REGIONAL HIV/AIDS PROGRAM IN SOUTHERN AFRICA FINAL REPORT

October 1999–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT

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USAID's Implementing AIDS Prevention and Care (IMPACT) Project

Impact Implementing AIDS Prevention and Care Project

Regional HIV/AIDS Program (RHAP) in Southern Africa

Final Report

Submitted to USAID

By Family Health International

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In partnership with

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Population Services International (PSI)
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- CARE/Lesotho and CARE/South Africa
- Center for Positive Care (CPC), South Africa
- Ernst and Young (E&Y), South Africa
- Family Life Association of Swaziland (FLAS)
- Into the Limelight
- National Emergency Response Committee on HIV/AIDS (NERCHA), Swaziland
- Project HOPE, Malawi
- Project Support Group (PSG) of South Africa
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GLOSSARY OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ANERELA+	African Network of Religious Leaders Affected by HIV/AIDS
ART	Antiretroviral therapy
BBSS	Biological and behavioral surveillance survey(s)
BCC	Behavior change communication
BCI	Behavior change intervention(s)
BSS	Behavioral surveillance survey(s)
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CoH	Corridors of Hope
CO	Country office
CPC	Center for Positive Care
CSW	Commercial sex worker
CTO	Cognizant Technical Officer
E&Y	Ernst and Young
FBO	Faith-based organization
FHI	Family Health International
FLAS	Family Life Association of Swaziland
FSW	Female sex worker
GPS	Global positioning system
HBC	Home-based care
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HRG	High-risk groups
HQ	Headquarters
IA	Implementing agency
IMPACT	Implementing AIDS Prevention and Care (Project)
IR	Intermediate results
JHUCCP	Johns Hopkins University's Center for Communications Programs
LAPCA	Lesotho AIDS Programme Coordinating Authority
LOP	Life of project
LDTD	Long-distance truck drivers
MARP	Most-at-risk population(s)
MDG	Millennium Development Goals
MEASURE	Monitoring and Evaluation to Assess and Use Results
M&E	Monitoring and evaluation
MOHSW	Ministry of Health, Swaziland
NAC	National AIDS Commission (in Malawi)
NACA	National AIDS Coordinating Authority (in Botswana)
NGO	Nongovernmental organization
NERCHA	National Emergency Response Committee on HIV/AIDS
NSF	National HIV/AIDS Strategic Framework
OI	Opportunistic infection

PATH	Program for Appropriate Technology in Health
PE	Peer educator
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLA	Participatory learning appraisal
PLHA	Person living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
PRA	Participatory research appraisal
PSG	Project Support Group
PSI	Population Services International
RHAP	USAID's Regional HIV/AIDS Program (for southern Africa)
RMFR	Recipient monthly financial report
RRF	Rapid Response Fund
RSPO	Regional Senior Program Officer
SA	South Africa
SACBI	South Africa Cross-Border Initiative
SFH	Society for Family Health
SHARP!	Sexual Health and Rights Promotion program
SI	Strategic information
SOW	Scope of work
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
SO	Strategic objective
TA	Technical assistance
TB	Tuberculosis
TO	Task order
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States government
VCT	Voluntary counseling and testing (for HIV)
WVI	World Vision Inc., Zambia

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I. EXECUTIVE SUMMARY

Beginning in 1999, USAID obligated a total of $7,219,000 in funding to the Implementing AIDS Prevention and Care (IMPACT) Project in support of USAID's Southern Africa Regional HIV/AIDS Program (RHAP). RHAP, originally coined Corridors of Hope (CoH), was implemented by the following United States government partners: Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation, Population Services International (PSI), the Futures Group, Johns Hopkins University (JHU), and FHI. The main goal of the project was to deliver HIV/AIDS prevention services at cross-border areas where the risk for transmission of HIV and other sexually transmitted infections is high. To a lesser extent, the project aimed to improve access to home-based care and to reduce stigma and discrimination. The project was implemented through local partnerships in five southern African countries: Lesotho, Malawi, South Africa, Swaziland, and Zambia. The project, referred to as IMPACT/RHAP from here on, primarily targeted commercial sex workers, truck drivers (broadly defined as transport workers), and migrant farm workers along the borders in these countries, while one subproject channeled anti-stigma/discrimination messages to religious communities.

The project design was based on the results of assessments that highlighted increased vulnerability among mobile populations, the continued importance of targeting high-risk groups in generalized epidemic settings, and the need to provide a means for sharing and transferring project successes across borders. The program was implemented through the following local subgrantees: CARE Lesotho; Project HOPE in Malawi; the Center for Positive Care (CPC) in Limpopo, South Africa; the Family Life Association of Swaziland (FLAS); World Vision Inc. (WVI)/Society for Family Health (SFH) in Zambia; the African Network of Religious Leaders Affected by HIV/AIDS (ANERELA+) in South Africa; and the Project Support Group (PSG) of South Africa.

Interventions

The priority interventions for the IMPACT/RHAP project were prevention and care for highly vulnerable populations, coordination and management of activities between borders, capacity building, and assessment and surveillance. The main strategy for implementing the prevention and care activities involved peer education and resource centers for behavior change communication (BCC), distribution of condoms, counseling, and referral for treatment of STIs. In response to the changing dynamics of the HIV/AIDS epidemic, some sites eventually expanded project implementation to include integrated voluntary counseling and testing (VCT), basic home-based care and support activities, and anti-stigma and discrimination messages.

Accomplishments

1. Inputs/Outputs

One of the major accomplishments of this project was the increased capacity of 23 sites (e.g., coverage areas or health centers) in five countries to implement high quality HIV prevention activities and conduct effective financial and program management. Technical and financial staff and peer educators were recruited, trained, and supported with a variety of pertinent refresher trainings and on-site visits. Training had a positive effect on the implementers' capacity to deliver services, improving the knowledge and skills base that is necessary for positive behavior change in communities. The project also financed the procurement of necessary equipment and supplies, and contributed to transportation expenses.

Over the life of the project, more than 500 peer educators were recruited and trained to conduct BCC by employing robust participatory approaches that appealed to the target groups. Group and/or individual BCC messages for HIV/STI prevention reached more than two million people. Other clients visited the resource centers, which were staffed by project personnel and peer educators, for BCC; these interventions included face-to face counseling, video presentations, distribution of written material, and various forms of "edutainment."

The peer education strategy was successful in reaching highly mobile and difficult-to-reach populations. IMPACT/RHAP improved access to HIV/AIDS and STI education and services for previously neglected communities, and community participation in health matters increased significantly due to the efforts of trained peer educators. In many of the communities, the project overcame the initial resistance to the use of commercial sex workers as peer educators among other target groups, such as truckers and youth. All of the IAs reported gaining the trust of the communities and establishing positive reputations.

More than three million condoms were distributed for free at outreach events in the communities, in drinking places, and at strategically placed condom outlets that were replenished regularly. More than 2,800 BCC materials in various forms (e.g., flyers, posters, pamphlets, and leaflets) were distributed, and T-shirts and caps were used for promotional purposes.

Peer educators referred about 3,000 clients for STI treatment to RHAP-funded STI clinics run by Project HOPE in Malawi and CoH Zambia, while approximately 3,000 additional clients were referred to other health facilities. Some IAs provided basic care and support services, with close to 5,000 households receiving visits.

2. Outcomes/Impact

FHI conducted baseline and end-of-project surveys in all countries, which formed the basis for measuring project achievements. In Zambia, the project conducted two rounds of Behavioral Surveillance Surveys (BSS); findings from these surveys confirmed changes in behavior as a result of project interventions. Ongoing monitoring data and anecdotal success stories were used to assess project results.

