peer educators discussed them during small group discussions and one-on-one sessions.

3.1.2 Pillar 2: Safeguard health through increased use of quality HIV and other essential Health Services

Transport corridor communities and the mobile workers who interact with them have historically been underserved not only by HIV/AIDS services but by other essential health services as well, including

FP/RH, STI, malaria, MCH and TB. During ROADS I, the Project helped develop community infrastructure, including strong relationships with District Health Management Teams (DHMTs). These provided an excellent opportunity to extend the expanded menu of services in ROADS II.

3.1.2.1. Rapid baseline assessments. *Roads to a Healthy Future* provided an opportunity not only to introduce new programming to improve essential health services along regional transport corridors but also to take stock of, improve and expand access to HIV services provided. Requests by USAID missions to expand/improve health services in *SafeTStop* communities were addressed through a rapid but systematic process that built on the Project's commitment to put transport workers, community groups and health care providers at the center of identifying needs and devising sustainable solutions relevant to their resource levels.

The Project conducted rapid baseline assessments that informed ROADS II programming which included identifying perceptions and practices of community members and transport workers regarding priority health issues, strengths and gaps in current services, and the optimal roles of community institutions (e.g., clinics, district hospitals, pharmacies/drug shops, S*afeTStop* Resource Centers, and community volunteer groups) to contribute to improved services. The second step involved assessing the health facilities/services within the context of community morbidity and mortality patterns. For health centers and district hospitals, the assessment included assessing the physical infrastructure; number and cadres of staff; type and extent of services offered including such elements as immunization coverage, FP uptake and HTC provision; adequacy of supplies and logistics; and management and supervision systems. FHI 360 and its clinical services partner, Jhpiego used facility-based assessment tools that were adapted as necessary for use in typically small, resource-constrained transport communities. For pharmacies/drug shops, HU/PACE expanded its HIV assessment tool to diagnose skills, physical facilities, and gaps in the public and private pharmaceutical care sector. Community-based outreach health services (e.g., directly observed therapy (DOTS) for TB, HTC, contraceptive and ITN distribution) were also assessed for capacity of volunteer personnel, adequacy of physical facilities, supplies and materials, and uptake of services.

These internal assessments were conducted by teams comprised of community cluster members and health providers assisted as necessary by *Roads to a Healthy Future* staff or consultants. The results were shared at inclusive stakeholder meetings to validate conclusions, prioritize health gaps and needs, and map how all existing facility- and community-based resources applied synergistically, could respond to these needs. These stakeholder meetings provided the impetus for the establishment or strengthening of community health management teams with representation of community- and facility-based service providers as well as end-users.

3.1.2.2 Enhancing the quality and range of HIV/AIDS services. Since October 2005, ROADS extended HIV/AIDS palliative care services in transport corridor communities where these services were previously nascent or non-existent. By the end of the Project, ROADS II had trained more than 2,100 local volunteers from PLHIV, youth and low-income women clusters to deliver home- and community-based care services according to national standards and guidelines. In addition, 480 pharmaceutical care personnel were trained to provide HIV/AIDS care and referral in transport corridor sites, with a focus on ART adherence, treatment literacy and pain management.

The Project worked with community- and facility-based services in all sites to implement quality assurance (QA)/quality improvement (QI) systems based on international standards, including processes and tools adapted for transport corridor settings. ROADS staff promoted regular supportive supervisory assessments using standardized FHI 360 checklists to review performance in terms of SOPs. A key strategy adopted was to work with cluster members and health facilities to establish an internal QA/QI program for continuous analysis and improvement of services delivery, including timely replenishment of home-based care kit supplies consistent with minimum standards. In Burundi, for instance, the Project seconded medical doctors to hospitals in ROADS sites to offer technical support and mentor staff for effective HIV/AIDS management. This proved vital in aiding such services as HIV/TB integration and improving the quality of care for PLHIV in the country. The project also increased the number of adults and children living with HIV who received clinical care and treatment, including ART, through expansion of outlets and improvements to laboratory services. Consequently, the number of PLHIV on cotrimoxazole prophylaxis increased from 3,606 in 2008 to 9,950 in 2013.

In Burundi, the number of PLHIV on cotrimoxazole prophylaxis increased from 3,606 in 2008 to 9,950 in 2013.

In Djibouti, 144 counselors were trained; 7,335 individuals were counseled, tested and received their HIV test results.

In Uganda, 73,112 individuals were tested for HIV and received their results.

In Djibouti, in 2009, the Global Fund to Fight TB, AIDS and Malaria (GFTAM) discontinued funds to the Government of Djibouti and therefore the Executive Secretariat (National AIDS Control Council) was not able to provide HTC consumables (gloves, alcohol, needles, tubes, withers, cotton, etc.) to health facilities in the country despite the availability of test kits. The Project supported the Government of Djibouti by facilitating provision of HTC services at four health facilities; PK12 Health Center, Einguela Health Centre, Paul Faure Hospital (national referral hospital for tuberculosis), and Centre Yonis Toussaint (national referral center for STI/HIV/AIDS) through procurement of HTC consumables. This led to an increase in the number of people who tested compared to previous years. In order to offer quality services, 144 counselors were trained and a total of 7,335 individuals were counseled, tested and received their test results during the life of the Project.

In Uganda, ROADS II worked closely with the MOH to ensure quality of HTC services delivered at health facilities and fixed outreach points (e.g., *SafeTStop* Resource Centers) and consistent supply of HIV testing kits. ROADS II also created linkages with other USAID implementing partners such as AIDS Information Center (AIC), which provided support supervision in quality assurance of HTC services. In addition, ROADS partner, ATGWU worked with Kamuganguzi Health Center H/C III staff to provide QA to the HTC activities at the SRC and to conduct fixed outreaches for HTC in places frequented by truck drivers in an effort to ensure that HTC is carried out following the Ugandan National HTC guidelines. Support supervision and training for implementing partners, HTC volunteers and HTC laboratory staff were conducted regularly. A total of 73,112 individuals were tested and received results and those who turned HIV positive were referred to partnering facilities and organizations for further care and treatment.

3.1.2.3 Ensuring continuous access to ART among transport workers. In April 2005, the Expert Sub-committee on Harmonization of the East African Community (EAC) met to facilitate implementation of the EAC Council of Ministers decision of November 2004 urging partner states to negotiate as a block with manufacture and/or patent holders for procurement of HIV-related medications in the region. Despite significant strides by EAC, full adoption of recommended harmonized regimens and implementation is yet to bear fruit. The mobile cross-border population, especially truck drivers, continue to bear the brunt of this delay. As of June 2014, ROADS II continued engaging different stakeholders including EAC and ECSA at the regional policy level and at the national and site levels to enhance access.

ROADS provided space at the *SafeTStop* Resource Centers for fixed outreach ART services provided by clinicians, including medication refill and patient counseling tips on adherence and side effects. In 2013, ROADS II in Uganda collaborated with Reach Out Mbuya, a CDC-funded non-governmental organization (NGO) in Mbuya-Kinawattaka to establish an ART clinic/refill point at the Mbuya-Kinawattaka *SafeTstop* Resource Center specifically targeting mobile truck drivers and sex workers. This innovative refill service was carried out twice a month at the Resource Center as an outreach distribution site for the Reach Out Mbuya ART program. Reach Out Mbuya provided trained personnel from their ART department to carry out same-day CD4 count testing to those who test positive for HIV at the Resource Center, and provided ART to those who met the CD4 count requirements. ART refills were provided to truckers who were enrolled either at the Resource Center or at Reach Out Mbuya Health Center. Such a model offers opportunity for regional replication.

Abdalla Ssempijja, one of the clients benefitting from the arrangement between SafeTStop Resource Center and Reach Out Mbuya extending ART services to key populations in Mbuya Kinawattaka.

ROADS together with ATGWU organized mini-talks and presentations with truck drivers on drug adherence, carrying adequate chronic medications when traveling, and use of *SafeTStop* Resource Centers and other recommended health outlets along transport routes.

3.1.2.4 Extending essential clinical health services in *SqfeTStop* sites

Strengthening sites to deliver high-quality FP/RH, malaria, MCH and TB services in facilities and communities. With funding from USAID/EA, ROADS extended FP/RH and GBV services in ROADS II sites, recognizing the project's close partnerships with local health facilities and deep reach in communities. This support was a continuation that built on ROADS I FP/RH and GBV interventions.

The rationale for integrating FP/RH and GBV services into ROADS programming is that FP reduces mother-to-child transmission of HIV and maternal and neonatal deaths; members of cluster groups partnering with ROADS across the region had unmet FP/RH needs; there was high prevalence of sexual violence; and ROADS design was such that it readily accommodated the inclusion of FP/RH and GBV services into broader transport corridor programming.

ROADS II strategic partners JHU/CCP and HU/PACE Center collaborated in the implementation of activities in the participating countries and built on the FP/RH work initiated under ROADS I, while introducing new activities to address GBV and develop curricula and training modules for FP, GBV and community-based distributors (CBDs). ROADS II partnered with the Institute of Reproductive Health/Georgetown University to pilot Standard Days Method (SDM) in Burundi.

Since inception, the project supported interventions in Burundi, DRC, Rwanda and Tanzania.

Clinical trainings. Having identified the needs of different sites, the following training was offered:

Area	Topics
FP	Contraceptive technology updates (CTU), including methods that are safe and effective for HIV positive women, and FP compliance requirements of the United States Government (USG).
RH	STI and prevention and management of cervical cancer
Malaria	Training on new treatment policies, case management, and prevention of malaria in pregnancy including intermittent preventive treatment (IPT) and distribution of ITNs during ANC.
MCH	Focused Antenatal Care (FANC); Basic Emergency Obstetric and Neonatal Care (BEONC). Focused Antenatal Care (incorporating TB, PMTCT and malaria in pregnancy), prevention of postpartum hemorrhage, skilled care, immunization, growth monitoring, and integrated management of childhood illnesses (IMCI), including safe water.
TB	TB screening, diagnosis (microscopy), treatment directly observed therapy (DOTs), and TB/HIV integration.

ROADS II developed a training module in GBV through working with its strategic partner JHU/CCP that was used for all trainings on GBV. ROADS II strengthened the integration of FP/RH and HIV/AIDS services by training HIV clinic-based health providers in family planning and GBV. *Supportive supervision.* A supportive supervision system (including training follow-up, mentorship for trainees, and data collection) was developed according to the needs of the sites in each country. Where possible, local supervisors were trained, and tools developed to enable them to provide day-to-day on-site supervision of services delivered. Where this was not possible, supervisors

Francine Mukayigire, the nurse-in-charge of Gihundwe Health Center's maternity wing is one of the staff members trained in obstetrics and neo-natal care. The project trained 120 facility and community health workers in Gihundwe, Rwanda.

from ministry of health (MOH) were called upon to perform some of this supervision temporarily while facility-based supervisors were coached and mentored. Where in-house supportive supervision was provided, the MOH followed-up with health providers within three months after training to offer supportive supervision and clinical mentorship. During supportive supervision visits, the knowledge and skills acquired during training were reinforced. Supervisors made quarterly visits to the facilities to check on performance. Occasionally, technical assistance and supervision were provided by ROADS technical staff in the different countries as well as from the Regional Office in Nairobi.

Strengthening systems through facility improvements. Based on the baseline assessment of health facilities, supply of basic equipment and minor renovations were undertaken. This included resuscitation kits, Intrauterine Contraceptive Devices (IUCD) insertion kits, FP buffer stocks, infection prevention supplies such as buckets and safety boxes, furniture, examination tables for ANC, delivery tables, delivery sets and gloves etc. Minor renovations were also done including repainting hospital facilities, partitioning rooms to create additional consultation rooms, repairing leaking roofs, and replacing broken doors and windows. These significantly improved delivery of quality services to communities.

Additionally, in sites where modern contraception was not provided by the available health facilities, such as faith-based facilities, ROADS, together with local authorities, established secondary posts where contraceptives were provided to communities.

*Standards-based management and recognition (SBM-R).*With approval from the District Health Medical Team (DHMT), Jhpiego introduced its proven QA/QI approach, SBM-R. SBM-R is a practical management approach for improving performance and quality of health services. It is based on the use of operational, observable performance standards for on-site assessment. World Health Organization (WHO) standards were used to calibrate the quality of health care offered. Subsequently, the staff measured their own adherence to the quality standards with some assistance from supervisors.

Gikondo Secondary Health Post is one of the facilities established by ROADS Project in collaboration with local authorities in Rwanda to meet the Family Planning needs of the community.

Strengthening household and facility integrated care. The Project supported the improvement of FP/RH services at communities and health facilities. In community, ROADS II provided support to community clusters by training community volunteers in family planning including sexual and gender based violence (SGBV). Trained community volunteers actively sensitized at-risk groups such as sex workers and other community members on the use of family planning services and how to prevent and address SGBV. They also referred clients requiring more services to health services.

In Tanzania, some cluster members were trained as community-based distributors to offer services to communities.

The cluster volunteers disseminated messages of many of the MCH interventions, such as birth planning and sleeping under ITNs. They were also trained and equipped with knowledge and skills on other health interventions, such as community IMCI, hygiene, infection control, and malaria control that are safe and feasible in the home setting. They made referrals to health facilities appropriately due to the strong linkages between themselves and the health facilities.

Strengthening commodity availability and supply chain. ROADS II proactively planned with participating facilities to ensure adequate supplies through existing supply chains.

In each country, ROADS held meetings with key commodity supply agencies and DHMTs to clarify supply mechanisms and determine methods for strengthening commodity supply for health facilities in each site. For clinic-based services, commodities, including drugs, were available through central medical stores/national drugs systems, including PEPFAR's bilateral procurement mechanism. FP commodities were supplied through ministries of health and other donor/FBO/national-linked agencies. Malaria drugs and long-lasting ITNs were supplied by ministries of health and donors. Vaccines were supplied by national governments, United Nations Children's Fund (UNICEF) and other donors in several countries. For community outreach services such as HTC, home-based care and services provided at *SafeTStop* Resource Centers, some supplies were available from local Ministries of Health. To address gaps in commodities for community Resource Center services, the project paid for additional commodities as needed. In some areas, ROADS II budgeted for transport to assist facilities pick up commodities from central supply points.

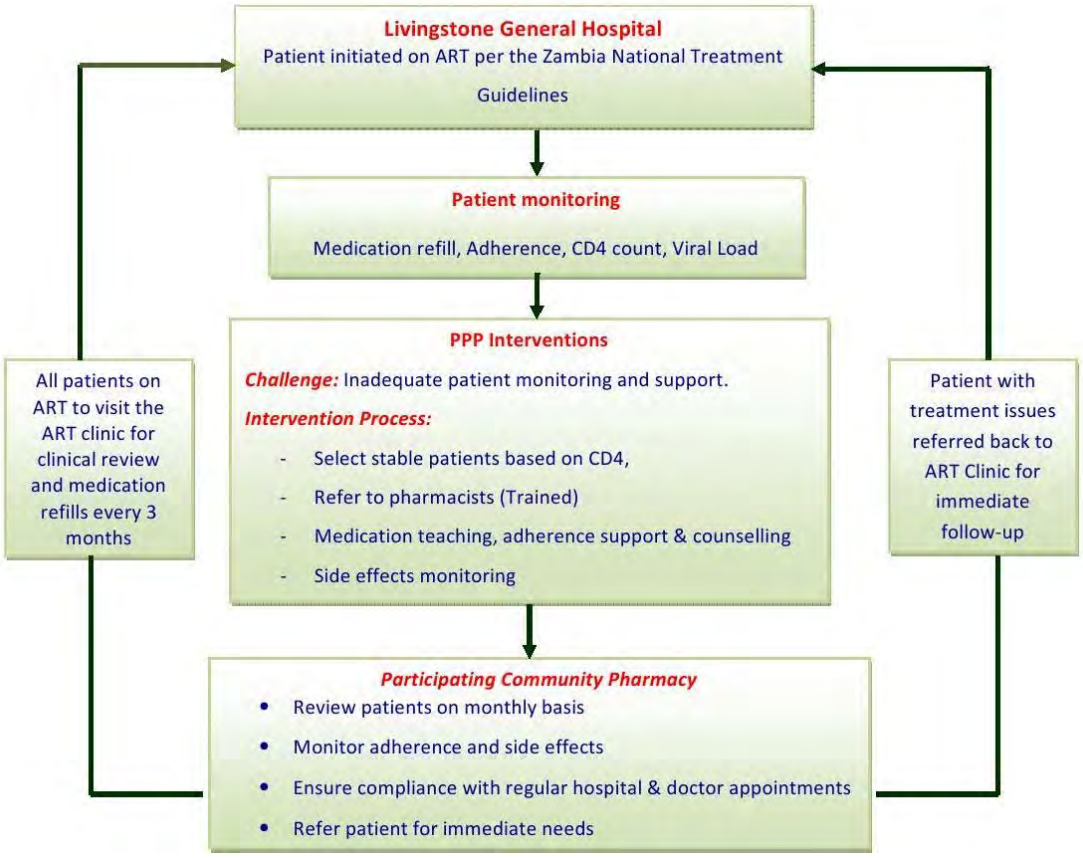
3.1.2.5 Strengthening pharmaceutical care personnel. Pharmacies/drug shops are the first line of care for truck drivers and community residents in *SafeTStop* communities, particularly where health facilities are far from town. Through HU/PACE Center, ROADS continued to build the skills of pharmaceutical care personnel at pharmacies/drug shops and health facilities, recognizing their important role and building on initial work under ROADS.

HU/PACE Center also trained drug store and pharmacy operators from Southern Sudan, Rwanda and Tanzania, on HIV and STI prevention, diagnosis and treatment. The trained drug store and pharmacy operators later organized community outreach activities and also supported communities during their regular facility-based interactions with clients, based on individualized risk assessment and objective needs expressed by clients, and also referred clients for HIV and other health services.

In Kenya, ROADS II through HU/PACE Center supported local pharmacy operators to establish associations e.g., Mariakani Outreach on Drug Use Adherence and Management (MODAM) that supported HIV prevention interventions. ROADS II also developed behavior change communication (BCC) messages and materials in addition to the existing national package which were disseminated to the community by the drug store operators.

In Zambia, HU/PACE Center conducted a HIV/AIDS prevention, treatment and care training targeting private sector pharmaceutical care providers but also involved pharmaceutical care personnel in the various public health facilities and ART clinics in Livingstone, to strengthen their capacity to provide basic HIV/AIDS prevention and management services to their clients.

Thereafter, Livingstone General Hospital in collaboration with the HU/PACE Center (ROADS), partnered with private pharmacies in Livingstone in a 'Public-Private-Partnership (PPP)' to initiate a pilot. This was meant to reduce barriers that prohibit clients' adherence to ART and promote education and information sharing between community pharmacists and the clients. Five community pharmacies were selected and stable ART patients were transferred from Livingstone General Hospital to the local pharmacies for regular medication adherence counseling and patient education. The patients visit the hospital for clinical appointments; while drug collection and other services are obtained at the community pharmacies. This PPP was widely documented through articles in peer-reviewed journals[9].



3.1.2.6. Expanding availability of health services through *SafeTStop* Resource Centers.

The project extended essential clinical and promotional health services in *SafeTStop* Resource Centers by using consistent adapted strategies and branding across countries to increase uptake of quality services among the transient and resident populations. The branding was uniform to increase visibility in a language understandable by the community. To draw truck drivers and other mobile men out of risky environments, ROADS supported a network of branded alcohol-free *SafeTStop* Resource centers, which offered HIV education, HTC, condom distribution, diagnosis and treatment of STIs, referral linkages and

[9] King, RC & Fomundam, HN (2010). **Remodelling pharmaceutical care in Sub-Saharan Africa (SSA) amidst human resources challenges and the HIV/AIDS pandemic**. *Int J Health Plan Manage*. 2010 Jan-Mar;25(1):30-48

Fomundam H, Tesfay A, Maranga A, Chanetsa L, Muzoola V & Oyaro F. (2012). **Identifying treatment and healthcare seeking behavior as a means of early HIV/AIDS intervention in Africa**. *World Journal of AIDS* 2:165-173

Fomundam H., Maranga A., Kamanga J., Tesfay A., Choola T., Nyangu S. & Wutoh A. (2014). **Improving HIV Treatment Adherence through a Public Private Partnership in Zambia** (*World Journal of AIDS*, 4, 107-117)

recreational activities (e.g. satellite television, movie screenings, pool games, chase etc.) at hours convenient for the target group.

In Djibouti, the PK 12 *SafeTStop* Resource Center managed by MASSABA was used as an information resource center on STIs, HIV and other related health issues as well as a condom distribution outlet. SRC visitors accessed condoms, prevention messages, and referrals to PK 12 Health Center for HTC, treatment for STIs and other health related services through the peer educators and also accessed edutainment facilities.

Peer educator conducting a peer education session among truckers in Mariakani SafeTStop Resource Center.

In Uganda, to bring services closer to the people, services such as testing and counseling were carried out at the *SafeTStop* Resource Centers and at places accessible to the target population and at their convenient times. For instance, testing and counseling services were carried out till late (up to 11pm) at the SRCs to ensure that truckers could access the services at their convenience. HTC outreaches were also carried out at trucker hangouts such as truck parks, to ensure those unable to access the SRCs were reached.

3.1.3 Pillar 3: Enhance Economic and food security as a prevention/care and community sustainability strategy

3.1.3.1 *LifeWorks* Partnership Trust

ROADS II recognized that HIV prevention programming requires a holistic approach to community strengthening, and acknowledged that poverty is a key driving force of the epidemic. Economic empowerment of poor women and older orphans contributes significantly toward increasing their capacity to reduce individual involvement in risky behaviors. ROADS continued working with the private sector to strengthen existing or start-up new companies run by local community members, or local entrepreneurs, through the framework of *LifeWorks Partnership Trust.* This initiative was an innovative confluence of private sector, public sector and local communities, to tackle root causes of HIV infection.

The initiative, with significant support from private companies worked to reduce vulnerability and enhance care and support of target populations. *LifeWorks* was pioneered by USAID/EA, and though its innovations were being adapted and scaled-up throughout the region with bilateral funding, USAID/EA

continued to support overall management and direction of private sector programming through ROADS II.

Lifeworks companies

The *LifeWorks* companies – *LifeWorks* Shukrani Limited and *LifeWorks* Zawadi Bora Limited were registered in December 2008. *LifeWorks* Shukrani employed 23 direct employees and 15 indirectly employed persons from whom the business outsourced materials from. A previous monitoring and evaluation activity estimated that the indirect beneficiaries of the initiative were over 450 persons that included children, siblings, parents, spouses who had benefited through small business start-ups, upkeep, payment of school fees among other basic needs.

Using local fabrics, women in transport corridor communities are developing high-end home and fashion accessories for international export. By earning a 'living' wage, employees of Shukrani reduce their individual and community vulnerability to HIV infection

In 2013, as part of its sustainability strategy post-award, *LifeWorks* Shukrani Limited was restructured to incorporate Undugu Fair Trade Limited (UFTL), a company with similar mission to LifeWorks Shukrani and bringing strong market network and infrastructure to the company. *Lifeworks* Shukrani has developed linkages to the World Trade Organisation (WTO) and has attracted technical assistance from CBI Netherlands, managing a sales volume of US$ 100,141 over the period. *LifeWorks* Shukrani had developed over 50 products categorized in three portfolios namely tourist market, corporate market, excess capacity and export market. Partnership with UFTL increased Shukrani's ability to tap into a well-developed marketing infrastructure of traditional handicrafts. However, the application of the same business model/infrastructure with textile products proved challenging as existing customers were hesitant to place orders due to price differentials between *Lifeworks* Shukrani products and those sourced from Asia. During participation in Frankfurt Trade Fair in February 2014, the participants surveyed prices of Textile-based products from Asian businesses and found most of them to be below Lifeworks production costs.

LifeWorks leveraged private sector services through contributions amounting to over US$420,000. The contribution were realized through private sector support that constituted volunteer time of service from Board of Directors, staff time in developing organizational systems and strategies, mentoring, and donation of space, equipment and materials. Various development and government organizations sponsored the staff to attend trainings in export preparedness, design and pricing. The private sector contributors included Unilever, SCANAD, Mabati Rolling Mills, General Motors East Africa, Deloitte and Touché, Kemboy & Company advocates, Export Promotion Council of Kenya, Value added Africa,

Voices of Africa, CBI Netherlands, Vital Voices Global Partnership & ExxonMobil Foundation and UFTL among others.

Two subsector studies targeting the textile were done within the period that included 'A global End Market Analysis (EMA)', done by strategic partner DAI that highlighted several design issues that need to be addressed prior to a renewed effort to compete internationally; 'Desk market research on EU market for home textiles' by Nomudus and sponsored by UNDP recommended on design improvements and development of Lifeworks Shukrani products for the European market. Over 50 products were developed and samples were shipped to Trade Aid (New Zealand), Servv International (USA), Ten Thousand Villages (Canada), Lovethatstuff (UK), EZA (Austria) and Afroart (Sweden) and Value Added Africa (VAA, Ireland). The greatest challenge affecting LifeWorks Shukrani was the cost of raw materials which has challenged the company's ability to maintain a global competitiveness and the 2007-2008 post-election violence in Kenya that had a negative impact on the tourist and external trade sector.

LifeWorks Zawadi Bora Ltd was a mushroom growing company ran by the community members and was finally handed over to the community in 2010 having supported 140 persons who were drawn from caregivers and people living with HIV. *Lifeworks* Zawadi Bora limited produced mushrooms for the western and Nyanza market. This enabled the community to transfer the donated land to the company. The caregivers produced two cycles of mushroom crops, weighing over a ton and with a market value of US$2,400. The target markets for the products were Kisumu and Eldoret. Zawadi Bora had an agreement with Acacia Transporters Ltd, plying Busia-Kisumu road, to deliver mushrooms to high-end market consumers and collect payment. The extension services and advice for mushroom husbandry was provided by the Jomo Kenyatta University of Agriculture and Technology.

The current governance structure for *LifeWorks* Shukrani enables UFTL, as a member of Shukrani Board, to manage all operational matters without recourse to the umbrella company of LifeWorks Partnership Trust, a majority shareholder in LifeWorks Shukrani. Lifeworks Partnership Trust Limited's veto remains applicable only if Shukrani Board propose to amend the over-riding social mission of the business of assisting the vulnerable in society.

3.1.3.2 Household level food and economic security in *SafeTStop* communities.

Under ROADS II, FHI 360 responded to key recommendations made as part of the evaluation of ROADS I project in 2008 relating to the strategic direction of its economic strengthening component. Following PEPFAR guidelines for economic strengthening, ROADS II strategy sets down a pathway where households are enabled to move from activities that decrease their initial vulnerability to those that improve quality of life and contribute to economic growth. Thus, the Economic Strengthening component had three sub-components:

- Developing a financial safety net: mobilizing internal funding, developing social capital and governance and promoting savings discipline through the formation of savings and loan groups
- Maximizing household production for direct household consumption and the local market
- Expanding production for the commercial market.

Interventions were based on an understanding of households' abilities to manage risk, and reduce underlying vulnerabilities before moving towards activities that brought increased income.

Valentine Muranpabuka, tending vegetables in her kitchen garden in Rwanda. She tested positive for HIV in 2004. She joined a support group Tubafashekubaho cooperative of people living with HIV (PLHIV). The group of 42 was trained in kitchen gardening and GSLA by ROADS Project. From the GSLA, she obtained loans which enabled her buy a cow, renovate her house using iron sheets and buy vegetable seeds which she has used in her kitchen garden. "I have never been on anti-retroviral drugs because my CD4 count has improved due to the vegetables which I use from my kitchen garden."

ROADS II worked with local implementing partners, as well as its strategic partner Development Alternatives Inc. (DAI) to provide technical assistance to communities in six countries (DRC, Djibouti, Mozambique, Rwanda, Tanzania and Zambia). Consistent with PEPFAR guidelines for Economic Strengthening interventions, ROADS II promoted 'HIV-sensitive' rather than 'HIV-exclusive' programming, whereby sensitization on the approach is community-wide, and members were encouraged to engage in economic strengthening activities not by virtue of their HIV identity but on the basis of their common economic profiles and aspirations. ROADS II used the 'community cluster' structures to mobilize the following audiences: low-income women; at-risk youth (18 to 24 years); sex workers; caregivers of orphans and other vulnerable children; persons living with HIV; and fisher folk.

ROADS II offered a portfolio of activities, accessed depending upon the individual participant's household situation, and the local opportunities available, including:

- Mobilizing, sensitizing and training members in the Group Savings & Loans Association (GSLA) methodology
- Capacity building of ROADS implementing partners to understand key concepts and best practices related to economic strengthening, including on-going follow up and monitoring

- Training (direct provision, mentoring) and field support in small plot horticulture, small livestock husbandry and small and micro-business best practices
- Rapid market assessments and business modeling to determine higher level commercial activity
- Conducting rapid 'spot' reviews to monitor levels of application of skills and knowledge at GSLA and individual member household level.

Summary Achievements: ROADS II's Economic Strengthening achievements included the following;

- **644 GSLA groups formed,** with a total membership of **12,017 persons**
- A total of **US$2,538,348 saved** and **US$2,119,451 loaned** between group members
- Introduction of a **Household Production Guide methodology**, promoting peer-to-peer learning of local best practices in small livestock, small plot horticulture and small business. This was translated into Kiswahili and Kinyarwanda for Tanzania and Rwandan participants.
- **Three Household Economic Assessments** conducted (Rwanda, Tanzania, Zambia) in 2013 and covering a total sample of 3,011 persons, identifying ROADS II members who participated in Economic Strengthening activities to be experiencing low levels of household hunger, relatively high levels of household assets and high levels of dietary diversity and they ascribed this to be a result of their engagement in economic strengthening activities under ROADS II.

Specific achievements

(i) Improved changes in savings behavior

Changes in savings behavior laid the foundation for accessing loans, using internal funds generated by members themselves. ROADS GSLA members have;

- *Adopted new savings behaviors:* these behaviors enable an accumulation of capital for individual use, thereby overcoming a common myth that 'the poor cannot save';
- *Developed a sustainable structure for future*. GSLA groups use no external capital, consistent with PEPFAR guidelines; once the initial training is over, the group is thereafter self-sustaining, meeting weekly or fortnightly at a member's home or local venue and requiring only periodic monitoring to ensure adherence to process;
- *Accessed capital for the first time*. GSLA members are now routinely loaning and repaying, having learned that the growth of their own groups' portfolio is dependent upon these functions;
- *Developed valuable social capital.* Regular disciplines of meeting to save, agree to rules, take loans and repay, and documenting their own processes has its own value to members.

A qualitative review of GSLA activity, conducted in December 2011 in Rwanda and Tanzania concluded that 'benefits from GSLA are consistent with the intent of the ROADS project.' These include increasing member access to savings and loans. The majority of members were confident that they were better off than their neighbors who did not join GSLA.

(ii) Improved 'productive behaviors'

ROADS provided a series of focused trainings to GSLA members, selected based on performance criteria and active membership in GSLA. As part of on-going learning and reflection, ROADS conducted periodic internal programmatic reviews of aspects of its ES interventions, including reviews of how GSLA groups were performing, and to what extent participants took up key 'productive behaviors' in IGA/small business, small livestock management and small plot horticulture management.

The reviews noted clear gains in knowledge and uptake of skills in best practices related to organic agriculture; GSLA members also reported diversification of income sources, away from sole reliance on agriculture; and the most significant changes reported by participants included a shift to organic practices (reducing reliance upon, and cost of, chemical fertilizers), skills to maximize the use of small spaces of land, and greater confidence as farmers that they can create change in their own lives.

GSLA members opening a cash box during their meeting.