Both the target populations and the project staff/volunteers benefited from the project. There was reported behavior change within project staff and communities, and HIV/AIDS and STI knowledge increased. Some transport workers, commercial sex workers, and members of the community reported a reduction in their number of sexual partners; increases in frequency of condom use; increased health-seeking behaviors; and reduced stigma and discrimination toward people living with HIV/AIDS (PLHA). In one case, peer education sessions were so effective that following a session, four men immediately went to the clinic for treatment of STIs. There was also a reported increase in the number of people willing to know their HIV status.

Project staff and volunteers reported an increased level of knowledge and skills in HIV/AIDS prevention and care, which enabled them to interact confidently with communities. The skills gained were beneficial to the individuals themselves, empowering some to deal with their own reproductive health issues. Another significant outcome was the institutional capacity building among the RHAP IAs resulting from technical assistance and financial support from FHI.

This report provides an overview of the project's goal and objectives, describes the evolution of the project over its eight-year span and the activities conducted, and proposes lessons learned and recommendations for future programming.

II. PROGRAM OBJECTIVES, STRATEGIES, IMPLEMENTATION, AND RESULTS

A) INTRODUCTION

Ample research has shown that mobile populations and border communities have the highest rate HIV prevalence among subgroups in most societies, a statistic that applies to Asia, Latin America and the Caribbean, and Africa equally, despite the differing severity of the epidemic in these three regions. In southern Africa, the epidemic has become the most severe in the world; HIV prevalence in many border communities has climbed to levels not previously thought possible. Therefore, starting in Fiscal Year 1999, USAID's Africa Bureau began providing funding for Corridors of Hope. CoH, which comprised the IMPACT Project, the AIDSMARK Project, Population Services International (PSI) and the POLICY Project, among others, aimed to intensify the prevention and care response for mobile populations who frequently cross international borders among southern Africa countries and for vulnerable populations at busy border trade towns. A total of $7,459,000 in IMPACT Field Support, Centers for Disease Control (CDC)/LIFE, and President's Emergency Plan for AIDS Relief (PEPFAR) funds were obligated to IMPACT for its contribution to this cross-border initiative, which was referred to as the Regional HIV/AIDS Program (RHAP).

When CoH began, the bulk of funding for AIDS prevention was provided by USAID bilateral programs, other multi-bilaterals, and the National AIDS Committees themselves. USAID's bilateral HIV programs in Africa were being enhanced by Leadership and Investment in Fighting an Epidemic Initiative (LIFE) and the Expanded Response Initiative. However, these efforts were constrained in two ways: 1) the epidemics in non-presence countries are, by definition, not addressed by the bilateral programs and thus continue to fuel the subregional epidemic; and 2) bilateral programs must give priority to host country population needs and may have difficulty

justifying border programs that serve many nationalities. The rationale for a regional prevention response in southern Africa was to fill these gaps, as well as to provide a means for sharing and transferring project success across borders more efficiently than could be obtained by conventional means.

The CoH Project was initially created to deliver HIV/AIDS prevention services within high-risk transmission areas in eight countries of southern Africa: Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. The goal of the project was to assist the broader RHAP effort to build a comprehensive prevention and care environment for the most vulnerable populations in high priority border towns in southern Africa, focusing on supporting outreach programs, STI prevention and control, and community mobilization. The program's first intermediate result was "Increased access to HIV/AIDS services in high transmission border communities," with four major subcomponents:

- increased access to behavior change interventions (BCI)
- increased access to condoms
- increased access to services for STIs
- increased access to AIDS support and care services

CoH conducted the program in accordance with United States government guidelines and founded on local, regional and international partnerships. The main USG partners of CoH were MEASURE Evaluation; PSI, through its local affiliate Society for Family Health (SFH); the Futures Group's POLICY Project; Johns Hopkins University's Center for Communication Programs (JHUCCP); and FHI's IMPACT Project. The activities of these prime partners addressed the following: prevention and care for highly vulnerable populations; coordination and management of activities between borders; capacity building of local organizations; assessment and surveillance; and anti-discrimination and stigma reduction efforts. The program focused on condom social marketing, behavior change among most-at-risk populations, and STI management; the cornerstone of the program was the use of peer educators to deliver information on HIV/AIDS.

As prescribed by USAID, the role of IMPACT in the CoH project was to focus on supporting outreach programs, STI control, and community mobilization. IMPACT also supported outcome evaluation and the dissemination of results through periodic reports, monographs, and a project website. The CoH prevention and care interventions supported by FHI through RHAP were primarily implemented through behavior change communication, featuring peer education, resource centers, and distribution of free condoms; counseling and referral for treatment of STIs and voluntary counseling and testing (VCT); and basic home-based care and support services. IMPACT contributed to the project by filling gaps in programmatic areas to build a comprehensive prevention environment for the most vulnerable populations in high-priority border towns in southern Africa.

The primary target groups were commercial sex workers (CSWs) and transport workers in five southern African countries: Lesotho, Malawi, South Africa, Swaziland and Zambia; they were reached by IAs that received subgrants and technical assistance from FHI. IMPACT's main regional and local implementing partners for RHAP were ANERELA+, based in South Africa; CARE International in South Africa and Lesotho; the CPC in South Africa; the FLAS: Project

HOPE in Malawi; PSG, in South Africa; and WVI in Zambia. Other subgrantees or subcontractors included Afribike in the region, Into the Limelight in South Africa, the National Emergency Response Committee on HIV/AIDS (NERCHA) in Swaziland, and Sechaba Consultants in Lesotho.

Following a program review meeting in January 2005, USAID decided to strategically shift CoH into a new phase of implementation. It was decided that RHAP should phase out funding CoH's direct service delivery in countries with bilateral USAID health programs and instead continue to fund cross-border activities directly in Lesotho and Swaziland; in essence, the project was to lose its regional scope. The suggested "shift" resulted in significant changes for RHAP, calling for an end to cross-border activities and transferring the management of each country's activities to the respective bilateral programs funded through local USAID Missions.

Starting in FY05, no new implementing partners were introduced; new activities were held to a minimum during this reporting period as a result of this strategic decision. The first phase of close-out of subagreements with core RHAP IAs under FHI took by place in late 2005; the second and final phase occurred in March 2006. The first project to be transformed into a semi-autonomous organization was CoH/Zambia, which involved the shifting of World Vision's office locations as well as a transfer of management roles and responsibilities from FHI/South Africa to FHI/Zambia during the first quarter of FY05. The remaining RHAP IAs, however, continued to receive technical assistance from the STI expert in the FHI/Zambia office that had been supporting the project periodically since it began.

After the core IMPACT/RHAP activities ended in March 2006 as per USAID directives, the remaining funding obligations were used for project close-out and to fund ad hoc activities requested by the USAID/South Africa office, which covers South Africa, Lesotho, and Swaziland. This included an audit of internal drug controls within the Swazi Ministry of Health by Ernst and Young, a regional conference for USG partners, and a meeting for USAID/South Africa and its partners.

This final report for the IMPACT/RHAP Project is a combined and consolidated summary of the reports from the five country subprojects, as well as documentation compiled by the FHI country office and headquarters staff members who supported the activities. The sections below describe the context of the region in which the program was implemented; program strategies, implementation, and results; lessons learned and recommendations for the future programming.

B) REGIONAL CONTEXT

1. The HIV/AIDS Epidemic

Globally, more than 39 million people are living with HIV and more than 90 percent of those infected live in the developing world. Sub-Saharan Africa continues to bear the brunt of the global epidemic. Two-thirds (63 percent) of all adults and children with HIV live in sub-Saharan Africa, and its epicenter in southern Africa.[1] Southern African countries carry the highest HIV

[1] WHO 2006.

prevalence rates in the world, with Swaziland topping the list with 40 percent prevalence in some parts of the country.