(iii) Improved quality of life for ROADS GSLA participants and their households

Qualitative evidence suggests that the Economic Strengthening component contributed towards empowering participants to make positive decisions related to their sexual behavior. While a direct causality could not be claimed, members of GSLA groups reported that they were developing economic confidence and economic resilience (seen as the ability to cope in response to external shocks as measured through proxy indicators such as changes in household asset levels, numbers of sources of income, dietary diversity), and no longer rely on transactional sex as an income source.

ROADS II presented its economic strengthening work at a number of national, regional and international conferences including PEPFAR Implementers' Conferences Uganda 2008, Namibia 2009; USAID Partner Conferences; and have had abstracts accepted in various conferences such as Global Youth Enterprise and Livelihoods Development Conference, (Making Cents) Washington 2010; International Conference for Exchange & Research on HIV/AIDS, Rwanda 2011 (awarded Best Abstract: Socio-Economic Impact and Socio-Support category).

The external evaluation of ROADS II in 2012[10] concluded in relation to the economic strengthening component that "the Evaluation Team was most impressed with the economic strengthening component…the ROADS II economic strengthening approach provides a foundation for building the internal capacity of individuals, households, and communities to build, strengthen, and maintain their livelihoods through entrepreneurial activities, resulting in better individual and community health outcomes, including a stronger focus on the need for HIV/STI, malaria, and TB prevention, as well as less socioeconomic vulnerability" (p 36).

[10] Final Evaluation Report on the Roads to a Healthy Future (ROADS II) Project in East, Central and Southern Africa; O'Grady M, Husain I, Macharia R, Pick B, USAID 2012

3.1.4 Pillar 4: Reduce alcohol/substance abuse as barriers to healthy behavior

The association between social alcohol use, reduced sexual inhibitions and HIV transmission is well known. Alcohol use/abuse is particularly problematic among men who are frequently away from home, confirmed anecdotally in our *SafeTStop* Resource Centers, but the problem is also rampart in many ROADS communities. Until recently, however, HIV prevention programs generally overlooked or at best only marginally addressed this transmission factor, providing an opportunity to take a new look at alcohol and its relationship to HIV, including acceleration of disease progression, and reduction of ART adherence and treatment efficacy.

The overarching aim of the ROADS II alcohol risk reduction strategy was to reduce alcohol-related harm as an HIV prevention strategy in the community. The strategy employed a multi-component approach which aimed at addressing harms caused by alcohol misuse in terms of risky behavior that leads to contracting HIV as well as adhering to drug regimens if already HIV positive. This included the following approaches:

3.1.4.1 Expanding community access to alcohol and substance abuse counseling. ROADS expanded alcohol counseling through different avenues including *SafeTStop* Resource Centers, health facilities, support groups and community volunteers. Project volunteers who had been trained as peer educators were further oriented on alcohol risk reduction and they were then provided with key messages to convey to the community during routine activities such as small-group discussions, interacting through immediate social networks, social events and other community gatherings. The volunteers were also equipped with necessary information to facilitate referrals for community members requiring needed services such as enrollment into the established Community Alcohol Support Groups (CASG) or to health facilities for more counseling and other related services.

Dominica Mapunda and Sadiki sorting tomatoes to be sold in Songea market in Tanzania. The two are reformed alcoholics. Mapunda was trained as a peer educator and formed a Community Alcohol Support Group for 10 community members. The members are now engaging in economically productive activities such as tomato growing.

ROADS also worked with opinion leaders to convey alcohol risk-reduction messages. These included faith-based leaders, members of the local government and politicians, who were encouraged to take advantage of various community gatherings to mobilize the community on alcohol-related issues.

3.1.4.2 Further expand and build greater capacity at community level for addressing alcohol and substance abuse issues through structural interventions. ROADS provided technical assistance in setting up community and ward-level Alcohol/GBV Taskforces to address hazardous drinking and GBV in the context of HIV and broader health, including referral for services resulting in behaviors such as sexual and gender-based violence. The Taskforces comprise local council leaders, community members, CBOs, health care providers, GBV desk officers, the police and other relevant community stakeholders.

The Taskforces were oriented on various issues relating to alcohol such as reducing opening hours for drinking establishments, regulating local production and selling of alcohol, prescribing distances of bars from schools, regulating the sale of alcohol to minors, etc. The Taskforces were empowered to develop tailor-made approaches to be implemented to raise awareness on alcohol and GBV issues within the target communities.

Guided discussions on alcohol abuse were integrated into peer education and special discussions at the *SafeTStop Resource Centers.* The Resource Center volunteers were trained and held alcohol-reduction and related issues with truck drivers and other mobile men at the resource centers.

3.1.4.3 Support communities in developing community and culturally appropriate public health and law enforcement responses to reduce dangerous practices related to alcohol abuse.
ROADS provided education to the community not only on how to moderate drinking but also how to substantially reduce HIV risks associated with drinking such as reduction of sexual partners, ensuring proper and consistent condom use and developing health-seeking habits. The alcohol programming, carried out in ROADS sites along transport corridors in Kenya, Uganda, Mozambique and Tanzania involved the distributing of appropriate educational materials such as factsheets and brochures. The materials were either produced by ROADS or sourced from collaborating partners and government institutions. By the end of the project, several materials with alcohol risk reduction messaging had been distributed to the communities in the four countries.

3.1.4.4 Sharing lessons among communities. ROADS approach, especially the Community Alcohol (reduction) Support Groups (CASG) built on the pioneering work of the Busia, Kenya PLHIV Cluster's, which established an Alcoholics Anonymous chapter to assist members who were struggling with ART adherence due to alcohol abuse. CASGs were formed by trained volunteers, who on completion of their training brought together community members in their immediate social network struggling with alcohol and substance abuse. This offered a platform for members, with support of the trained volunteers (facilitators) to share their experiences and support each other on their road to recovery. This support system proved crucial in recovery among many community members, some of who completely stopped or significantly reduced alcohol consumption, thereby reducing their chances of contracting or transmitting HIV. These support systems also promoted ART adherence among HIV – positive group members. By the end of the project, 539 groups were established in Kenya, Uganda, Mozambique and Tanzania with a membership of about 7,500 individuals.

Due to the regional platform offered by ROADS II, lessons from one country were shared among other countries to improve and strengthen programming. Lessons learned were also shared at workshops such as the technical consultative meeting on alcohol and HIV held from 12-14 April 2011, in Windhoek, Namibia aimed at exploring approaches to reduce the risk of alcohol especially in connection with its impact on acquiring HIV/AIDS. The meeting allowed stakeholders to exchange and promote good practices for the reduction of alcohol associated sexual risky behaviors. ROADS II also presented an abstract to the Kettil Bruun Society that was presented during the 39th Annual Alcohol Epidemiology Symposium held in Kampala, Uganda from June, 3 – 7, 2013.

3.1.5. Pillar 5: Improved safety nets for most vulnerable children and families

Béatrice Mukarukundo one of the 2,696 vulnerable children supported by the Project in Burundi aspires to be a medical doctor.

ROADS took a conceptually integrated approach for support of OVC, addressing in a seamless fashion the evolving needs of OVC. This involved providing essential and life-sustaining services such as food, health care, shelter, protection and psychosocial support and progressing beyond these basic needs to address educational support including some vocational training and expanded health services to including FP/RH and finally income/job creation for older orphans. The Project worked with community OVC caregivers, key stakeholders including relevant government departments, local leadership and children themselves to establish the right mix of services most wanted by orphans and vulnerable children in their particular locality. Each transport corridor community identified dimensions of quality with a key focus on access to services, continuity, appropriateness, community participation and sustainability. The Project strengthened the OVC support tracking system including supportive monitoring and supervision, periodic data quality assurance (DQAs) and development of appropriate tools to ensure that services made a difference in the lives of vulnerable children.

3.1.5.1 Promoting health of children, adolescents and young adults. In its implementation, the Project ensured a holistic approach to promoting the health of orphans and most vulnerable children (OVC/MVC) by ensuring that health services were integrated, age-specific, gender sensitive and provided through venues that were accessible to them. The Project used multiple channels (including cluster meetings) for improved health education and multiple service delivery points within and outside of formal health centers (e.g., through youth centers, magnet theater performances, churches, mosques) to increase health-seeking behavior and access to services. The Project also addressed environmental health issues and access to FP with emphasis on child spacing by women of reproductive health age as strategies for promoting the health of vulnerable children, as well as the FP /RH needs of older OVC.

3.1.5.2 Expanding identification and treatment of pediatric AIDS cases. At the start of ROADS II, the number of infants and young children reached in the care setting and being treated with ART remained low compared to adult ART provision. As part of the increased emphasis on quality of services under

Roads to a Healthy Future, the Project built the capacity of HTC counselors, home-based care providers, OVC caregivers, and health workers in clinical settings to capitalize on opportunities for identifying and treating pediatric AIDS cases. The Project trained home-based and OVC caregivers to take a more family-centered approach to home-based care visits to inquire about the HIV status of family members including, early infant diagnosis (EID) and follow up of mother-infant pairs. They also received additional skills to enable them provide ongoing counseling to children and adolescents living with HIV. Families with HIV positive children received nutritional support and counseling as part of the comprehensive package of care services.

In September 2007, FHI 360 was part of the Abbott Determine Donation Program in Burundi, Ethiopia, Kenya and Rwanda. The program supported expanded access to HIV testing and treatment services for pregnant women and children. By 2008, ROADS II initiated interventions for diagnosing HIV in children born to infected mothers. In March 2008, ROADS signed a memorandum of understanding (MOU) with Clinton Foundation HIV and AIDS Initiative (CHAI) in Burundi to diagnose early HIV among children born to HIV positive mothers in sites supported by ROADS.

In 2008, ROADS also supported four anti-retroviral therapy (ART) sites in Burundi – the ANSS clinic of Kirundo, Kirundo Hospital, Muyinga Hospital and Kayanza Hospital and by the end of September, 2008, the four sites had provided ART to 1,466 clients, of whom 139 were children. In the same year in Uganda, 223 OVC and their caregivers were counseled and tested for HIV and eight OVC tested positive and were referred to Joint Clinical Research Centre (JCRC) for further pediatric care management. ROADS II identified potential HTC counselors in consultation with respective ministries of Health and by the end of FY 2009, 290 health providers and community-based HTC volunteers were trained in HTC and ART in accordance with each country's policy guidelines.

Nasra Tinyimana (Kirundi name for 'fear God') from Burundi is proof that HIV positive couples can give birth to a HIV-negative child. Before enrolling into the program, Tinyimana's mother had suffered three miscarriages and together with her husband never believed they could give birth to a HIV-negative child.

In 2009, ROADS II focused on family-centered OVC programming, guided by respective national OVC policy frameworks. Through peer education, older OVC reached fellow OVC with age-appropriate HIV prevention messages. In collaboration with other partners, ROADS II conducted HTC and clinical outreach among OVC and caregivers, with over 50 per cent of OVC counseled, tested for HIV and received their test results. This partnership resulted in increased accessibility to ARVs and treatment for opportunistic infections for OVC in some project sites.

To effectively increase enrollment of children in pediatric AIDS care and treatment, ROADS trained health workers in delivery of ART services. By the end of 2009, the Project had trained 127 health providers in delivery of antiretroviral

therapy services. In addition, the Project also provided ART services through six service outlets in Burundi. Individuals newly enrolled on ART (adults and children with advanced HIV infection) were 967, including 37 children below 15 years of age. The number of adults and children receiving ART at the end of March, 2010 was 2,970, including 222 children less than 15 years.

In Burundi, the Project also promoted access to prevention-of-mother-to-child transmission (PMTCT) services including prophylaxis and referral to care, ART and community-based support. This included supporting number of operational service outlets offering PMTCT leading to an increase from 44 in 2008 to 163 in 2013.

The number of PMTCT sites increased from 44 in 2008 to 163 in 2013 in Burundi.

3.1.5.3 Provision of commodities and beyond. To cater for the needs of OVC, the Project trained OVC caregivers who provided food, clothing, shelter, educational and psychosocial support in ROADS communities. OVC clusters worked closely with relevant government departments to ensure they were linked with national- and district-level OVC programming at each site. The Project provided skills building and economic strengthening for older orphans to help them meet the needs of vulnerable children for such things as shelter improvements, food and clothing as well as broader community needs, thus addressing longer-term sustainability.

In addition, OVC received direct support mainly comprising of school fees payment, materials and health care provision. All OVC received at least one service in addition to psychosocial support. Among the services provided were nutrition and food support, basic health care, economic strengthening, shelter and protection. In some selected countries, ROADS mobilized for items such as clothes, food, and ITNs, which were distributed to extremely vulnerable children. To also enhance sustainability, the project utilized local resources including labor contribution by community members during shelter construction for the vulnerable children.

3.1.5.4 Protection for vulnerable OVC/MVC. ROADS addressed the legal and human rights of vulnerable children and youth whose lack of educational and economic opportunities and social skills development, when paired with the need to contribute economically to their households, may place them at greater chance of risk behaviors leading to HIV, including higher intake of alcohol or other drugs, transactional sex and gender-based violence. In Rwanda for instance, 658 individuals (MVC parents/guardians and care givers) formed 25 GSLAs and saved Rwandan Francs (RWF) 10,499,500 (USD 16,153) in economic strengthening. The money will be utilized to graduate the supported MVC.

ROADS ensured the inclusion of rights-based counseling and life skills for vulnerable youth, and particularly explored strategies to address gender inequalities that expose girls and young women to physical abuse and exploitation. Using youth clusters, young girls and women were mentored to adopt healthy behavior and steer clear of risky sexual behaviors. The project also extended protection services including access to legal support and advocated for justice when OVC were aggrieved through gender-based violence or other ways.

3.1.6 Pillar 6: Safeguard women and children from violence and sexual exploitation

Due to the high prevalence of forced sex and GBV in the region, ROADS II continued and strengthened the community-level advocacy and programming support initiated under ROADS to help local partners develop strategies to change social norms of men (and communities) around GBV.

3.1.6.1 Understanding and addressing the root causes of violence.
ROAD II vision is to strengthen the community-level advocacy and programming support to help local partners develop strategies to change community social norms especially those that perpetuate GBV.

Aaron Mushahara and wife Cornélie Muryoryo. Muryoryo bore the brunt of her husband's violence. However, this changed after a peer educator trained by ROADS in Burundi explained to him the consequences of his violent actions towards his wife. He has since changed and is a role model and advocate against GBV in the community.

In order to design programs that respond to the needs of the communities, ROADS II conducted rapid participatory assessments at all sites with local partners. Regarding gender, ROADS assessments revealed the following: local norms actively valued risk-taking by men and boys; among both men and women, GBV was generally accepted, even referred to as "discipline"; many sites lacked GBV services or programs entirely; where they existed, there were significant gaps (e.g., lack of post exposure prophylaxis; providers ill-equipped to address GBV; lack of multi-sectoral coordination; minimal enforcement of law protecting against GBV); women were legally disenfranchised from land or property ownership; economic inequities predisposed women to engage in high-risk survival strategies; leadership opportunities were limited for women (e.g., in 2006, of the 79 district chairpersons of the Uganda Electoral Commission, only 1 was a woman) and; many women expressed reluctance to access HIV, FP/RH and other health services for fear of partner reprisal.

To reduce the incidence of violence, there was need for consensus among community members that violence is unacceptable and harmful. Working with various community stakeholders including the clusters, ROADS used a gender transformative approach to look at ways that the socialization of boys and young men make women vulnerable. This included discussions of manhood and masculinity and analysis of gender roles, working with whole communities to promote changes in social norms around gender and violence against women and girls.

3.1.6.2 Community advocacy and coalition building. For community advocacy and coalition building, the Project used a resource awareness tool that brought together representatives of key community groups affected by GBV and community resources (e.g. police, local administrators, faith groups, schools, health and social services) to define GBV and its typical behaviors, root causes, ways it manifests in the

community, and what particular community groups can do to prevent and respond to GBV. This community dialogue resulted in consensual action plans consisting of objectives, actions, timeframes, participating groups, resources and a monitoring and evaluation strategy. Through this approach, several communities established multi-sectoral GBV (such as GBV/Alcohol) Task Forces to implement programming i.e. responding to incidents of GBV. ROADS also worked with community-based expert organizations such as MIFUMI (a local organization that provides capacity building to community-based organizations in Uganda), consultants and on-staff technical experts to provide capacity building and technical support to local implementing partners (IPs) and community structures involved in GBV issues.

3.1.6.3 Capacity development through program implementation. Having identified issues and developed action plans, ROADS provided technical support in building the capacity of stakeholders and community members to deal with the identified issues. The trainings were either integrated into other project activity trainings such as FP/RH and peer education trainings or as separate trainings discussing gender issues alone. In Kenya for instance, the Project updated the existing peer education training curriculum for mobile men and their sexual partners to include GBV.

In Uganda, MIFUMI trained clusters to support communities respond to cases SGBV including identifying existing support services within the community where GBV issues can be addressed such as the police, GBV help desk, local community courts, health facilities for Post Exposure Prophylaxis (PEP) and other agencies for legal support.

3.1.6.4 Improving the health response. Working through health facilities, partners and collaborating partners, ROADS improved services in health facilities for post-rape services and counseling. In Tanzania, sex workers developed strong linkages between the Gender Desk at the police station and health facilities, where GBV victims are referred and where they receive prompt treatment, due to the strong collaboration. In Burundi, the Project supported initiation of PEP services at health facilities which mostly served rape and sexual assault victims, thereby curtailing transmission of HIV.

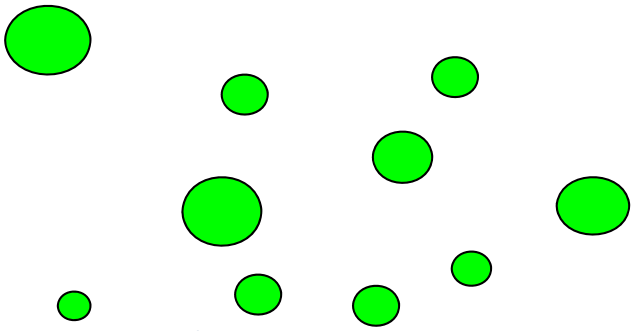
3.2 COMPONENT 2:

Promising Innovations, State of Art Practices, and Policy Advocacy and Harmonization

3.2.1 Program Innovations

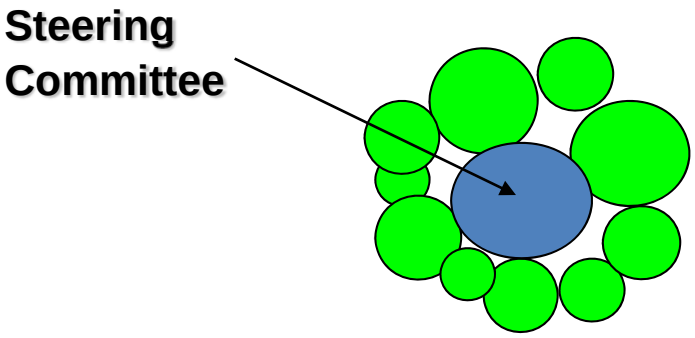
Over the implementation period, ROADS II identified and developed program innovations that were piloted, evaluated and adapted for other settings in East, Central and Southern Africa ECSA with USAID/EA funding, diffusing them through the Mission's regional platform in eight countries. Key highlights include:

- Use of the *cluster community-organizing model* as a platform to establish new program components in transport corridor sites. With USAID/EA support, ROADS II linked together 110 clusters in ECSA, with a membership of more than 120,000 individuals in 1,445 indigenous volunteer groups, expanding the regional platform for shared learning and South-South collaboration. New interventions



CBOs in a typical community.

and innovations diffused through this platform included strengthened facility and community-based delivery of FP/RH services in Burundi, DRC, Rwanda, Tanzania and Uganda; implementation of maternal and newborn (MNH) programming in Burundi and Tanzania; community-based alcohol counseling linked with HIV services model established in Busia, Kenya and diffused in most ROADS II countries; gender-based violence programming enlisting health workers, local leadership, law enforcement, and the judiciary (Burundi, Rwanda, Tanzania and Uganda); and *LifeWorks* economic strengthening activities (Kenya, Rwanda, Tanzania and Zambia, Mozambique, Djibouti and Democratic Republic of Congo);



CBOs in a cluster.

- A cost-share tool to monetize volunteer time, by type and cadre, to valuate community contributions to HIV and broader health programming. The tool, which also calculates the value of in-kind contributions (e.g., meeting space donated by schools, churches, mosques), demonstrated that ROADS I exceeded its total cost-share requirement of US$3.6 million with volunteer time alone (valued at US$3.9 million by end date of August 5, 2010), and ROADS II had exceeded 102% of its cost share by the end of the project (collected USD 1,916,846 against a target of 1,887,804)
- This indicated that, through USAID/EA, ROADS is fostering sustainable community development in line with President Obama's Global Health Initiative (GHI);
- A model for *public-private partnership* that transcends limited corporate social responsibility campaigns to promote sustainable, high-impact engagement of a corporation with host countries, donor agencies, and health and development partners. This model, dubbed the "Dubai Model" by partner Dubai Ports World, is reflected in a Global Development Alliance signed in Djibouti (June 2010) by DP World, USAID and ROADS to establish a community center at PK12, the major truck stop in Djibouti. The center, which has a defined sustainability strategy, will provide Djiboutians and vulnerable visitors with health education, services and referral, and serve as a platform for e-learning and vocational education. With USAID/EA support, the Dubai Model was proposed for adaptation in Mozambique;
- A *strategy to enlist the local business community in HIV programming*, highlighting costs of HIV to local businesses (most impact studies have focused on entire sectors and large companies), tapping grassroots corporate social responsibility (CSR) capacity, and testing whether participation can increase customer base, profitability, long-term involvement in health programming, and project cost share (e.g., using local businesses as education and referral points). This innovation was developed in Kahama and Kagongwa, Tanzania, with local business leaders and proposed for adaptation in Mozambique;
- *ART Pilot*. ROADS II collaborated with Reach Out Mbuya, a CDC-funded NGO in Mbuya-Kinawattaka, Uganda to establish an ART clinic/refill point at the Mbuya-Kinawattaka *SafeTstop* Resource Center specifically targeting mobile truck drivers and sex workers. This innovative re-fill service was carried out twice a month at the resource center as an outreach distribution site for the Reach Out Mbuya ART program. Reach Out Mbuya provided trained personnel from their ART department to carry out same-day CD4 count testing to those who tested positive for HIV at the

resource center and provided ART to those who met the CD4 count requirements. ART refills were also provided to truckers who were enrolled in Reach Out Mbuya Health Center. This however pointed to the need for regional cross-border discussions on a harmonization policy to ensure access to ART services for mobile populations;

- Use of an *electronic polling tool* to anonymously gather sensitive information on sexual behavior in group settings. This is significant given that interviewers can bias responses delivered openly from an individual within a group setting. ROADS II used this non-intrusive keypad tool to elicit intimate details of sexual behavior among audiences in Kenya, Tanzania and Uganda, including anal sex and other taboo behaviors not explicitly mentioned in standard "ABC" messages. The tool enabled more frank responses from respondents and which indicated that "ABC" messages are often misinterpreted—inhibiting individuals from internalizing risk—and that risky behaviors are not limited to traditionally defined groups (e.g., men who have sex with men, sex workers). This information guided new message development by the project, moving from a focus on most-at-risk populations to most-at-risk behaviors.
- ROADS developed the *Household Production Guide* that was piloted in Rwanda and Tanzania. This innovative tool uses evidence-based behavioral methodologies to promote a series of "productive" behaviors that enhance household productivity, and thereby promotes economic resilience.
- The initial $100,000 funding through USAID/EA in 2011 to implement a nutrition intervention in Rwanda laid the foundation and provided vital baseline information for on-going implementation under USAID/Rwanda funding. In 2012, USAID/Rwanda awarded $300,000 for a nutrition program implemented in Rusizi District with the aim of reducing malnutrition prevalence in children below five years of age, lactating and pregnant women populations in all sectors of Rusizi District.
- ROADS's strategic partner John Hopkins University (JHU) developed a *handbook on FP/RH, GBV and MNH* for community health workers and peer educators. The handbook was used by MOH in Burundi, Rwanda and Tanzania in Burundi. The purpose of the handbook is to equip community health agents (including community health workers, community-based distributors and peer educators) with up-to-date and accurate information on FP/RH, GBV and maternal and neonatal health (MNH). Following discussions with ECSA, ROADS developed draft GBV/Child Sexual Abuse (CSA) materials for potential adaptation and roll-out in ECSA countries utilizing the ECSA platform.

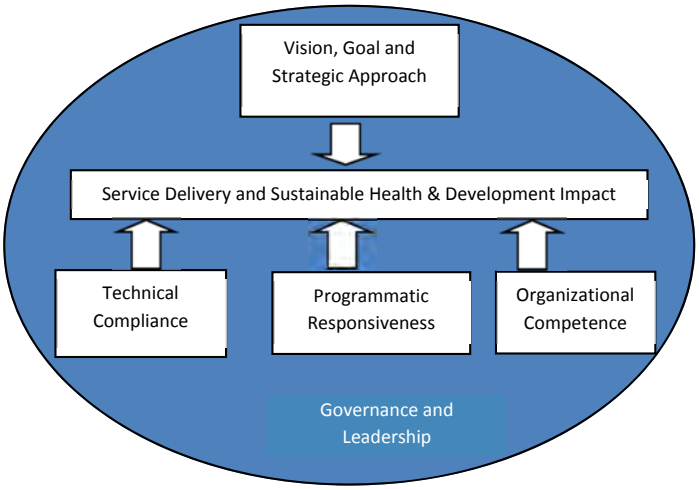
3.2.2 Capacity Building Strengthened among Implementing Partners for Sustainability

Capacity Building and Strengthening Framework:

Working through the clusters, ROADS developed and strengthened local organizations' capacity to implement evidence-based programming and manage institutional systems that promote accountability and resilience through the implementation of a Capacity Building Framework that identified three key outcomes:

i. Improved organizational capacity of indigenous partners to successfully conduct internal operations in transparent, efficient and cost-effective manner;
ii. Improved technical capacity of indigenous partners to deliver quality HIV/AIDS and related health services to communities they serve;
iii. Improved programmatic capacity of indigenous partners to design, plan, implement, monitor and evaluate programs; and apply lessons learnt to improve programming.

ROADS Capacity Building and Strengthening Framework



Process and Activities:

The project used a six-step process as a foundation for achieving these outcomes: i) *Fostering relationships* with transport corridor communities through participatory site assessments with community groups and other local health and development partners, and consequent validation of findings and prioritization of needs at site-based stakeholders' feedback and planning meetings; 2) *Organization of clusters* under which the identified Anchor organization undergo a pre-award financial assessment by FHI 360 to determine whether it has sufficient financial systems and policies to identify immediate weaknesses and/or gaps that need to be addressed before and after the funds disbursement are planned for;3) *Mapping resources and planning for joint action* (including its associated budget) under the leadership of the cluster Steering Committees; 4) *Facilitating individual participatory organizational capacity assessments (OCAs)* that yields both qualitative and quantitative profiles of the organization's strengths and gaps across a development continuum that consequently informs development of tailored capacity improvement plans based on the partner's long-term sustainability goals; 5) *Implementation and monitoring capacity improvement plans* through set benchmarks that are used to gauge effectiveness of the capacity strengthening efforts over time; and 6) *Evaluation, documentation and dissemination on progress* through regular reviews (annual, mid-term) conducted through field surveys and qualitative interviews to capture changes and track progress against baseline thus informing sustainability and transition readiness. The results are shared with the partners and stakeholders through various identified channels and information sharing forums.

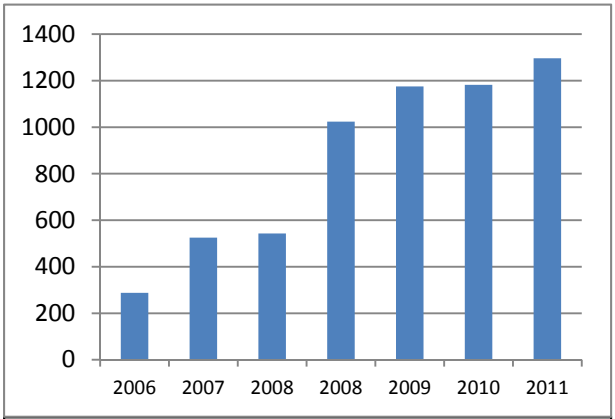
Capacity building and strengthening included formal, informal, individual and group activities that increase knowledge, build skills, create systems and develop sustainable networks. TA providers are sourced from point closest to the request. The approaches included:

- *Trainings* to address knowledge and skills with a focus on developing and/or strengthening competency. In conducting training in the PEPFAR elements, ROADS II coordinated closely with bilateral USAID missions and external agencies to ensure training is not duplicative. The project also identified opportunities for local partners to participate in training funded through other projects, and to include individuals from other projects in ROADS II trainings as feasible. The project linked with national training systems (e.g. Ministry of Health, Ministry of Agriculture, etc.), and conducted

Training of Trainers (ToT), on-site and on-the-job training including seconding staff (e.g. seconding of medical doctors to health facilities in ROADS sites in Burundi; and seconding of capacity building and M&E technical staff to the Djibouti Executive Secretariat) to facilitate development of a pool of local expertise. Appropriate technical supervision and follow-ups were conducted to reinforce compliance and good practice.

- *Coaching* was provided to improve learning and job performance, with a focus on meeting staff and volunteers' knowledge and skills needs and developing their ability to meet their performance goals. Coaching was done by FHI 360 project staff, partners, and identified cluster members.
- *Mentorship* involved facilitation of a learning relationship between individuals within and across the cluster membership. This provided a mechanism for less experienced (knowledge, skills, ideas) staff and volunteers to get advice and practical support from their more experienced professional colleagues to achieve specific professional results.
- *Organized learning forums* included project meetings at site, national and regional levels; technical workshops; and exchange visits. Clusters and organizations were able to identify, plan and budget for such cross-learning opportunities.
- *Development and/or adaptation of tools and resources.* Tested tools and resources were tailored/adapted in collaboration with partners and stakeholders to inform design of interventions, provide performance support, monitor compliance, and ensure quality assurance and improvement.
- *Systems strengthening* through support for facility improvement and procurement of commodities and supplies including linkage to national systems for commodities supply and cold chain management.

Achievements:



CBOs participating with ROADS: *Participation of local groups across ROADS' countries has been stable or grown. When CBOs have dropped out, others have stepped in to take their place, with the benefit of capacity strengthening through the project.*

i) **Expansion of Indigenous Organizations' Involvement in HIV/AIDS Response.** The cluster approach enabled the participation of ***85 clusters*** of youth, low income women (LIW), persons living with HIV (PLHIV), and orphans and vulnerable children (OVC) in East, Central and Southern Africa, strengthening the capacity of ***1,296 indigenous volunteer groups*** in health and development programming with a ***volunteer base of 92,666 people in ROADS sites since 2005.*** Clusters have drawn upon their own resources (volunteer time, community space, supplies etc.) and used donor funding as a catalyst.

ii) **Increased Pool of Local Expertise.** Under ROADS, ***31,371 individuals (FY2006-2011)*** from different cadres of managers and service providers (facility-based health care providers and community health workers) have been trained and supported to manage programs, strengthen institutional systems and provide services. Capacity strengthening has been conducted in organizational and programmatic thematic areas such as monitoring and evaluation, good governance, strategic planning, financial management, advocacy and conflict management, etc. targeting managers, steering committees, and organizations' boards thereby developing and/or strengthening institutional systems and quality of program management. Similarly, technical capacity strengthening has been conducted in Abstinence Be(ing) Faithful (AB), Other Prevention (OP), Palliative Care, OVC, HTC, PMTCT, ART, FP/RH/MNH, stigma and discrimination reduction, HIV-related community mobilization

and strategic information, and other related health issues such as GBV, alcohol and HIV, economic strengthening, nutrition, water and sanitation, etc. resulting in an increased base of HIV/AIDS and related health service providers across different cadres.