In southern Africa, HIV infection rates have been growing far more rapidly for women than for men. According to the UNAIDS 2007 AIDS Epidemic Update, 61 percent of people living with HIV in sub-Saharan Africa are women. The social burden of HIV/AIDS is heavier on women because they tend to be the caregivers of sick and orphaned children. Because of high unemployment rates, low levels of education, and high poverty in the region, women often carry the economic burden for both their own and their extended families. There has proven to be a close link among poverty, lack of education, unemployment, and HIV infection.

More than one-third of the population in the region is composed of youth between 15 and 24 years old. Sub-Saharan Africa is home to 6.2 million of the roughly 10 million of the world's youth infected with HIV; 75 percent of these HIV-positive youth are female. A high HIV prevalence rate in women translates to increased infections among newborn babies, and HIV prevalence and morbidity due to AIDS in sub-Saharan Africa remains high. UNAIDS reports that some 1.7 million (1.4 million-2.4 million) people were newly infected with HIV in 2007, bringing to 22.5 million (20.9 million-24.3 million) the total number of people living with the virus in the region.

2. Human Development Index

The Human Development Index (HDI) provides a composite measure of three dimensions of human development: life expectancy, education, and standard of living. The HDI reflects the positive association between income on one side, and health and education on the other. Since the mid-1970s, almost all regions of the world have progressively increased their HDI score, but the major exception is sub-Saharan Africa. Twenty-eight of the 31 low-HDI rated countries are in sub-Saharan Africa. Since 1990, this region has stagnated, partly due to economic reversal but principally because of the catastrophic effects of HIV/AIDS.[2] Life expectancy in this region is lower than it was three decades ago. Several countries in southern Africa have suffered catastrophic reversals; life expectancy has decreased by 20 years in Botswana, 16 years in Swaziland, and 13 years in Lesotho and Zambia.[3] Prevention and treatment of HIV/AIDS remain among the most significant conditions for a resumption of positive human development trends across the region.

3. Government Commitment

The commitment of the governments of the countries in this region toward mitigating the effects of HIV/AIDS was weak in the beginning of the epidemic in southern Africa, but there have been varying levels of action since the year 2000. With the exception of the government of Botswana, most countries were slow to acknowledge and accept the devastating effects of the epidemic and commit adequate financial resources to embrace comprehensive HIV prevention packages. Government policies have recently been revised with the adoption of multisectoral policies to mitigate the epidemic. There is now strong support and endorsement from the highest authorities

[2] UNDP Human Development Report 2006.
[3] Ibid.

in countries like Lesotho and Malawi. To demonstrate this, the King of Lesotho declared HIV/AIDS a national disaster, and the Lesotho AIDS Programme Coordinating Authority (LAPCA) resides in the office of the Prime Minister. There are also many HIV/AIDS sectoral policies in education, health, and the workplace.

Malawi is one of the countries with a government that has spearheaded commitment and involvement to address the HIV/AIDS epidemic. There is an active HIV/AIDS policy with specific recommendations on prevention of mother-to-child-transmission of HIV (PMTCT). Launched by the National AIDS Commission in 2004, the policy recommends routine testing for PMTCT. A multisectoral plan for response to HIV was disseminated in 2000. The plan, referred to as the National HIV/AIDS Strategic Framework (NSF), defines priorities for the national response.

Most countries in southern Africa have since declared the HIV/AIDS epidemic to be a national disaster. Countries have targeted their efforts on programs such as HIV prevention for mobile populations and PMTCT; these efforts followed commitments to meeting the Millennium Development Goals (MDG), as well as the Abuja commitment to an HIV-free and AIDS-free generation by 2010[4] and universal access to HIV prevention, treatment, care, and support services.

C) COUNTRY CONTEXT

1. Lesotho

Geographically, Lesotho is completely surrounded by South Africa. In 2006 the country had a population of approximately 2 million and an HIV prevalence rate ranging from 23.6 percent to 38.1 percent.[5] Since 2000, there has been increasing national concern about HIV/AIDS, resulting in the intensification of multisectoral efforts to tackle the pandemic, including the development of a National AIDS Strategic Plan. HIV/AIDS is the single greatest factor contributing to the growth of vulnerability of the poor in the foreseeable future. Gender inequities, mobility, and poverty underpin HIV/AIDS transmission in Lesotho. Rural-urban migration has resulted in oscillatory migration patterns where workers move between urban workplaces and rural homes on a regular basis, resulting in a breakdown of family structure. HIV/AIDS is depleting both skilled and unskilled labour and is rapidly eroding traditional coping methods within communities by reducing the capacity of households to produce or purchase food, depleting household assets, and exhausting social safety nets.

The HIV/AIDS risk assessment that was carried out in 2000 revealed exceptional HIV vulnerability at each of the investigated sites. There was a “sociocultural context of casual and commercial sex exacerbated by profound mobility.”[6] Truckers, bus and taxi drivers, traders, soldiers, migrant laborers, and transient sex workers move from town to town, with the populations in Maputo and Maseru seen as an important bridge linking transient and residential

[4] UNICEF Annual Report 2006.
[5] UNAIDS 2006.
[6] HIV/AIDS Risk Assessments 2001.

communities. Therefore, residential communities linked to these bridge populations needed interventions.

2. Malawi

Malawi is one of the poorest countries in the world, ranked 151 of 162 countries in the 2001 UNDP Human Development Index.[7] In Malawi, 65.3 percent of the population lives in poverty; this poverty is worse in rural areas than in urban areas. Nearly 90 percent of the country's poor live in rural areas. The southern region, Mulanje, is the poorest of the three regions. According to the National AIDS Commission, the national HIV seroprevalence is estimated at 14.4 percent among those 15 to 49 years old,[8] equal to approximately one million people infected with the virus.[9] Despite this significant rate, prevalence is even higher in urban areas, at 23 percent, and in semi-urban areas, at 20.8 percent.[10] Rates in rural areas are similar to the national rate, with a prevalence of 14.5 percent. The primary method for HIV transmission in Malawi is through unprotected heterosexual intercourse. Surveillance data from antenatal clinics shows a slow but steady increase in HIV infections, with the highest rates, 25.7 percent, continuing to occur among women ages 20 to 24.

3. South Africa

A 1999 risk assessment of trade and transit sites along the Durban-Lusaka Highway indicated that Musina town is a high transmission area of STI and HIV/AIDS, primarily as a result of the large number of truckers and travelers who pass through. At the beginning of the project, an estimated 3,000 truckers passed through Musina each month. The next busiest border site, Groblersbrug, hosted approximately 2,400 trucks each month that were in transit to Zimbabwe, Botswana, Zambia, and the Congo.[11] Consequently, high numbers of sex workers and low-income vulnerable women have been recorded around the border.

4. Swaziland

Swaziland, which shares borders with South Africa and Mozambique, is a tiny country in southern Africa. At present, Swaziland carries the highest adult HIV prevalence in the world at 33.4 percent, with a range between 21.2 and 45.3 percent depending on the target group.[12] Among young women 15 to 24 years old attending antenatal clinics, HIV prevalence was 39 percent nationally and 43 percent in Manzini.[13] The trend in HIV prevalence showed an astonishing increase from 3.9 percent in 1992 to 31.6 percent in 1998.

In Swaziland, an assessment to describe the general environment for HIV/STI transmission at the country's border sites was carried out in the late 2000.[14] The findings revealed relatively few sex

[7] UNDP Report 2001.
[8] National AIDS Commission, *HIV and AIDS in Malawi: 2003 Estimates and Implications*, January 2004.
[9] National AIDS Commission HIV Surveillance Report, November 2003.
[10] Government of Malawi, 2005–2009 National HIV/AIDS Framework.
[11] Ibid.
[12] UNAIDS 2006.
[13] Ministry of Health and Social Welfare, Swaziland 2005.
[14] HIV/AIDS Risk Assessments at Cross-Border and Migrant Sites in Southern Africa, 2001.

workers and truckers; there were also few high-risk border sites because of the relatively small size of the country, which can be traversed by car within only a few hours, facilitated by simple and rapid immigration and customs procedures requiring little waiting time at the border. Compounded by complex trade and employment patterns with neighboring countries, the risk of HIV and STI infection was concentrated in the major cities, rather than at the borders.