ROADS Project Capacity Strengthening - Number of People Trained (FY2006-2014)	Total
Indicator	
# of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	12,467
# of individuals trained to provide HIV-related palliative care for HIV-infected individuals, including those trained in facility-based, community-based and/or home-based care including TB/HIV	3,561
# of providers/caretakers trained in caring for orphans and vulnerable children	2,051
# of individuals trained in counseling and testing according to national and international standards	1,083
# of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	4,729
# of individuals trained in HIV-related policy development	1,637
# of individuals trained in HIV-related institutional capacity building	5,843
Total Number of People Trained	**31,371**

iii) **Improved Fiduciary Accountability.** The majority of the cluster members had never participated in a donor-funded program before ROADS. For example, of the 412 participating groups in Rwanda in 2011, 83% had neither received donor support nor capacity building prior to ROADS. By providing direct funding to local implementing partners, the project strengthened the capacity of local organizations to source and manage funds and other resources entrusted to them for the implementation of quality programs. With trainings and technical support in areas such as good governance, conflict resolution and financial management, clusters manage their affairs under the leadership of the Steering Committees and Anchor organizations. Where financial management capacity did not yet exist, the project initially managed funds on behalf of clusters, strengthening this capacity over the project and eventually handing over responsibility.

Over the years, there has been minimal disallowance of costs; and some organizations have successfully sourced other funding for their activities;

- In 2008, over 51 individuals from the Youth Cluster in Malaba – Kenya were trained in proposal writing as part of addressing sustainability, resulting in the submission of seven proposals to the National Youth Enterprise Fund that provides small grants to help Kenyan youth establish or grow small businesses. Five of the seven proposals were successful in attracting Kenya Shillings 47,000 each ($700) for various business initiatives;
- Lunganya CBO based in Mariakani, Kenya partnered with ROADS in February 2006 to April 2008 when funding stopped due to ending of USAID ROADS funding for programming in Kenya and transition to the APHIA II funding mechanism. Over the period April 2009 to December 2010 the organization received funding of Ksh. 6,077,500 (US$71,500) through the APHIA II Coast Project for the implementation of peer education and GBV activities.

iv) **Leadership Development.** With their improved skills, community members are gaining skills to assume positions of local leadership. Individuals are applying skills developed through ROADS in a range of areas beyond the project with some able to join the formal sector and hence benefit their families and communities. Trained volunteers are engaging with other health and development organizations as volunteers or employed staff, while some have assumed office in local and national structures such as town councils, election commissions, political parties, health facility boards, and other technical committees.

v) **Increased Access to HIV/AIDS and Health Related Services.** With technical support from ROADS and in close collaboration with national AIDS commissions and ministries of health, local partners designed and implemented programming in HIV prevention, care, treatment and support and related health issues. There was also support for facility improvement and procurement of commodities and supplies including linkage to national systems for commodities supply and cold chain management. In addition, partnerships among community groups created through the cluster approach facilitated joint programming among groups working in the same program area thus expanding coverage while minimizing duplication of effort. Service statistics indicated approximately 4,335,883 individuals were reached/served with HIV/AIDS and related services through the project (2006-2014).

3.2.3 AfriComNet and University Courses

Johns Hopkins University Center for Communication Programs (JHU/CCP) has been a major provider of technical support for the African Network for Strategic Communication in Health and Development (AfriComNet), an association of health and development communication practitioners who reside and/or work in Africa. AfriComNet activities were aimed at enhancing capacity in and commitment to strategic health communication in the region. The target groups reached through AfriComNet activities include HIV/AIDS, FP and health communication practitioners in Africa. Other target groups reached include African institutions working in HIV/AIDS prevention, care and support and development communication; academic staff in universities and academic institutions of higher learning; and strategic behavior change communication practitioners involved in health and development communication in Africa. AfriComNet is managed by a two-person Secretariat based in Kampala, Uganda with direction from a ten-person Board of Directors elected from among the network's members. By end of 2013, AfriComNet membership had grown to 1,564 representing 56 countries, with over 50% drawn from the transport corridor countries.

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- ***University Network and Programs***

Over the ROADS II implementation period, AfriComNet expanded its network of African universities and training institutions from five to 10 drawn from eight countries: University of Nairobi School of Journalism (Kenya); Makerere University Department of Mass Communication and School of Public Health (Uganda); Jimma University School of Public Health (Ethiopia); University of Namibia Department of Information and Communication (Namibia); Stellenbosch University HIV and AIDS Program (South Africa); Mildmay Center (Uganda); Muhimbili University School of Public Health

(Tanzania); the National University of Rwanda (Rwanda); University of Zambia School of Public Health (Zambia); and Moi University Department of Public Health (Kenya).

The Network finalized training materials for eight short courses: Basics of HIV and AIDS Strategic Communication; HIV and AIDS Stigma and Discrimination; Monitoring and Evaluation of HIV and AIDS Communication Programs; Applied Skills in HIV and AIDS Communication and Counseling; Community Mobilization for Health and Development; Understanding and Using DHS Surveys for Health Programs; Social Marketing for Health and Development; and Developing Social and Health Communication Materials for Print, Radio, Television and Social Media available through participating universities. A total of 723 participants were trained by the end of the project.

- ***Regional Practicums***

During the ROADS II implementation period the project supported participation in three regional practicums. In 2009, the practicum, held in Kampala, Uganda featured Family Planning Communication and Advocacy Responses in Africa. It was held alongside the International Family Planning Conference on Research and Best Practices. The practicum that drew 119 participants from 13 countries highlighted the various FP communication initiatives in the region and discussed some of the challenges related to FP communication. In 2010, the practicum focused on HIV Prevention amongst Married and Cohabiting Couples in Africa. This three-day practicum was held in Johannesburg, attracting 115 participants from over 16 countries. In 2011, AfriComNet participated in the first regional capacity building partners' forum held in Nairobi, Kenya, where the Network's coordinator presented *Building Strategic Communication Capacity of African Universities: the Centers of Excellence Program,* focusing on the network's work with universities. The forum provided good networking and publicity opportunities for AfriComNet and its activities.

- ***Annual Awards for Excellence in HIV/AIDS Strategic Communication in Africa***

During the project's lifetime, several awards were presented promoting excellence in HIV/AIDS strategic communication in Africa. The 2008 the activity was held in Uganda, 2009 in Namibia, 2010 in South Africa, 2011 in Ethiopia and 2012 in Tanzania. Some of the awards were held during parallel meetings such as the HIV/AIDS Implementers meeting in 2009 and ICASA conference in 2011.

- ***Information Dissemination***

With funding from USAID/EA, AfriComNet used its website www.africomnet.org as the main channel for disseminating information to its members and audiences. In FY 2008, AfriComNet re-designed its website to allow expansion to other areas of health and development communication beyond HIV/AIDS to include malaria, reproductive health, and child health. The re-design also included brochures to match the new website look, and email-based dissemination of weekly HIV/AIDS news and the second volume of its newsletter.

1,034,567

Number of website visits reached in AfricomNet's website in 2014.

The total number of website visits reached 1,034,567 in 2014. An FY 2010 analysis of the site user patterns by country showed that most of the website traffic originated from 'dot com' sites which are mostly USA based; the second highest source of traffic was from Network organizations (.net) and education institutions (.edu); while Zambia and South Africa accounted for the highest (country specific) source of

web traffic. Further re-design of the website informed by comments from network members as well as an analysis of the various web statistics to understand user patterns included the home page *www.africomnet.org* featuring the main activities of the network including the universities program, award, practicum and a collection of communication resources.

The network disseminated weekly news updates and produced a Newsletter, which was disseminated through the list serve and other avenues. Other disseminated materials included electronic resource kits from practicums, key reference materials and tools on different subject matters.

- ***Addressing AfriComNet Sustainability:***

In 2012 and 2013, ROADS supported two Board meetings held in Nairobi, Kenya that discussed among other issues the future direction of the network post-ROADS II support. Consequently the project supported the development of an operational manual for the Board of Directors.

AfriComNet's new strategic plan is focused on establishing National Chapters as the mechanism to reach its members and promote in-country networking of strategic behavior change communication practitioners to strengthen capacity and share knowledge at the country level. The secretariat will support them to register as legal entities, which will enable them solicit for in-country funds to support their activities.

ROADS supported meetings held in Rwanda and Tanzania towards the establishment of local Chapters. Both countries nominated a five-member working group to spearhead discussions and advise on the modalities for the formation of their local Chapters. In countries, such as Tanzania, where forums such as the Tanzania Strategic Health Communication (TASHCOM) exists and whose objectives align with those of AfriComNet, the Network is establishing formal relationships through Memoranda of Understanding to enable them serve as National Chapters or affiliates of AfriComNet. Those countries will use such structures as TASHCOM to raise funds for their activities. In Tanzania, for example, TASHCOM) charges a membership fee to support its activities.

The Network is in the process of establishing a Chapter in Kenya (group currently exploring registration options – under the Kenya Health Communication Network) and in Ethiopia the Network held initial discussions with members and planned for a meeting in September 2014. The Network also held initial meetings with members in Rwanda and they are exploring how the chapter can be linked to an existing Rwanda Communications initiative. Discussions have also been scheduled for Zambia and Uganda.

3.2.4 Policy Support

Over the ROADS II implementation period, the project organized and/or participated in various regional level policy forums aimed at supporting a more harmonized and coordinated regional transport corridor programming. Key highlights include:

- ***Strengthening Pharmaceutical Care in the Region***

ROADS worked with its strategic partner Howard University/PACE to strengthen pharmaceutical care capacity across the region since ROADS I through the LWA and Associate Awards. Capacity strengthening has mainly involved training, mentorship and working with pharmacy and drug shop personnel who handle medication for prophylaxis and treatment (over the counter and prescription medication) in project sites; and establishment of private-public partnerships to expand serviced delivery. The trainings were aimed at strengthening their position as community healthcare resources in HIV/AIDS

and family planning (FP). By end of project, 480 pharmaceutical care personnel had been trained to provide HIV/AIDS care and referral in transport corridor sites, with a focus on ART adherence, treatment literacy and pain management.

In addition, USAID/EA funding supported the implementation of policy-oriented activities including:

- In September 2008, Howard University and the Pharmacy Council of Tanzania convened a two-day summit on *Improving Medication Dispensing, Utilization and Health Information at the Community Level* to address the knowledge gap on HIV/AIDS among lower-level pharmaceutical care personnel including dug shops. The summit that brought together the Pharmacy Council, the Tanzania Food and Drug Authority, the National AIDS Control Program, the Nursing Council, pharmacists associations, pharmacy assistant and dispenser associations, and academia came up with recommendations that included regulatory reform and training to enable lower-level pharmaceutical care personnel to address HIV/AIDS issues currently being handled by pharmacists. Consequently, Howard University conducted training for 148 drug shops staff in aspects of HIV prevention, care and treatment;
- In 2010, Howard University carried out a HIV policy assessment in Kenya, Uganda, Tanzania and Zambia with the aim of appraising provisions made in the national policy documents that address Loss to Follow-Up (LTFU) from the ART program. The assessment aimed to evaluate how the national monitoring and evaluation plans and HIV/AIDS policies address LTFU. It explored the existence of mechanisms to ascertain true ART outcomes of death, treatment discontinuation, transferred out and loss to follow-up; evaluated strategies employed to reduce morbidity and mortality of patients on ART and provisions made to reduce direct and indirect costs to the patient; explored the steps taken to make ARV drugs simple and non-toxic to patients; and underscored the existence of a regional approach to address the ART needs of mobile populations. *Key findings* from the Report on Regional Policy Review on HIV/AIDS Treatment Loss to Follow-Up included*:* only two (Uganda and Tanzania) of the four countries reviewed specifically captured LTFU as part of the cohort indicators, but in spite of this inclusion clear target to monitor the program performance are not set; all the 4 countries reviewed have no policy guide in place for active tracing and status ascertainment of ARV clients that default, rather this role is undertaken by NGOs; there is free ARV services in the public health institutions of the four countries with options of private access to ARV services, but except for Tanzania the included Home Base Care (HBC) and community collaboration strategies do not specifically address tracking of patients that are classified as defaulters; and more significantly the policies of the 4 countries did not actively address the problems of mobile population and did not even reference the existing regional intergovernmental initiatives to provide a policy lead in this process.
- *Key recommendations* from the assessment highlighted the need for: LTFU to form an integral part of the national level M&E framework; an inclusion of a regional Inter-governmental initiative agreement on mobile population as part of the National Policy; and a process of harmonization of the HIV policy framework across the region to encourage easy access to ART service by mobile population.

- **Collaboration with East, Central and Southern Africa (ECSA)**

In 2008, ROADS collaborated with East, Central and Southern Africa (ECSA) in discussions that led to the development of a resolution by the 2007 ECSA Health Ministers Meeting to encourage national AIDS programs to introduce alcohol and substance abuse task force within their programs. Consequently, ROADS ensured that a renewed emphasis on programming related to alcohol and substance abuse within the context of HIV/AIDS was included in the ECSA recommendations for 2008.

In 2009, the project worked closely with the ECSA Health Community Secretariat on emerging issues critical to efficient and effective delivery of HIV/AIDS services, including collaboration with ECSA to lead discussions on ART clients lost-to-follow-up and alcohol/substance abuse in the context of HIV at the 48th ECSA Health Minister's Conference held in Ezulwini, Swaziland on March 16-20, 2009. Prior to the meeting, ROADS II developed concept notes on these issues to frame the discussion and ensure they were placed on the official meeting agenda. At the meeting, ROADS II presented progress to date on its work with ECSA developing alcohol sub-committees within national AIDS committees and plans for a regional Alcohol/Substance Abuse Task and experts meeting; as well as presenting on ART lost to follow-up at three sessions, including one attended by the assembled health ministers on March 19, 2009. As a result of ROADS' efforts, two actions were urged by the ministers under ECSA/HMC48/Resolution 7: "particularly concerned by the increase in number of ART patients lost to follow up in the region…work with partners to develop innovative, cost-effective interventions for retaining patients on ART in the region by 2012; "noting the relationship between alcohol use and substance abuse with HIV transmission…through the HIV-Alcohol Task Force, facilitate integration of alcohol prevention into national HIV prevention policies and programs and organize a task force meeting to review the status of the implementation of agreed actions." Action on GBV was also urged by the assembled ministers, building on earlier ROADS work with ECSA.

ROADS also participated in a series of discussions on cross-border and regional programing in TB control organized through USAID/EA. The first meeting was held on January 31, 2013 to discuss on 'Scope of Cross Border and Regional Programming in TB Control' based on the persisting need to reach out beyond the borders of any country in the region of East and Horn of Africa to address the growing challenge of mobile and cross border population in providing TB treatment. A follow-up meeting was held on April 11, 2013 with a focus on formalizing how to move ahead to have a regional programing in TB. The forum is now housed in ECSA-HC with a functional secretariat. Some of the expected deliverables include mapping of existing and ongoing initiatives, including the inter-country referral system in the different regional groups identified – EAC, IGAD and ECSA to avoid duplication of efforts; and development of a paper on cross-learning among countries.

ROADS II participated at the ECSA-HC 7th Best Practices Forum, held in Arusha, Tanzania, August 12-13, 2013. The theme was "Strengthening the Responses to Emerging and Re-Emerging Health Concerns in ECSA Region."

ROADS II supported development of a generic GBV and CSA curriculum and training materials. It also reviewed the content for these modules to ensure they are appropriate, accurate, complete, and up-to-date for service providers in East, Central and Southern Africa region.

3.2.5. Collaboration with EAC and SADC

In 2008, ROADS participated in a regional transport coordination meeting sponsored by the East Africa Community to review programming along the corridors in terms of partners and programmes and possible gaps. Key outcomes included identification of EAC as an appropriate regional coordinating body, and ROADS regional initiatives related to integrating alcohol and HIV/AIDS programming in collaboration with ECSA.

ROADS is on the regional TWG to define minimum package of services for SADC region. In 2013, ROADS sites in Zambia were sampled to provide baseline information for developing minimum package

of sex workers. In addition, ROADS was invited by RHAP/USAID South Africa to participate in various SADC consultative meetings.

In 2009, ROADS II participated in a joint meeting and field visits with East African Community Regional Cross-Border Transport Corridor Stakeholders. The Project shared lessons to inform regional planning and policymaking on HIV and vulnerable border areas in line with EAC plans.

In 2013, while participating at the ECSA-HC 7th Best Practices Forum, held in Arusha, Tanzania, ROADS proposed a Regional Transport Corridor Meeting with active participation from EAC. During the meeting held in Nairobi in September 2013 that drew wide participation from diverse regional stakeholders including the transport sector (unions, Kenya National Highways Authority, FEAFFA), private sector (Trade Mark East Africa) and government ministries such as health and East Africa Affairs. The participants produced the following key recommendations:

1. Under the leadership of the East African Community (EAC), establish a Multi-sectoral Task Force to spearhead strategic action for regional integrated health programming along transport corridors (e.g., mapping, policy review, research agenda);
2. Building on existing national strategies, develop a regional strategy for integrated, comprehensive health programming along the corridors through an inclusive approach with all key stakeholders[11] (e.g., minimum package of services);
3. Establish an inclusive Regional Advisory and Oversight Forum within EAC with responsibility for coordinating regional integrated health programming along the transport corridors, regional policy formulation, regional program monitoring, capacity building and technical assistance, regional research, knowledge management, etc.
4. Develop a specific regional strategy for public-private sector engagement in integrated health programming along transport corridors.

Consequently, these recommendations heralded the establishment of a regional Task Force where ROADS is a member. The recommendations have also reverberated in subsequent regional forums addressing provision of standardized quality and sustainable HIV and broader health services to mobile populations and transport corridor communities.

In September 17-18, 2013, ROADS participated in the East Africa Cross-Border Study Validation Meeting held in Mombasa, Kenya. The meeting convened by EAC with support from USAID/EA brought together stakeholders from EAC partner states to review findings on available HIV and broader health services in cross-border communities, including gaps and opportunities. This study came as a backdrop to the on-going EAC process of implementing the One Stop Border Post (OSBP) Initiative at common borders, and the acknowledgement of challenges anticipated in smooth provision of integrated basic health services within partner states and with adjoining regions. Key policy and program recommendations echoed those made and/or efforts undertaken by ROADS II, such as harmonization of policies in the EAC region, specifically relating to access to HIV/AIDS services across partners states; designing, strengthening and implementing HIV prevention strategies known to work for mobile populations and cross-border communities; and promoting multi-sectoral collaboration within and across borders.

11 Stakeholders include public and private sectors, donors, civil society, host communities, and mobile populations including transport and migrant workers.

In September 30-October 1, 2013, ROADS participated in an International Organization for Migration (IOM)-organized regional consultation meeting entitled "Coordinated Scale-Up of Comprehensive Health Programming along Transport Corridors in East Africa, and in particular at One Stop Border Posts (OSBPs)" that was held in Dar es Salaam, Tanzania. The purpose of the meeting was to consult with key regional and member state government partners, select regional implementing partners and other development partners on lessons learned and recommendations for coordinated health interventions along the transport corridors of East Africa, particularly at OSBPs.

Members of the EAC Task force on scale up of integrated health and HIV programming along transport corridors

Subsequently, ROADS has played a key role in various EAC Regional Task Force meetings on Integrated Health and HIV/AIDS Programming along Transport Corridors in East Africa held in 2014. These include: the Expert Meeting to Develop a Technical and Financial Proposal to Support Interventions on HIV/AIDS, STIs and TB in the EAC region that was held on April 7 – 8, 2014 in Arusha, Tanzania; the 2nd Meeting of Expert Task Force on Scale Up of Integrated Health and HIV Programming along Transport Corridors in East Africa held on April 23 – 24, 2014 in Nairobi, Kenya with the aim of reviewing and adapting key documents that will guide the scale up of integrated services along the transport corridors; the EAC country consultations on the 2nd Strategic plan on HIV and AIDS, TB, and STIs 2015 – 2010 meeting held on June 11, 2014 in Nairobi; and the 8th EAC Regional HIV/AIDS Partners' Forum held in Kigali – Rwanda on Friday, 27th June 2014 with the purpose of facilitating multi-stakeholder interaction by bringing together key regional partners working in the area of HIV/AIDS in Eastern Africa so as to share information and identify opportunities for new and strengthened networking and collaboration.

ROADS II supported the selection of sites for a study to provide a regional perspective on HIV/AIDS burden at cross-border communities in East Africa and key populations commissioned by EAC with USAID/EA funding.

In 2014, ROADS II supported a mapping exercise in Burundi and Rwanda to profile and map out health care and HIV/AIDS service (biomedical, behavioral and structural) providers along major transport corridors. This will facilitate effective engagement and coordination of EAC (and its partner countries) and stakeholders in integrated health and HIV/AIDS programming along major transport corridors in the East African region.

ROADS II supported a desk review and situation analysis of HIV/AIDS along major transport corridors and cross-border communities in the region. The purpose of this exercise was to support the EAC Secretariat to conduct a situational analysis to highlight the gaps in service delivery along the transport corridors in the region, as a preliminary deliverable towards the development of a regional strategy for integrated health and HIV/AIDS programming along the transport corridors in the EAC region.

3.2.6 Monitoring and Evaluation Systems Reinforced

ROADS' M&E system was designed to measure key outputs and periodic outcomes. The system aimed to ensure that quality M&E data was generated in a timely fashion for documentation and dissemination of ROADS project performance, results, and capacity. It was to build the capacity of local implementing partners to not only manage and analyze data but also to utilize data for decision making. ROADS II strengthened M&E processes and systems established under ROADS I at site, national and regional levels to guide participatory, coordinated and efficient data collection, and thereon the analysis, use and provision of that data to track achievement of project objectives and to inform programmatic decision-making at all levels. The ROADS regional M&E system was designed to coordinate with, support and compliment country specific structures, which were based on respective national monitoring and evaluation (M&E) systems following the "Three-Ones" principle. The system was established to be consistent with USAID/EA requirements while providing a platform for integration with respective national (government and PEPFAR) requirements. Local implementing partners were central in the process of development and implementation. Information gathered through the strengthened M&E procedures provided partners and stakeholders with a clear understanding of how they were contributing to HIV/AIDS reduction and mitigation, as well as policy development and advocacy. A key aspect of this approach was community capacity building.

Following ROADS I mid-term evaluation, ROADS II implemented a series of recommendations that resulted in the development of a revised M&E plan that enabled ROADS II project performance to be predicated, measured and improved. The plan had an inbuilt mechanism for improvement by building on lessons learnt during implementation and challenges encountered. The plan provided a framework for measuring a multi-faceted program with several technical areas (HIV/AIDS prevention and mitigation; reduction of gender based violence; reproductive health including promotion of family planning and promotion of maternal, new-born and child health, malaria, support to vulnerable families improve their income and food security among other new program elements).

The objectives were identified for the ROADS II M&E system:

- Improved quality of data produced by *Roads to a Healthy Future* and its implementing agencies (IAs) and partners;
- Improved timeliness of data for use in program improvement and reporting;
- Improved coordination of data management and utilization;
- Establishment of a mechanism for disseminating data and feedback from regional-level to country- and site-level;
- Monitor performance of demand creation for health services at community level;
- Monitor performance in addressing social determinants for health among orphans and vulnerable children (OVC), home-based care clients and other vulnerable target populations;
- Systematic measurement of the program's contribution to achieving respective national and PEPFAR objectives, through defined project performance indicators;

- Provision of targeted capacity building to enable implementing partners to record, report, and use data to plan, manage and improve services;
- Ensuring best practices are documented and disseminated.

To meet these objectives, and responding to specific recommendations identified by USAID as part of the mid-term evaluation for M&E infrastructure, the following activities highlights initiatives undertaken to ensure a robust system:

- Initiatives to strengthen country and site level capacity including identification of M&E personnel with the right mix of skills
- Targeted mentorship by the country M&E and program team to implementing partners
- Capacity building of local implementing partners in data collection, management and utilization as well as Data Quality Assessment.
- Development and utilization of services standards and checklists
- Multi-disciplinary programmatic review meetings at site, country and regional levels
- Periodic review of the system and tools
- Participated in community/local and national level reporting forums including membership to relevant technical working groups.
- Documentation of lessons learnt through systematic assessments and implementation science.
- Conducted integrated bio-behavioral surveillance surveys to contribute to the body of knowledge in respective countries and provide a platform for evaluation of interventions by all national partners

Key M&E accomplishments

- Strengthened systems and procedures including availing tools and checklists to ensure collection of quality data
- Strengthened planning tools and guidance including regional and country M&E plans and Performance Management Plans
- Established integrated regional database that met the complex multifaceted nature of the project
- Use of cutting-edge technology in M&E
- Capacity building and support to sites and implementing partners
- Documentation of lessons learnt and surveillance surveys in several countries

Knowledge Management

ROADS II enhanced its Knowledge Management Systems with the objective of documenting project outcomes, processes and systems. The table below illustrates the different special studies, assessments and other documentation activities undertaken during this implementation period:

Title	Type of Document	Target Audience	Dissemination Channel
1. Democratizing Health and Development Programming in the Era of USAID Forward: Lessons from a Community Organizing Approach in East and Central Africa	Cluster assessment booklet drawing key processes, lessons learned, recommendations, and success stories/community voices from the four countries	• USAID/East Africa • USAID bilateral missions • USAID/Washington • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies (regional end-of-project meeting, etc.) • Electronic dissemination via web sites
2. *Integrating Economic Strengthening into Health Programming: Household Economic Assessment in the East, Central and Southern Africa (ECSA) Region*	Household economic assessment (HEA) drawing lessons learned from three countries	• USAID/East Africa • USAID bilateral missions • USAID/Washington • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies (regional end-of-project meeting, etc.) • Electronic dissemination via web sites
3. *Access to HIV and Other Health Services along Transport Corridor in East, Central and Southern Africa*	Multi-country report examining the HIV situation and access to related services along select corridors, drawing on spatial and statistical data from DHS, AIS, SPA, BMS, etc.	• USAID/East Africa • USAID bilateral missions • USAID/Washington • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies (regional end-of-project meeting, etc.) • Electronic dissemination via web sites
4. *Promoting Gender Equality and Women's Leadership: Lessons from a Community Organizing Approach in East and Central Africa*	4.1. Booklet including processes, lessons learned and case studies from Kenya, Rwanda, Tanzania and Uganda (formal external printing)	• USAID/East Africa • USAID bilateral missions • USAID/Washington • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies (regional end-of-project meeting, etc.) • Electronic dissemination via web sites

5. *ROADS Technical Resources*	5.1. Technical Briefing Documents: HIV Prevention, HIV Counseling and Testing, HIV Care and Support, Antiretroviral Therapy (Burundi), Gender, Most Vulnerable Children, Family Planning/ Reproductive Health (internal desktop publishing)	• USAID/East Africa • USAID bilateral missions • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies (regional end-of-project meeting, etc.) • CD-ROM • Electronic dissemination via web sites
	5.2. Training materials: curricula and facilitator's guides for all technical areas above (internal desktop publishing)		
	5.3. Learning stories from ROADS countries (internal desktop publishing)		
	5.4. Messages and BCC materials (e.g., posters for key populations that appear on the Kenya/NASCOP web site)		
	5.5. Films and video clips: short documentaries from Burundi, Kenya, Rwanda and Tanzania		
6. *ROADS II Final Report*	Comprehensive final report reviewing achievements, challenges and lessons learned through the LWA and AAs (internal desktop publishing	• USAID/East Africa • USAID bilateral missions • USAID/Washington • ECSA • EAC • SADC • Government counterparts (national, provincial, district, local) • Civil society • Development practitioners	• Hard copies • Electronic dissemination via web sites
7. *Abstracts/Articles for Peer-Reviewed Journals and Conference Presentations*	8.1. Articles/ presentations/posters on the ROADS nutrition assessment in Rwanda, cluster assessment, HEA, IBBSS in Djibouti, BMS in Tanzania, focused programming for females sex workers, etc.	• Broader health and development community	• Selected journals (new USAID peer-reviewed journal, Global Health Portal, etc.) • International conferences (IAS, ICASA, etc.)

ROADS publications and video for wider dissemination

Recognizing its key role in community programming for HIV and broader health, ROADS participated in a PEPFAR Evaluation Dialogue Meeting as a PEPFAR implementing partner. To facilitate in-depth discussion around various topics in this report, the Institute of Medicine (IOM) held a public dialogue session on April 1, 2013 in Washington DC where ROADS Project Director participated as a discussant in two breakout sessions: HIV Prevention and Gender.

In addition, the Project Director participated as a committee member and panelist at the Institute of Medicine Workshop on Evaluation Methods for Large-Scale, Complex, Multi-National Global Health Initiatives in January 2014 in London. The workshop shared insights gained from the conduct of recent evaluations of the U.S President's Emergency Plan for AIDS Relief; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the U.S. President's Malaria Initiative; the Affordable Medicines Facility-Malaria; and other large-scale global initiatives. She was also a reviewer of materials emanating from the workshop including *Evaluation Design for Complex Global Initiatives*, which were published by The IOM National Academies Press Washington, DC as resources for program managers and evaluators.

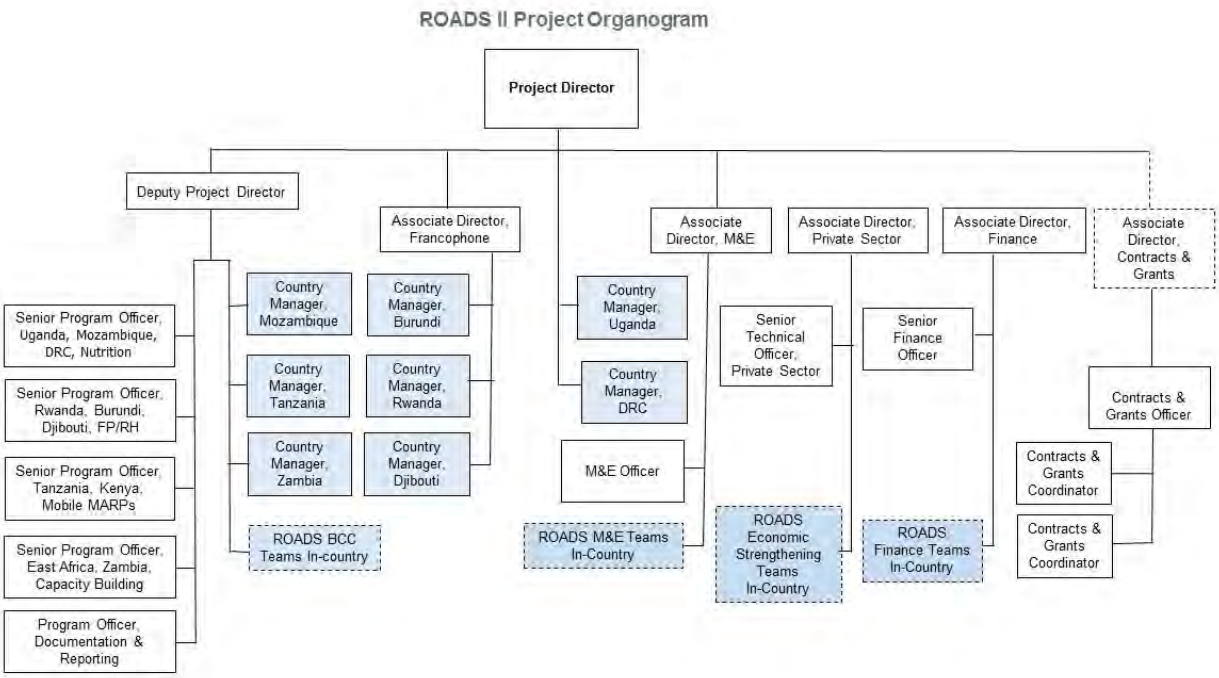
Section 4: Management Approach

Management and Staffing

The ROADS II management structure was informed by the ROADS management design as reframed by the recommendations of the mid-term reviewers of ROADS in January 2008, follow-on discussions with USAID missions and the programmatic and financial dimensions of ROADS II. The management

structure of ROADS was strong and provided adequate leadership across countries, using mostly African and local expertise in management and technical areas.