5. Zambia

Zambia is one of the countries with a high national HIV prevalence rate: 16.5 percent in the 15–49 age group. HIV/AIDS has not only compounded the country's health problems, but has had far-reaching socioeconomic consequences. The increasing poverty levels, partly a result of high unemployment levels, have fuelled the spread of the epidemic especially among women. HIV rates are particularly high along major highways and border posts. A slight decline in HIV infection levels from 28 percent in 1994 to 25 percent in 2004 has been observed in urban areas among pregnant women ages 15 to 39[15]. In rural areas, however, HIV prevalence increased from 11 to 12 percent in 1994-2004. An estimated 30 to 49 percent of infants born to women infected with HIV become infected, constituting around 21,000 infant infections every year.[16]

D) PROGRAM STRATEGIES AND ACTIVITIES

FHI activities under RHAP addressed prevention and care for highly vulnerable populations; assessment and surveillance; capacity building; and coordination and management. BCC, through peer education, was the backbone of the program, but to respond to emerging needs, some sites eventually added basic care and support activities to their portfolio of interventions. Over the life of the project, the main service-delivery interventions of IMPACT/RHAP were BCC, including peer education; drop-in resource centers, some of which offered STI screening; distribution of free condoms; basic home-based care and support services; and counseling and referral of clients for STI treatment and VCT. In addition, a strong emphasis was placed on strategic information activities.

1. Strategic Information (surveillance, assessments, monitoring, and evaluation)

Several assessments were carried out to inform the design and implementation of interventions and to monitor and evaluate their effectiveness; these data also informed USG programming in the region. USAID initially funded IMPACT to conduct a series of assessments to learn more about the risk environments of border crossings and trade towns along the roads connecting countries in southern Africa. The findings were used to prioritize sites according to risk environment and importance in subregional HIV transmission. The first assessment was conducted in 1999 along the Durban-Lusaka corridor (which transects South Africa, Zimbabwe, and Zambia); the second took place in mid-2000 and focused on the Lesotho-South Africa nexus; and a third was conducted in late 2000 to explore the routes connecting Swaziland, Mozambique, and South Africa.[17]

[15] Ministry of Health Zambia 2005.
[16] UNAIDS 2006.
[17] FHI 2001 – HIV/AIDS Risk Assessments at Cross-Border and Migrant Sites in Southern Africa.

The assessments indicated exceptional HIV vulnerability at each of the sites investigated, and a sociocultural context of casual and commercial sex exacerbated by profound mobility. Truckers, bus and taxi drivers, traders, soldiers, migrant laborers, and transient sex workers, were moving from town to town, engaging in unprotected sex. Interventions were urgently needed to introduce HIV/AIDS projects at every site. This gave a strong rationale for targeting high-risk groups in high-prevalence settings, among which are border sites.

Over the course of the project, the IMPACT mechanism continued to be used to conduct assessments that informed USAID, FHI, and partners about the current situation of the epidemic in the region and the effectiveness of programming. The results of these strategic information activities were used to inform programming decisions and approaches at many levels.

IMPACT enlisted the services of consultants and full time staff who are technical experts in various fields. For details on the findings of the following strategic information activities, please refer to the individual reports that were produced for each:

i. HIV/AIDS Risk Assessments. Between 1999 and 2002, IMPACT contracted PSG to conduct several assessments of HIV/AIDS risk situations at cross-border and migrant sites in southern Africa. The findings from these assessments brought to light the high-risk sexual dynamics that were fuelling the HIV epidemic in the region, and the recommendations gave birth to the CoH project. The assessment report "*Lesotho and Swaziland: HIV/AIDS Risk Assessments at Cross-Border and Migrant Sites in Southern Africa*" was published in 2001, and 1,120 copies were disseminated. Botswana's and Swaziland's reports were published separately.

- *Lesotho/South Africa:* The research was conducted in 10 sites, five sites in Lesotho and five corresponding sites in South Africa: Caledonspoort Bridge, Ficksburg Bridge, Maseru Bridge, Van Rooyens Gate, and TeleBridge. There is exceptional HIV vulnerability at each of the sites, and a sociocultural context of casual and commercial sex exacerbated by profound mobility. Truckers, bus and taxi drivers, traders, soldiers, migrant laborers, and transient sex workers move from town to town and put partners at risk by engaging in unprotected sex.

- *Swaziland:* The Swaziland assessment sought to describe the general environment for HIV/STI transmission at the following border sites: Ngwenya-Oshoek, Lavumis-Golela, Lomahasha-Namaacha, and Komatipoort-Ressano Garcia. The researchers found the regional HIV risk contexts to be projected beyond the borders to the major cities, as they lie in the countries' interior rather than at the border. In addition, they found mitigation programs were urgently needed to help countries cope with infections acquired in South Africa.

- *Botswana:* The assessment along Botswana's major transport routes and population corridors was started in April 2002 by PSG in collaboration with Botswana National AIDS Programme representatives, the University of Botswana, and the Botswana National AIDS Coordinating Authority (NACA). The assessment aimed to identify key STI transmission dynamics and the underlying sociobehavioral and sociocultural

factors contributing to high rates of HIV transmission. An additional objective was to identify prevention and care priority areas, communities, and possible interventions suitable for each surveyed site. In total 25 sites were surveyed along the three national highways, the Ramatlabama-Ramokgwebane highway, the Trans Kalahari Lobatse-Mamuno highway, and the Caprivi-Francistown-Kasane Corridor. The sites surveyed were on the highway or capillary routes feeding into the highways named above. Surveyed sites can be divided into regional sites, those on the border with other countries, and internal sites, those found inland away from the border. Of the 25 sites surveyed, eight were border/regional sites and the other 17 were internal. Data was collected using numerous data collection techniques that included site inventory compilation, focus group discussions, key informant interviews, participant interviews, observation, and participatory research and learning appraisal (PRA/PLA).

- *Namibia:* For purposes of the Caprivi, Namibia, assessment, Namibia was divided into three regions: from Walvis Bay to Windhoek; the Trans Kalahari area from Windhoek to Botswana; and the southern areas from Windhoek to South Africa. The report of the assessment was produced in several parts, with the final report completed in early 2002 and disseminated at the RHAP Regional Meeting in September 2002. The results facilitated rapid project preparation in this region.

ii. Baseline Surveys at All Project Sites. It was important to establish a benchmark against which project achievements would be measured, as accomplishments are demonstrated by significant changes in performance data at all sites.[18] This was the justification for conducting baseline evaluations at all project sites, most of which were done by PSG. In addition, PSG provided technical assistance to Project HOPE for a baseline survey on a new border site, Mwana, as part of project planning. This resulted in Project HOPE successfully launching the new project site.

iii. HIV/AIDS Rapid Assessment Guide. IMPACT/RHAP published this PSG report in 2001. It is a 30-page guide providing easy to understand material on conducting assessments of high-risk environments. It provides an outline for each of the five components of Rapid Assessments: mapping, site inventory, ethnographic study, focus group discussions, and behavioral surveys.