The project continued to maintain its headquarters in Nairobi, building on the decentralized management structure put in place in FY 2008 to better respond to program needs across countries as supported by the bilateral Missions. The LWA supported the Nairobi-based management and technical staff and staff with regional oversight responsibilities as well as costs of regional activities (e.g. policy work, strengthening AfriComNet, etc.). Country programs funded by bilateral missions under ROADS II operated as independent cooperative agreements (associate awards) staffed at levels appropriate to the specific scope of work to ensure successful delivery of the program. The organizational structure below illustrates the staffing structure that was operational for the broader period of the project:



In-country presence, with technical and programmatic oversight from Nairobi, was critical to effective implementation and communication with missions. Financial management was administered primarily by the regional office in Nairobi, Kenya. In-country staff were responsible for day-to-day management and implementation of program activities funded by associate awards, with some funding from associate awards also covering regional and external technical assistance. In-country management staff met regularly with USAID mission health officers and HIV activity managers to update them on progress, represented the project at country implementing partner meetings and participated in thematic group meetings. Driven by local need identification, additional technical and management staff were placed in specific countries as defined by the needs of the particular program. ROADS II in-country staff were located within the pre-existing FHI 360 country offices to take advantage of shared services where possible (e.g., administrative staff such as finance officers, human resource staff, secretarial support and drivers), as well as linkages with management and technical staff from other FHI 360 and ROADS partners

to draw on their resident expertise and ensure program linkages. The Nairobi office team augmented in-country support through short- to medium-term technical assistance visits in countries as appropriate.

Management team meetings comprising FHI 360 key staff and a senior representative of ROADS strategic partners were held over identified periods to review strategic program direction and implementation issues against the work plan for the Leader and the various Associate Awards. Similarly, quarterly (and later annual) regional meetings were held that brought together ROADS country managers and key technical staff to convene in-depth updates on country-level programming as well as identify best practices and innovations for scale up in the region.

In addition, members of the Regional Office Management team conducted periodic country visits to review progress and provide management and program support as appropriate and also meet with USAID and key stakeholders including governments.

- **Financial report**

ROADS II provided strong financial, operational and program management systems to ensure cost effectiveness and compliance with the FHI 360 and USAID rules and regulations. As at July 31, 2014, ROADS II obligated amount was $140,219,961 as shown in the table below:

USAID Mission	Start Date	End Date	Total Commitment	Total Obligated Funds	Ceiling Balances
EAST AFRICA	1-Aug-08	31-Jul-14	$17,000,000	10,774,870	$6,225,130
TANZANIA - Award II	6-Oct-09	31-Jul-14	$20,038,458	20,038,458	$0
TANZANIA - Award I	29-Sep-08	31-Dec-09	$3,593,286	3,593,286	$0
BURUNDI	29-Sep-08	31-Mar-14	$18,743,191	18,743,191	$0
RWANDA	29-Sep-08	31-Dec-13	$14,900,000	14,900,000	$0
DRC	29-Sep-08	31-Dec-09	$800,000	800,000	$0
ETHIOPIA	30-Sep-08	31-Dec-09	$100,000	100,000	$0
UGANDA	2-Oct-08	30-Nov-10	$4,685,000	4,685,000	$0
SUDAN	21-Nov-08	31-Dec-09	$2,701,000	2,701,000	$0
ZAMBIA	11-Sep-09	10-Sep-14	$25,000,000	24,596,972	$403,028
MOZAMBIQUE	1-Sep-10	31-May-15	$14,059,026	12,710,316	$1,348,710
KENYA	11-Mar-11	10-Mar-13	$1,000,000	1,000,000	$0
DJIBOUTI	27-Sep-12	26-Sep-17	$4,500,000	2,600,000	$1,900,000
DRC	21-Nov-12	20-Nov-15	$5,600,000	2,100,000	$3,500,000
RWANDA ROADS III	1-Oct-13	30-Sep-16	$7,500,000	2,200,000	$5,300,000
Total			**$140,219,961**	**$121,543,093**	**$18,676,868**

ROADS II Obligations by Missions

The following table shows USAID/EA's cash disbursements analysis:

Budget Line Items	FY9	FY10	FY11	FY12	FY13	FY14	Total
Personnel & Consultants	499,521	725,084	611,690	630,971	439,633	340,579	**3,247,477**
Fringe Benefits	128,430	146,296	134,476	122,275	181,562	102,229	**815,267**
Travel	126,642	138,043	144,030	133,628	57,263	80,320	**679,927**
Equipment	9,539	30,919	25,930	58,039	4,611	(37,243)	**91,795**
Supplies	23,437	23,693	22,506	18,705	4,230	9,161	**101,730**
Contractual	5,691	47,473	596,546	464,741	244,452	80,661	**1,439,565**
Other	297,347	413,379	431,574	370,135	236,998	171,400	**1,920,833**
Indirect Costs	310,759	405,405	436,070	436,157	339,478	273,729	**2,201,598**
Total	**1,401,366**	**1,930,292**	**2,402,822**	**2,234,649**	**1,508,226**	**1,020,837**	**10,498,192**

ROADS II LWA/East Africa Cash Disbursement Analysis

- **Subawards with Strategic and Local Partners**

ROADS II collaborated with implementing and strategic partners through its sub-agreement mechanism. FHI 360 through ROADS II made financial resources available to local agencies through its sub-agreement mechanism. At the end of June 2014, a total of $**1,439,564.63** had been obligated to the partners.

Sub-recipient	Start Date	End Date	Actual Exp thru: July 30, 2014
Regional: JHU/CCP/AFRICOMNET - RO	1-Dec-08	30-Apr-13	647,922.14
Regional: Howard University: ROADS II FP Primary	1-Oct-08	30-Sep-12	121,251.60
Regional: ROADS II - POP/MCH	1-Oct-09	30-Sep-11	39,584.55
Regional: Howard University: ROADS II Loss To Follow Up	1-Sep-10	30-Nov-10	39,736.00
Burundi: Georgetown Univ/IRH: FP/GBV subproject	1-Jan-10	31-Aug-11	30,713.00
Djibouti: PLS Sante: Improving Counseling & Testing	1-Jul-11	30-Sep-12	16,635.49
Djibouti: MASSABA: HIV/AIDS Prevention Activities	15-Aug-10	30-Sep-12	129,585.11
Kenya: Lifeworks Shukrani: Women Economic Strengthening	15-Feb-13	31-Mar-14	81,066.80
Rwanda: Rusizi Health Center: Rusizi FP S	1-Sep-09	31-Dec-09	8,032.02
Uganda: ATGWU: Uganda SafeTStop Resource Center	1-Apr-11	31-Jan-14	184,252.52
Uganda: MPSOHDA: Mbuya Kinawattaka Youth Cluster	1-Aug-11	31-Jan-14	61,018.20
Uganda: KWG: Mbuya Kinawattaka LIW HIV/AIDS Project	1-Aug-11	31-Jan-14	60,069.51
Total			**1,439,564.63**

ROADS II LWA/East Africa Sub-award Expenditure Analysis

- **Cost share**

At the end of June 2014, ROADS II had realized a total cost share value of US$ **1,916,846**, derived mainly from volunteers' time, space, supplies and equipment contribution for the various program activities.

Period	FY09	FY10	FY11	FY12	FY13	FY14	Total (USD)
Volunteers	364,126	339,039	212,999	126,893	13,810	34,837	1,091,703
Space	11,888	20,045	138,148	187,741	45,379	24,825	428,027
Supplies/eqp	54,836	132,793	45,249	31,542	11,295	11,554	287,269
Others	509	2,457	33,052	18,183	756	54,889	109,847
Grand Total	**431,359**	**494,334**	**429,448**	**364,359**	**71,240**	**126,105**	**1,916,846**

LWA Cost Share Contribution

Section 5: Lessons Learned and Recommendations

Lessons Learned

Capacity Strengthening

- At community level, there is great untapped interest in participating in health and development programming and in developing appropriate skills.
- In underserved corridor communities, educational and literacy levels are generally low, requiring development of appropriate tools and materials.
- Capacity-strengthening in 'corridor' communities requires focused, intensive skills-strengthening early in the program to foster meaningful participation with impact.
- When myriad local groups are brought together, longstanding rivalries and actions emerge, requiring specific focus on conflict avoidance/resolution.
- With targeted capacity strengthening, community partners can go beyond a "beneficiary" role to design and implement high quality programs with deep reach in the community.
- New partners at the grassroots can attract and manage significant funding effectively, efficiently and transparently with proper capacity strengthening.
- Periodic trainings are not sufficient to ensure retention, use and transfer of skills among groups with initial low capacity; ongoing supportive supervision, coaching and mentoring is essential.
- Corridor communities are often economically disadvantaged, forcing a difficult choice between making ends meet and volunteering. This requires strengthening capacity of a large volunteer base so that there are "more people doing less," and volunteering can be worked into daily routines.

Economic Strengthening

- Initial community expectation often revolves around 'hand-outs'; this learning process is continual and requires sensitivity in initial mobilization and sensitization activities. ES programming requires careful planning with other programming components so as to provide consistent messages about expectations from the project.
- Households frequently need ongoing support rather than one-off activities to change behaviors.
- Field-testing of a new methodology (such as Household Production Guide) across the region builds consistency in delivery but allows for country contextual nuances.

- Value of **social cohesion of GSLA** to re-orient members away from an expectation of continuing project support mentality. A group or collectivist mentality remains in some instances and still hinders genuine entrepreneurialism for many.
- **Moving away from classroom-based delivery** of technical assistance and towards the household builds GSLA member ownership and sets a platform for sustainability. This however requires concerted support, coaching and monitoring.
- Investment in M&E and **follow-up TA is a continual need**; initial efforts to build capacity of the implementing partner to understand concepts and best practices around ES yielded huge benefits
- '**AIDS-sensitive' not 'AIDS-exclusive' approach-**need to consider Key Populations targeting against this principle of ES programming
- **'Graduation' metrics are required** to identify households that are lifting out of ES and towards more sustainable livelihood activities and to support them adequately. Households do not show a straight progression from 'vulnerable' to 'less vulnerable' but move from one to the other and back again depending on local economic changes as much as individual performance.
- Higher-end value chain activities take time to move to; GSLA groups need ongoing market information and market facilitation: **one-time trainings do not work.**

FP/RH and GBV Program

Capacity for provision of FP services at participating facilities

- Conducting baseline assessment on KAP in community and facility prior to program design is critical in addressing/targeting gaps identified thus contributing to effective systems strengthening and use of resources
- Recruitment and deployment of dedicated FP/RH Technical Officers ensures effective and efficient implementation of activities and collaboration with partners, MoH, CBOS, NGOs etc.
- Use of MOH trainers and national training materials helped make the activity relevant and tailored to individual country needs. This also helped the interventions be more sustainable as external trainers were not required
- Expanding the roles of community based health workers and drug shops/pharmacies is strategic in delivering message on FP, which promote uptake of services at facility level
- Training community volunteers and health workers at facilities using local languages such as Kiswahili in Tanzania and Kirundi in Burundi helped in understanding, knowledge retention and confidence.
- Evidence-based scale up of SDM in Burundi can inform future progress/replication in other ROADS countries should SDM funds become available.
- Collaboration with District authorities ensures sustainability of services (E.g. establishment of secondary posts in Rwanda where Districts provide space and personnel for FP services)
- Training of facility-based providers in LAPMS helps in providing a wider choice of methods to clients at facilities. Such include IUDs, Implants and permanent methods (For both men and women).
- By training health providers at community, facility levels, the police, local government and judiciary staff in GBV, ROADS has observed an increased awareness and expertise in handling GBV cases at all sites. Both gender now discuss GBV issues openly
- Through effective collaboration with Ministry of Health and Technical Working Groups for FP/RH, ROADS contributed to the design of CBD and GBV curricula for Rwanda, Burundi and Tanzania

- At facilities where trained FP providers were not transferred for a long period of time, this enhanced continuity of services and ensured effective linkages with the community component
- Training facility based providers to provide Youth Friendly Services (by other donors at Tunduma TZ) enhanced service provision to this target group.
- Motivation of community volunteers included, e.g. conducting monthly meetings to discuss topical issues and receive technical assistance in FP/GBV/HIV, having identification clothing for PEs and CBD Kits for CBDs and recognition in the community for their services enhanced their morale and continued participation in the project.
- Training of facility providers on FP/HIV integration enhances efficiency and effectiveness and quality of care

FP commodity security in the sites

- Availability of basic or adequate equipment, materials and supplies at facilities increases the use and quality of services (feedback from MoH in participating countries).

Demand and awareness for FP services

- Linking CHWs to nearest facility for supportive supervision, supplies and referrals improves quality of services in the community
- Developing FP and GBV training materials for community health workers in local languages such as Kirundi (Burundi) and Kiswahili (Tanzania) is an effective approach.
- Cluster volunteers engaged (including youth clusters) in peer-based activities relating to HIV/AIDS were able to effectively integrate FP/RH/GBV issues into their community discussions, as well as refer appropriately for FP/RH/GBV services.

Barriers inhibiting uptake of FP services

- There is improvement in the level of male involvement on FP/RH issues albeit slow. CBDs report being able to visit couples more and more as opposed to earlier situation where they counseled only women without their partners. Such couples are effective in having more men listen to FP and GBV messages and counseling. There is significant increase in men accompanying their partners to ANC clinics.

Provision of quality FP services

- At facilities where ROADS II provided equipment and supplies, there is improvement in quality of services when compared to those that lack them. Such basic equipment includes, delivery beds, delivery kits, IUCDs, Speculums, BP machines, Fetoscope, Stethoscopes, examination lumps etc.
- When community health programs are designed it is important to make provision in budget for basic medical equipment and supplies for participating facilities that in most cases lack such support.

Alcohol/Substance Abuse

- Due to the profile of ROADS II sites, brewing and selling local alcohol is a thriving business, and therefore to make ends meet, many low income women are involved in this business. To address this, project beneficiaries were encouraged to get involved in ROADS II economic strengthening activities

which provide three levels of livelihoods support; 1) mobilizing financial safety nets through savings (GSLA); 2) maximizing household production; and 3) increasing market readiness.

- Availability and easy accessibility of local brews is a huge barrier to the alcohol risk reduction program. To overcome this, ROADS closely worked with various stakeholders in the community through the multi-sectoral alcohol/SGBV taskforces to ensure the implementation of the program, and solutions to deal with barriers to change are community-led and determined.
- These task forces also assist in dealing with another barrier which is lack of enforcement of policy and laws governing the regulation of alcohol production and sale.

Gender

- Facilitating platforms for disparate audiences to meet and discuss difficult, even taboo subjects in a neutral environment can initiate a process of constructive engagement and joint activity, such as bringing together police and female sex workers to discuss issues around GBV. However, building trust for sensitive community dialogue can be time-consuming and requires skilled facilitators.
- Men are more open to discuss gender roles, the impact of their behavior on the community, and constructive ways they can protect their health and the health of others when engaged in dialogue by other men, rather than people outside their peer group.
- It is critical to integrate gender analysis into assessment processes to; 1) identify gender issues influencing health-seeking behavior; and 2) establish baselines and guide program development, implementation and M&E.
- To advance gender-equitable programming, it is critical to include gender-specific indicators in performance-monitoring plans, e.g., % men and women composing cluster steering committees.

Recommendations

Cross-cutting

1. There is need to improve acquisition and distribution of IEC materials because this plays a significant role in educating and influencing behavior change among the mobile populations.
2. There is high demand for Alcohol/GBV risk prevention interventions in the community following mobilization and formation of Community Alcohol Support Groups and task forces. Formation of these groups should therefore be replicated in other ROADS sites and countries.
3. Networking with relevant collaborating partners and participating in technical working groups s should be encouraged in all ROADS countries.