iv. Biological and Behavioral Surveillance Surveys (BBSS). In Zambia, two rounds of surveillance was conducted at the project sites between 2000 and 2003 in collaboration with MEASURE Evaluation–Tulane University, the Institute of Economic and Social Research, and the University of Zambia and Tropical Diseases Research Center. The Round One BBSS was conducted in 2000 and included truck drivers only. The Round Two BBSS, conducted in 2003, included truck drivers, uniformed personnel, and light truck and minibus drivers. The main objective was to monitor the outcomes of existing prevention interventions through a cross-sectional assessment of risk behaviors among men at high risk for sexually transmitted infections, including HIV. Interesting findings came to light as a result of this survey, particularly the behavior change that it highlighted

[18] Refer to summary PIF data.

among the target group, truck drivers: frequency of visits to commercial sex workers (CSWs) had decreased, condom use increased, and the proportion of VCT clients receiving their results increased.[19] (See the BBSS reports for details.)

v. **Behavioral Surveillance Surveys.** Behavioral Surveillance Surveys (BSS) were also conducted in 2001 in Swaziland and Lesotho to capture information on sociodemographic characteristics of the respondents; sexual behavior; self-reported number of sexual partners; self-reported patronage of CSWs; self-reported condom use with different partners; knowledge and use of condoms; knowledge, attitudes, and opinions about HIV and AIDS; knowledge about STIs and STI treatment-seeking behavior; knowledge of voluntary testing and counseling; exposure to HIV prevention interventions; self-reported STI symptoms and treatment-seeking behavior; self-assessment and assessment of others' risk of contracting HIV; and the ability to identify effective methods to prevent HIV transmission.

- In Lesotho, the BSS partnership was with Sechaba Consultants, through a contract. The target populations were in-school youth, out-of-school youth, female sex workers, low-income migrant women, and the military. The BSS covered CARE's SHARP! Program target groups and geographical sites in Lesotho, and the data assisted CARE in strengthening its interventions. The Lesotho BSS was disseminated in December 2003 by the Government of Lesotho in collaboration with Sechaba Consultants, the US Embassy, and USAID. The dissemination was successful and contributed to public debate on HIV/AIDS.

- In Swaziland, the BSS partnership, with FLAS, targeted seasonal workers, factories, tertiary institutions, out-of-school youth, military, watchmen, and CSWs. FLAS was responsible for completing the protocol; recruiting and training survey personnel; adapting and translating the BSS questionnaire; mapping, collecting, and cleaning the data; and analyzing and disseminating the findings, all with TA from FHI. The results were disseminated in January 2003 by the Government of Swaziland and FLAS.

vi. **STI Assessments in Swaziland and Lesotho.** In 2002, IMPACT/RHAP assessed the quality of existing services in the Swaziland and Lesotho intervention sites to provide suggestions for improving STI service delivery.

vii. **ANC Sentinel Surveillance.** When USAID requested FHI to provide technical assistance to the ANC sentinel surveillance activities in Swaziland, FHI signed an agreement with the National Emergency Response Committee on HIV/AIDS between October and December 2002 for approximately $50,000. The objective of the agreement was to conduct an ANC Sentinel Surveillance Survey to obtain data showing the trends of HIV infection in Swaziland, and to contribute to advocacy and planning strategies for prevention and control of HIV/AIDS/STIs. The survey was conducted in late 2002 by FHI staff, a consultant, and NERCHA in collaboration with the Swazi Ministry of Health. The report was finalized and results were first communicated by the Swazi government in December 2002; final dissemination activities conducted by NERCHA and the

[19] Zambia BSS, 2003.

government were completed in July 2003. The results contributed to highlighting the alarming extent of the epidemic in Swaziland.

viii. **Assessment of Peer Education.** In 2004, FHI hired a consultant to carry out an assessment of the peer education methodology being used by the CoH prime partners. This was an important exercise given that peer education formed the cornerstone of project interventions. The peer education methodology was highly recommended and there was evidence of strong support from the community as shown by statements like this one from a 19-year-old male: "We give all our thanks to the peer educators who educated us. They taught us about VCT and especially on how to use a condom. If it wasn't for them showing me how to use a condom I would be sick by now."

ix. **Rapid Appraisal in Lesotho and Swaziland.** Toward the end of 2004, USAID requested that FHI support a rapid appraisal for HIV/AIDS program expansion in Swaziland and Lesotho. The survey was conducted by PSG with assistance from FHI. Results from this assessment supported the new school of thought on what was fueling the epidemic: multiple concurrent partnerships, resulting in a generalized epidemic. This had strong implications on the future of targeted interventions, influencing USAID's decision to shift its focus from most-at-risk target groups to more generalized and comprehensive interventions that have a stronger emphasis on care and support and VCT, rather than BCC.

x. **Mapping of Services at CoH Sites.** In October 2004, RHAP commissioned a study to map and assess the provision of VCT services, STI and tuberculosis diagnosis and treatment, distribution of condoms, and family planning services in the CoH sites in five of the countries participating in the program: Lesotho, Malawi, South Africa, Swaziland, and Zimbabwe. Site visits were made to all facilities in the five countries to hold talks with staff running the facilities and, where possible, to take Global Positioning System (GPS) readings for drawing GPS-aided maps locating the facilities in each site. This mapping was required for the development of the CoH BCC strategy.

xi. **Rapid Assessment of Community Home-Based Care in Lesotho.** An FHI/headquarters technical staff member, Sarah Bowsky, conducted this assessment during the second quarter of FY04. The recommendations from the report provided insight on how to implement limited care and support in resource poor settings. The timing of the assessment was opportune for CARE/Lesotho, which was seeking to expand and strengthen the integration of its care and prevention activities into the CoH project.

xii. **Final Evaluations at All Project Sites.** To measure project achievements against the baseline surveys conducted at the beginning of the project, FHI worked with PSG and the other IAs to conduct final evaluations for all project sites, for which the reports are available separately.

xiii. **MOHSW Internal Controls Vulnerability Review.** In response to a request from USAID/South Africa in early FY07, the RHAP/IMPACT mechanism supported the "Swaziland Health Check" during this reporting period. Through a Letter of Engagement

with Ernst and Young in South Africa, this initiative assisted the Swazi Ministry of Health (MOHSW) to assess critical issues related to their internal controls. It included a final debriefing trip by Ernst and Young staff to present the Vulnerability Review findings to the Principal Secretary and MOHSW senior staff. As a result, the Prime Minister's office instructed the MOH that its top priority for 2007 must be resolution of the drug crisis related to HIV/AIDS. This is one of the discrete activities identified by the USAID/South Africa Mission in which FHI invested some of its remaining RHAP funds in FY07.

xiv. **Data Collection for Ongoing Monitoring.** As with all of FHI's projects worldwide, monitoring plays a key role in program implementation. Collection of process indicators takes place on an ongoing basis and reports were submitted regularly to FHI by the IAs for compilation, analysis, and reporting to USAID. In the second quarter of FY03, visits to CoH sites were conducted by MEASURE to improve reporting of activities. Despite this support, process indicator reporting forms from all groups except CARE had to be returned for revisions and corrections. In the second quarter of FY04, all Corridors of Hope partners (MEASURE, PSI, FHI, the POLICY Project, and JHUCCP) were trained by USAID in M&E; this was followed by on-site training of partners to ensure accurate and timely reporting. The output data and narrative reporting tools were revised, and the outcome-level evaluation responsibility was allocated to MEASURE. At this point, FHI developed a standardized data collection/monitoring tool for all RHAP IAs to use for reporting purposes; it was piloted and revised over the course of the project to improve it based on inputs from the IAs and to take into account changes directed by USAID/PEPFAR. Each IA developed its own M&E plan for the project as well, with TA from FHI on their development, revision, and use.

2. Behavior Change Communication

The primary objective of the RHAP/IMPACT project was to reduce HIV transmission at cross-border sites by focusing on high-transmission populations in those areas. Peer education is an effective, non-threatening way to introduce HIV/AIDS-related BCC messages to targeted populations. The project relied on peer educators for BCC messaging through individual and group talks applying participatory methodologies, such as role plays, discussions, and use of picture codes.

There was difficulty in reaching the key target populations because of their high degree of mobility. The commercial sex workers were often not from the country where they were working, changed locations frequently, and traveled with truck drivers. Truck drivers rarely stayed more than one or two days in any one location and there was no pattern of return visits or likelihood of being systematically reached on successive occasions.

The "grey area" of transactional sex work also provided a challenge. In each site there were many women who did not see themselves as commercial sex workers, even though they were actively engaged in transactional sex. They may have had other sources of income or were looking for other sources of income such as selling goods at market, or factory work. They may have been school-age girls or young women sent by their families to villages to earn money to

bring home. These women did not necessarily identify themselves with the full-time bar- or brothel-based sex workers. They may have been working only on weekends or when short of money. In Swaziland, transactional sex is less brothel-based; in Lesotho more women can be found on the streets.

Project staff played a key role in enabling peer educators to access the harder-to-reach target groups. For example, uniformed officials at border sites required formal contacts through their hierarchical echelons in the organization.

i. BCC Strategy Document

The CoH Project developed a Draft BCC Strategy document through a partnership with FHI, AED/LINKAGES, and PSI. The strategy promoted the branding of CoH sites and standardization of services, and its formulation was informed by a mapping exercise conducted by FHI in the CoH sites. Momentum on this strategy stalled when RHAP shifted the focus from CoH targeted interventions. In addition to this overarching strategy for CoH, FHI used its own strategies for the various components of the RHAP project. They are detailed below.

ii. Peer Education

The project used peer education as the cornerstone of interventions. The NGO project PSG developed the peer education methodology used in this project as well as in other projects in southern Africa. This approach, first developed in 1990, is based on social diffusion theory, which asserts that people evaluate changes by subjective judgments of close, trusted peers who have adopted changes and provide persuasive role models for change. The model uses a cascade, or pyramid, approach in which professional coordinators train and supervise site coordinators who, in turn, train and supervise zonal coordinators who, in turn, train and supervise peer educators. There is also a strong component of community engagement; this strengthens local commitments and support.

Since the PSG model had a proven track record before being used in the IMPACT/RHAP CoH project, it was easily adaptable to RHAP needs. PSG was able to create uniformity in the interventions in the sites where it provided technical assistance.

Peer Educator Selection

A peer educator is a community member motivated to carry out volunteer services for her/his community. Careful selection of peer educators was important. Both male and female peer educators were recruited through a “snowball” method. Since the project targeted high-risk groups, most of the female peer educators were commercial sex workers, who were an appropriate group to motivate their peers into adopting positive behavior change. When recruiting CSW peer educators, the snowball method proved to be effective. This involved identifying several older commercial sex workers, who suggested others, who also suggested others, and so on. The selection required extensive involvement of the community in which the peer educator lived. For example, in Lesotho, community advisory committees were established

in each zone to nominate peer educators. This increased the level of commitment on the part of both the community and the peer educators.

Standard selection criteria based on age, sex, minimum level of education, residence, acceptability in the community, and commitment to volunteerism were the norm. As a result of high levels of unemployment in the region it was possible to recruit and sustain peer educators that met these criteria. Although most peer educators were illiterate or semi-literate, they generally responded well to training and supervision and, according to the supervisors who were interviewed, "developed good organization and people skills for the most part."[20]

Ideally, the closer the peer educator is to the target population in terms of age, gender, occupation, and education level, the more effective the peer education. Recruitment of truck and taxi drivers proved to be difficult because of their mobility and lack of time to work as peer educators. Malawi used out-of-school youth peer educators to reach drivers; in Musina, on the South Africa/Zimbabwe border, the same female peer educators worked with CSW and long-distance truck drivers. It became a challenge to recruit and maintain male peer educators, since the males were found to be less interested in volunteer work or more aggressive in seeking other sources of revenue. A relatively low rate of turnover among peer educators indicates that recruitment was successful. All projects had a record of peer educators who had worked on the project from its inception. There is also evidence that the projects showed flexibility and adaptability when recruiting, especially when difficulties were encountered.

Training of Peer Educators

After recruitment, peer educators received ten days of initial training using the 10 modular training that is part of this peer education model. The modules cover content areas including HIV/AIDS and STI transmission and prevention; robust participatory methodologies for effective BCC; and simple monitoring and evaluation to enable accurate recordkeeping. The prevention component included the role of condoms and detailed instructions on their use. The modules served as the basis for training the NGO partners in each country and were adapted for local needs. In Lesotho, CARE adapted the modules for each target population. Project HOPE simplified the modules for its use. CoH Zambia began applying the peer education model but the NGO World Vision had difficulty identifying and maintaining its outreach workers. WVI Zambia decided to engage fewer peer educators, who work full-time and are paid a salary. The NGO believed that the greater the financial incentives, the greater the commitment of the peer educator. However, it should be noted that all other project sites were able to recruit and maintain the commitment of peer educators without paying them a salary.

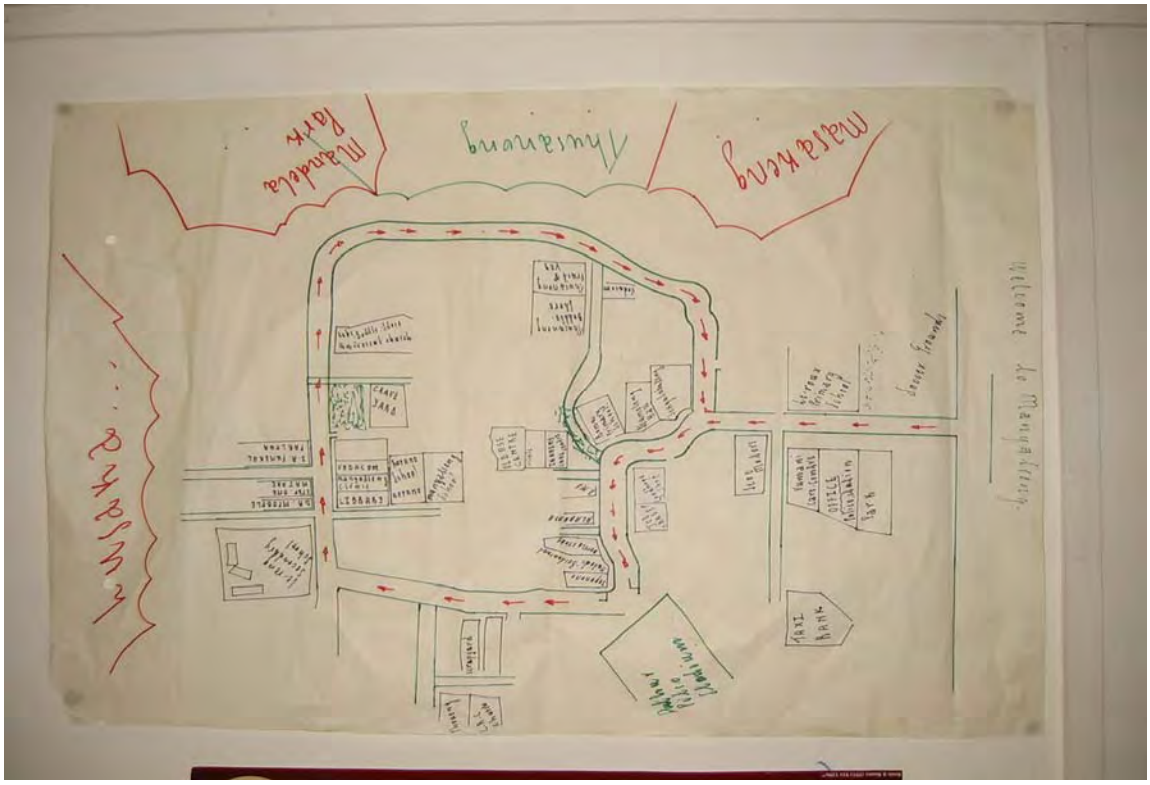
[20] Review of Peer Education Use by CoH, Iain McLellan, FHI Consultant, 2004.