FP/RH and MNCH

1. Urgent need to conduct training for FP providers in the public and private sectors in sites that FP/RH adoption is slow. This includes the drug shop owners and health care providers in the government-owned health units. There are glaring gaps in the knowledge levels for the providers especially in the mid- and long-term contraceptive methods.
2. There is an urgent need to improve the infrastructure of health facilities in some sites/countries to improve privacy while conducting FP/GBV services.
3. There is need to improve on contraceptive options provided in clinics/drug shops. For example, there was only one clinic providing injectable yet this is the most widely used contraception method in Uganda.

4. Staffing inadequacies need to be addressed in order to provide quality services.
5. Male involvement in MCH services need to be prioritized through incentives and sensitization in order to improve utilization of these services.
6. Training is very crucial in improving MNH services in most of the health facilities.
7. Provision of IEC materials for MNH and FP is very critical in the improvement of these services in health units.
8. GBV is still unknown as a public health problem in the community among health care providers. Therefore sensitization and training are necessary.

Economic Strengthening

1. ES programmes should specifically target households with orphans or adopted children living within, as an indicator of vulnerable households, and link any ES intervention to child-level outcomes. OVC household populations could be targeted for sensitization on Economic Strengthening interventions, and then allow self-selection into the intervention by individual households.
2. GSLA alone cannot be hailed as the *single financial service* acting as a change agent in the household economy but as a *critical starting point* to use of more formal financial services. Whilst accepting the value respondents see in pulling on GSLA resources as a response to seasonal shocks, programs should continue to encourage the use of these resources for productive, more than for consumption uses for loans thereby derived.
3. ES programs should explore country-specific options for transitioning from the physical 'cash-box' system of the traditional GSLA methodology and towards using mobile telephony technologies to improve security of members' savings whilst retaining the social value of the regular GSLA meeting. FHI360 has capability in using mobile technologies innovatively[12].
4. ES programs should enable GSLA members to 'graduate' from project support but to sustain their independent GSLA activities. Projects should support this by building capacity in GSLA members to understand their individual financial needs better, assess the local market providers' ability to meet those needs and to select the most appropriate product.
5. Positive outcomes within GSLA membership should inform any future provision of direct support, such as subsidizing national health insurance payments. Some GSLA members are able to and willing to pay for their own insurance; program information can inform that any project subsidy is better targeted towards those more vulnerable households. Projects should develop conversations with national health insurance providers, and facilitate linkages between those providers and GSLA groups, to enable the savings potential to be diverted to sustainable government health insurance programmes.
6. Programs should continue to move away from facility-based time-limited technical trainings and towards emerging field-based coaching/mentoring approaches that strengthen the peer-to-peer component of information and skill exchange to maximize upon the better practices that exist amongst some, but not all, households.
7. Programs should harness the motivations for engagement in IGA/small business more effectively, by linking with promoters/suppliers of innovative technologies and encourage the market to enter the more inaccessible rural areas.
8. Integrated programs need to develop stronger internal linkages across program elements to maximize upon a strong sense of social capital within the GSLAs to include health messaging, and then identify any impact that livelihoods outcomes have upon health-seeking behaviors.

[12] See http:/kdid.org/projects/field-support/mstar for an example of FHI 360's capabilities in using mobile technologies for development solutions

9. Programmers should build and maintain strong linkages with all line ministries involved in economic development per country government, in order to enable self-advocacy for support services by GSLA members as a move towards longer-term sustainability. Stronger operational linkages can evidence a strong strategic partnership, primarily by encouraging better engagement and demand for government services by GSLA members themselves, rather than as a 'project-driven' activity.
10. Programs should use such study approaches as baseline information to identify households that are more vulnerable *prior* to ES interventions, building the evidence that ES interventions do contribute to stronger household economies.
11. Future studies may also include linking livelihoods outcomes to ART adherence, nutritional outcomes and child well-being outcomes.

Annexes

ROADS Sites

Country	Province OR Region OR State	District OR County	Site
Kenya			
	Coast	Mariakani	Mariakani
	Coast	Mariakani	Maungu
	Western	Teso	Malaba
	Rift Valley	Nakuru	Nakuru Pipeline
	Western	Busia	Busia
	Eastern	Athi River	Mlolongo
	Eastern	Machakos	Machakos Junction (Kyumbi)
Uganda			
	Eastern Region	Tororo	Malaba
	Eastern Region	Busia	Busia
	South Western Region	Kabale	Katuna
	West Nile region	Koboko	Koboko
	Central	Kampala	Mbuya Kinawaka
Tanzania			
	Mbeya	Mbozi	Tunduma
	Iringa	Njombe	Makambako
	Coast	Temeke	Port of Dar
	Shinyanga	Kahama	Isaka
	Mwanza		Mwanza
	Sumbawanga		Sumbawanga
	Chalinze		Chalinze
	Ilula		Ilula
	Songea		Songea
	Tanga		Tanga
Rwanda			
	Kigali City	2 communes	Kigali/Magerwa/Gatsata
	North	Gicumbi	Gatuna
	Western	Rusizi	Rusizi
	Western	Rusizi	Bugarama
	Eastern	Kirehe	Rusumo
			Rubavu
Burundi			
	Kayanza	9 communes	Kayanza
	Muyinga	7 communes	Muyinga
	Bujumbura	1 Commune	Bujumbura
	Kirundo	7 communes	Kirundo
	Karusi		Karusi
D R C			

	Kivu	Bukavu City	Bukavu
			kolwezi
			Mokambo
			Sakaina
Djibouti			
		Djibouti Ville	PK 12
			Dikhi
Sudan			
	Central Equatoria	Juba	Juba
	Central Equatoria	Yei	Yei
	Central Equatoria	Morobo	Kaya
	Central Equatoria	Morobo	Morobo
	Central Equatoria	Lainya	Lainya
	Lakes State	Rumbek	Rumbek
	Wesstern Equatoria	Tambura	Tambura
	Western Equatorial	Yambio	Yambio
	Western Equatoria	Mundri	Mumdri
	Eastern Equtoria	Kapoeta South	Kapoeta
	Eastern Equtoria	Magwi	Nimule
Zambia			
			Chipata
			Chirundu
			Kapiri Mposhi
			Kazungula
			Livingstone
			Nakonde
			Solwezi
			Chililabombwe
			Sesheke
			Katete
Ethiopia			
		Addis Ababa	Wolenchiti
			Mojo
Mozambique			
			Munhava
			Trevo
			Luis Cabral
			Ressano Carcia
			Manga
			Moamba
			Inchope
			Changara

LWA Modifications

AMENDMENTS	PARTICULARS
LWA 623-A-00-08-00049-00	Award date / Letter dated Sep 15 2008 Effective dates: **Start Date : August 1, 2008** **End date : July 31 , 2013** *Total Estimated Amount $ 109,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 1,941,989.00*
Modification # 1 dated 09/15/09 **Effective Date : Sep 11 2009**	Action : Obligate additional US$ 55,000 Total Estimated Amount $ 109,000,000.00 Cost share Amount $ 1,887,804.00 Total Obligated Amount $ 1,996,989.00 New obligation expected to fund performance through approximately September 30, 2010 **Start Date : August 1, 2008 End date : July 31 , 2013**
Modification # 2 dated 09/17/09 **Effective Date : Sep 10 2009**	Action : Obligate additional US$ 2,499,800.00 Total Estimated Amount $ 109,000,000.00 Cost share Amount $ 1,887,804.00 Total Obligated Amount $ 4,496,789.00 New obligation expected to fund performance through approximately September 30, 2010 **Start Date : August 1, 2008 End date : July 31 , 2013**
Modification # 3 dated 06/14/10	Action : Increase the TEC by $ 91,000,000 Replace the Budget entirely Provide the use of SF425 / SF425a and discontinue SF-269,SF-269a and SF270 Replace the February 2004 Provision on Equal protection of the law for the faith based and community organizations with the same provision dated December 2009 *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 4,496,789.00* **Start Date : August 1, 2008 End date : July 31 , 2013**
Modification # 4 dated 09/28/10 **Effective Date : Sep 17 2010**	Action : Obligate additional US$ 2,003,00.00 Total Estimated Amount $ 200,000,000.00 Cost share Amount $ 1,887,804.00 Total Obligated Amount $ 6,499,789.00 New obligation expected to fund performance through approximately September 30, 2011 **Start Date : August 1, 2008 End date : July 31 , 2013**
Modification # 5 dated 09/28/11	Action : Obligate additional US$ 1,802,000 Insert new mandatory provision on “Trafficking in persons” *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 8,301,789* New obligation expected to fund performance through approximately September 30, 2012

	Start Date : August 1, 2008 End date : July 31 , 2013
Modification # 6 dated 09/20/12 **Effective Date : Sep 17 2012**	Action : Obligate additional US$ 1,307,000 *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 9,608,789* **Start Date : August 1, 2008 End date : July 31 , 2013**
Modification # 7 dated 07/03/13	Action: To extend the completion date from **July 31, 2013** to **January 31, 2014.** *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 9,608,789* **Start Date: August 1, 2008 End date: January 31, 2014.**
Modification # 8 dated 09/12/13	Action : Obligate additional US$ 650,000 *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 10,258,789* New obligation expected to fund performance through approximately January 31, 2014 **Start Date: August 1, 2008 End date: January 31, 2014.**
Modification # 9 dated 01/23/14	Action: To extend the completion date from **January 31, 2014** to **June 30, 2014.** Obligate additional US$ 516,081 Amend program description to implement additional HIV/AIDS activities along transport corridors in Eastern, Central and southern Africa. Change the Agreement Officer Representative. *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 10,774,870* **Start Date: August 1, 2008 End date: June 30, 2014.**
Modification # 10 dated 06/12/14	Action: To extend the completion date from **June 30, 2014** to **July 31, 2014.** *Total Estimated Amount $ 200,000,000.00* *Cost share Amount $ 1,887,804.00* *Total Obligated Amount $ 10,774,870* **Start Date: August 1, 2008 End date: July 31, 2014**.

ROADS II Results by Program/Technical Area and Year

PEPFAR Indicators	FY09			FY10			FY11			FY12			FY13			CUMULATIVE FY(09-13)		
Sub Area / Indicators	Totals	Totals Targets	% Achieved	Totals	Totals Targets	% Achieved	Totals	Totals Targets	% Achieved	Totals	Totals Targets	% Achieved	Totals	Totals Targets	% Achieved	Total	Targets	% Achieved
PMTCT	41,373	31,000	133%	49,851	41,000	122%	50,107	52,000	96%	43,800	90,602	48%		-		185,131	214,602	86%
PHPD	-	-		17,144	14,375	119%	14,752	19,000	78%	18,116	23,983	76%	10,316	8,050	128%	17,144	23,983	71%
SBC	1,362,177	1,213,052	112%	1,131,202	713,179	159%	1,075,626	1,095,844	98%	1,064,175	988,239	108%	778,457	634,212	123%	5,411,637	4,644,526	117%
MARPS	-	-		81,375	63,740	128%	115,277	75,402	153%	311,724	209,550	149%	159,049	117,870	135%	667,425	466,562	143%
HTC	113,683	115,500	98%	189,435	99,500	190%	227,848	236,700	96%	240,197	319,982	75%	97,786	77,580	126%	868,949	849,262	102%
OVC	23,993	13,001	185%	16,029	11,500	139%	16,517	11,330	146%	20,456	17,506	117%	17,482	6,500	269%	23,993	17,506	137%
PLHIV	25,111	22,288	113%	27,130	15,500	175%	25,560	7,700	332%	13,993	6,500	215%	11,760	11,000	107%	27,130	22,288	122%
Treatment	2,133	-		1,013	-		18	3,003	1%	441	-		18	-		3,623	3,003	121%
FP/RH Counseling	3,731	1,500	249%	23,234	6,000	387%	10,875	3,000	363%	16,332	6,500	251%	14,679	8,000	183%	68,851	25,000	275%
FP/RH Messages	37,845	23,500	161%	7,266	50,000	15%	35,111	35,000	100%	66,749	25,000	267%	51,502	20,000	258%	198,473	153,500	129%

ROADS Cluster Approach Results by Country and Year

	FY2006			FY2007			FY2008			FY2009			FY2010			FY2011			FY2012			FY2013/2014		
	C	A	M	C	A	M	C	A	M	C	A	M	C	A	M	C	A	M	C	A	M	C	A	M
ROADS TOTAL	24	239	25,394	50	466	40,956	48	554	52,455	64	978	67,615	80	1,068	84,813	82	1,131	87,128	98	1,358	110,596	109	1,445	121,020
Kenya	8	128	10,083	10	180	11,033	10	190	12,134	10	192	12,134	10	192	12,134	10	192	12,134	10	192	12,134	10	192	12,134
Uganda	6	33	6,927	10	56	11,278	11	64	11,278	14	137	11,067	17	134	22,874	17	134	22,874	17	132	22,783	17	132	22,783
Tanzania	8	73	7,984	8	73	7,984	10	85	8,273	15	130	9,242	18	130	9,242	18	130	9,242	31	294	22,068	31	302	23,589
Rwanda	-	-	-	8	88	6,258	8	88	6,258	16	359	21,794	19	443	28,117	19	443	28,117	21	505	36,237	21	509	36,238
Burundi	-	-	-	4	56	3,795	4	56	3,795	4	56	3,795	5	65	3,263	5	65	3,263	5	65	3,302	5	65	3,302
DRC	-	-	-	8	8	8	3	66	10,117	5	104	9,583	5	104	9,183	5	104	9,183	5	104	9,183	10	134	17,124
Djibouti	2	5	400	2	5	600	2	5	600	-	-	-	-	-	-	-	-	-	1	3	900	1	3	900
Zambia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mozambique	-	-	-	-	-	-	-	-	-	-	-	-	6	-	-	8	63	2,315	8	63	3,989	14	108	4,950

- C=Number of Cluster; A=Number of Local Organizations; M= Number of individual member
- Results Framework

ROADS TO A HEALTHY FUTURE (ROADS II) PROJECT RESULTS FRAMEWORK

Project Vision: To leave communities stronger.

Project Goal: Healthier population in the East Africa Region achieved through African leadership

Component 1: *Multi-Sectoral Transport Corridor*

Pillar 1: Create a safe environment for people to talk openly about HIV and other health issues, and promote health-seeking behavior:

Key Indicators and Illustrative five targets:

- 60 SafeTStop communities established and branded
- 28 SafeTStop Resource Centers providing HIV and other health messages
- 30,000 people trained
- 3.2 million community members and transport workers reached with HIV and other health messages

Pillar 2: Safeguard health through increased use of quality HIV and other essential health services:

Key Indicators and Illustrative five targets:

- 500 people trained
- 60 facilities upgraded to provide one or more health services in a clinical or community setting according to national or international standards

Pillar 3: Enhance economic and food security as a prevention/care and community sustainability strategy:

Key Indicators and Illustrative five targets:

- 7,500 direct sustainable jobs or income opportunities generated through LifeWorks
- 12,500 vulnerable households receiving training in appropriate-technology food production.

Pillar 4: Reduce alcohol/substance abuse as barriers to healthy behavior:

Key Indicators and Illustrative five targets:

- 120 health facility- or community-based alcohol/substance abuse support programs established
- 9,000 people participating in a community-based alcohol/substance abuse support program.

Pillar 5: Improved access to safety nets for most vulnerable families and children:

Key Indicators and Illustrative five targets:

- 49,000 OVC receiving direct support, including health services from the program;
- 80 percent of children in AIDS-affected households tested for HIV
- 2800 children enrolled in pediatric AIDS care and treatment.

Pillar 6: Safeguard women and children from violence and sexual exploitation:

Key Indicators and Illustrative five targets:

- 40 SafeTStop communities with a multi-sectoral VAW/G initiatives; - increased number of women who have experienced GBV and report it to health center or law enforcement
- 50 health facilities offering post-rape services.

Component 2: *Promising Innovations, State-of-the-Art Practices, & Policy Advocacy & Harmonization:*

Key Indicators and Illustrative five targets:

- 25 new programmatic approaches successfully introduced in the region
- 400 instances of new programmatic approaches are expanded in the region
- 450 events including providing leadership to our community sub-agreements, managing community task forces, and regional policy efforts.