Deployment after Training

Following training, the peer educators were allocated to their operational zones where they conducted their outreach (see Figure 1 below). A typical site might be divided into five zones, with a supervisor or team leader for each zone. Each zone would then have 10 to 20 peer educators for each supervisor to oversee. Supervisors periodically conducted spot checks, an effective way for them to determine how well a peer educator had prepared and who was present, and to offer on-the-spot feedback. The spot checks also helped keep the peer educators honest, since they knew a supervisor could show up unannounced at any time to see if they were actually implementing their work plan.

The methodology calls for peer educators to provide supervisors with their work plans indicating times and locations of their planned peer education sessions. Peer educators kept diaries for records of number of meetings and one-on-one sessions held, persons contacted, condoms distributed, and STI referrals made. They also attended weekly update sessions that served as a forum for sharing experiences, including challenges and how to overcome them. Their supplies of BCC materials and condoms were replenished at these meetings.

Figure 1: Peer Educator Location Map



Group Communication

Applying robust participatory communication methodologies, peer educators effectively used dramatizations of common risk behavior situations. These usually took the form of role plays

that involved them playing the parts of people in particular situations. Members of the target population participating in the session were then asked to comment on the behaviors and what it meant. The role play scenarios depicted real-life situations to enable audiences to "feel" the situation. Each role play was designed to end before the situation was resolved; the peer educators asked open-ended questions to get participants to finish the story. Questions like "What do you think will happen next?" or "What do you think the consequences will be?" or "Does this happen in our community?" were asked. The role plays ended in a lively discussion that fully engaged the community.

More elaborate dramas were also commonly used. They were acted out by the peer educators themselves or by traditional theatre groups affiliated with the project. In Mulanje, Malawi, staff recorded six dramas on video and showed them at the resource center. Following one performance of a traditional theatre group that featured male characters with multiple partners who contracted STIs frequently, four men from the audience went directly to the resource center to have their STIs diagnosed and treated.[21]

The dramas proved to be an effective method for communicating behavior choices and sexual realities including multiple sex partners, untreated STIs, stigma and discrimination, male reluctance to use condoms, transactional sex, sexual coercion, rape, and alcohol abuse. Many of these sensitive topics could not be dealt with as openly and frankly using other methods. Through ample use of humor, and by touching audiences emotionally, actors effectively delivered their messages. Observation of the discussions following the presentations of several dramas provided evidence that audiences understood the messages and identified with the characters and content.

All the dramas observed included content that directly linked the characters to condom use, timely STI health-seeking behavior and, to a lesser degree, voluntary counseling and testing. Questions like "What have you seen?" and "What should have been done?" were asked following the presentation of the dramas. Audiences were also encouraged to ask questions, stay afterward to ask questions directly to peer educators, or visit the resource center, as reported in the Peer Education Assessment.[22]

One-on-One Education/Counseling

Peer educators conducted one-on-one communication sessions with individuals and couples. These sessions usually were held after the above group education and addressed questions that were raised toward the end of the group gathering. This gave individuals an opportunity to explore their personal information needs and feelings. This is an important step in the process of behavior change because it leads to personal conviction, which is instrumental in adoption of a new practice.

The peer educators also conducted one-on-one sessions that were independent of any previous communication. These sessions would occur when they approached their peers, youth, or other members of the public who spent time in the areas of high risk behavior. Demonstrating how to

[21] An Assessment of Peer Education at CoH, Iain McLellan, 2004.
[22] Ibid.

use a condom, using the penis models, and following up on questions on STI symptoms were more appropriate during these sessions.

In end-of-project surveys, some respondents reported that they had reduced their number of sexual partners as a result of peer educator BCC sessions.

Collaboration with PSI on Edutainment Events

In several sites, the peer educators said their work was enhanced by the coordination of educational yet entertaining events (i.e. "edutainment") organized in collaboration with PSI/SFH. For example, in Lesotho and Musina, a PSI condom promotion van, equipped with loudspeakers to attract attention, visited sites such as the border post and taxi ranks in the day and "hot spots" at night. Popular music blared, DJs held contests, and free novelty items including T-shirts and caps were distributed. The peer educators promoted these events and were available to answer questions and make referrals to services or the project resource centers.

In Lesotho, peer educators were also linked to events organized by PSI, such as factory soccer (football) tournaments. In a South African site, an empty condom package was the price of admission for a popular music concert. These promotions harnessed audience participation and dissemination of HIV/AIDS and STI information. The peer educators wore uniforms sporting BCC messages (see Figure 2 below).

Figure 2: Peer Educators

iii. Condom Distribution

Condoms, a central element of peer education, were well promoted and distributed by peer educators. The NGO partners or site coordinators obtained free condoms from government sources or from Society for Family Health (SFH), which were regularly distributed to the peer

educators. Peer educators systematically checked and replenished condom dispensers in busy locations, such as border crossings and drinking places.

All peer educators were skilled in conducting male condom demonstrations using penis models and teaching how to use the female condom. Group and individual education sessions were followed by distribution of free supplies of condoms.

iv. IEC Materials Development and Distribution

Information, education, and communication (IEC) on HIV/AIDS are crucial components of a comprehensive package of BCC prevention services to reduce the number of new HIV infections. BCC includes mass media campaigns, school-based AIDS education, and peer education programs that aim to bring about changes in knowledge and behavior to reduce the risk of HIV exposure and infection. IEC materials compliment BCC efforts.

The CoH project used a variety of materials and methods for BCC, such as pamphlets, booklets, leaflets, billboards, T-shirts, caps, balls, and audio and video tapes. The IMPACT/RHAP project formed strong partnerships with the Ministries of Health and other NGOs, such as PSI, for provision of IEC materials. In some countries, including Swaziland and Lesotho, PSI produced target-specific IEC materials that were supplied to the peer educators for distribution. A few projects had the capacity to produce their own such materials; for example, FLAS produced a booklet on HIV/AIDS, which was highly popular (more than 6,000 copies distributed in one quarter). Written in the local language, Siswati, the booklet covers information on HIV, STIs, positive living, and family planning. CoH in Zambia is in partnership with SFH; they also produced their own materials.

Large billboards with BCC messages were often placed in locations where they could direct people to CoH resource centers for more information or STI and VCT services (See Figure 3). The billboards contained messages on HIV and STI prevention and adoption of safer sexual practices. Videos with HIV/AIDS and STI information were screened at the resource centers. Truck and taxi drivers were provided with audio tapes that contained BCC messages.

Figure 3: Billboard Close to a Resource Center at Muloza Border, Malawi

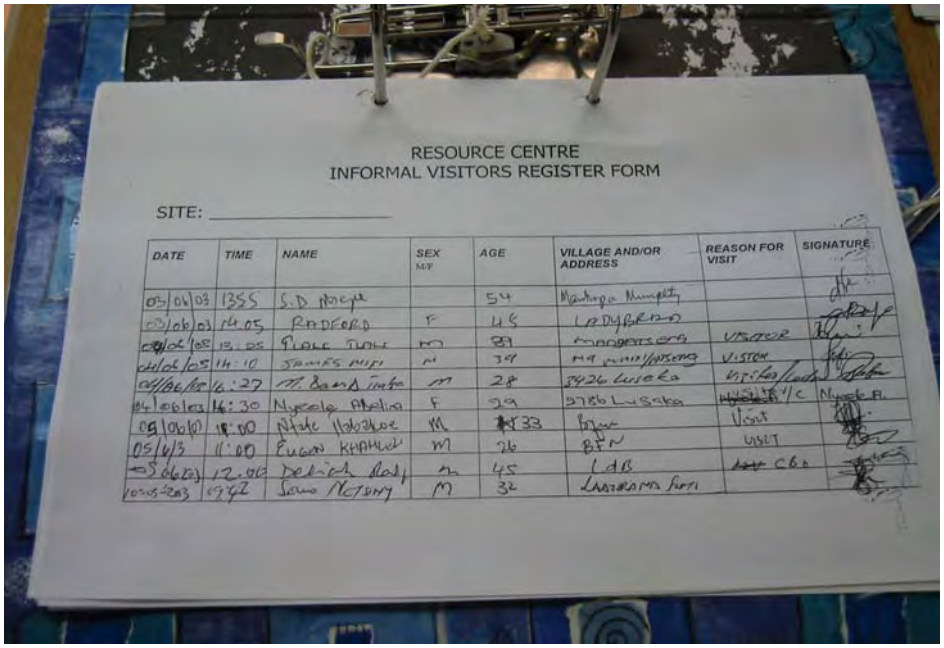
v. Resource Centers

Three out of the five projects ran resource centers. Project HOPE in Malawi, WVI/Zambia, and CARE Lesotho had operational multipurpose resource centers situated at strategic locations that enable easy access by the target population. The centers are marked by large billboards or signposts with the CoH emblem. They are mainly for youth and people from the surrounding communities who seek information on HIV/AIDS, STI, and condoms. Typically, peer educators staffed the resource centers under the supervision of project staff. The peer educators kept daily records of the number of persons, their gender, and reasons for attendance (see Figure 4).

After receiving peer education according to their information needs, youth proceeded to play games such as pool and snooker and play sports with equipment that was provided at the centers. The centers were good avenues to target these youth, who came from many areas. Most of them were unemployed, and the resource centers were their only source of entertainment. The centers played a major role in keeping young people from the streets and engaging in high risk behavior due to lack of entertainment. At the centers, clients had access to literature, magazines, and pamphlets on HIV/AIDS. To demonstrate community support for the project, in Lesotho a local chief donated a piece of land for gardening near the resource center. The youth manage the communal garden and grow vegetables, which are given to people living with HIV/AIDS and families in need of support. With support from UNICEF, the center procured irrigation equipment. It has a kitchen where meals are prepared, and this keeps youth at the center for most of the day. Sometimes the center is visited by as many as 35 people at a time.[23]

[23] Report on an Assessment and Mapping of services in the CoH project sites, Dec. 2004.

Figure 4: Resource Center Register



3. STI Management

In Malawi and Zambia, the projects run RHAP-funded clinics that provide selected STI screening and management services at the resource centers. The clinics are staffed by qualified health professionals skilled in the provision of information on HIV/AIDS, risks, and prevention, and carrying out physical examinations for the diagnosis and treatment of STIs. For example, in Malawi, the clinic serves mainly commercial sex workers, bicycle riders, traders at the nearby market, youth, and the community surrounding the border area. Due to lack of services nearby, some of the clients who visit the clinic for STI treatment come from a distance of 30 to 40 kilometers in Malawi, and some come from Mozambique.[24]

4. Home-Based Care (HBC)

The success of the project in attracting the attention of the greater community and the absence of other organizations conducting local interventions put pressure on the project to extend interventions beyond the original mandate of working with commercial sex workers and truck drivers. In addition, the extent and demand of the epidemic was gradually shifting toward care and support of the infected. For example, FLAS began the implementation of HBC activities in their last subagreement quarter. Project Hope and CARE Lesotho conducted some care and support activities. In most cases, the existing peer educators were trained to take on some care and support work. These activities were added on to the scope of work of peer educators, some of whom began by providing the services to their peers who were sick.

[24] Ibid.

5. Referrals for Service Delivery

Part of the peer educators' mandate was to refer clients who needed services that could not be provided during the peer educator outreach sessions, specifically STI and VCT services. Peer educators provided information on the signs and symptoms of STIs and included information on where people could go to seek diagnosis and treatment. They also encouraged their BCC clients to get tested for HIV and referred them to select VCT sites. This contributed toward increasing the health-seeking behaviors of people in the community. As an effort to follow up and strengthen the referral system, CARE introduced referral voucher cards to track referrals and treatment follow-ups.

6. Capacity Building and Technical Assistance

Certain key elements are used to assess capacity building efforts; capacity building of IAs focused on many of them. In this report, a few relevant strategies will be discussed:

- *Clear organizational mission, vision, and goals:* These should be well articulated and communicated to staff to inspire and facilitate movement toward achievement of objectives. Clear goals provide parameters for the scope of operations, which guide the activities to be undertaken. The CoH project had a clear goal and parameters—working with high risk mobile populations around border areas

- *Program strategy and relevance*: The project design of this CoH/RHAP project was shaped by literature from empirical research that confirmed the need for such services due to high HIV prevalence among the target population. Its relevance is also demonstrated by the partners that IMPACT/RHAP selected to work with. All of them had already been involved in HIV/AIDS prevention activities around the same target areas with funding from other sources/donors. For example, Project HOPE had been implementing prevention activities in Mulanje; CARE Lesotho had been doing similar work through its SHARP project. The project strengthened the capacity of the partners to deliver high quality work.

- *Human resources:* Human resources are the lifeblood of any organization. In cognizance of this, all the projects had a budget allocation for staffing. At the inception of the project and throughout its life, IMPACT/RHAP made efforts to ensure the availability of key staff members, primarily project managers, finance staff, and peer educators who implemented interventions. In addition, all staff members were taken through training and updates to develop and strengthen the skills they required to perform their duties.

- *Technical assistance approaches:* Building and sustaining the technical competence of staff and all other implementers played a pivotal role in the program. Several training and technical assistance activities were carried out. A description of the training that was conducted can be found in the Subproject Highlights section under Project Support Group, the partner that was mandated to provide technical assistance.

In addition to training, the program maximized sharing of available technical expertise within its regional partners. For instance, a technical expert in STI who was based in Zambia provided

technical assistance for the development of STI services and mentoring of professional staff of Project Hope in Malawi; FLAS in Swaziland; and CPC in Limpopo Province. To learn from each other, project staff and some peer educators traveled to model project sites in other countries. CoH staff had several opportunities to learn from each other at centrally located workshops. This was important for regional collaboration and standardization of approaches, which enhances the quality of service delivery.

- *Systems and infrastructure:* All IMPACT/RHAP projects were provided with budgets for the required equipment, furniture, and improvement of structures needed for effective service delivery.

- *Partnership building and community involvement:* All CoH projects effectively built and leveraged key relationships with important organizations. If nurtured, most of the relationships have the potential to be stable, long-term, and mutually beneficial. Notable are relationships with communities, governments, and other NGOs such as PSI/SFH. Through the use of local peer educators, the CoH Project is rooted in strong community involvement and support, which fosters sustainability.

- *Monitoring and evaluation (M&E):* Building and sustaining the capacity of IAs in M&E played a central role in this program. Implementing behavior change interventions with fluid populations requires rigorous M&E with clear and specific indicators. Capturing such data requires training and building the competencies of implementers to collect quality data. IMPACT/RHAP trained all program staff in the CoH projects in M&E with intensive on-the-job follow-up and support. Topics included data collection, data quality, data analysis, and data use; training targeted NGO staff and volunteers at the management and front-line data collection levels. FHI subcontracted an NGO, PSG, to provide ongoing supportive follow-up for data collection systems. In addition, MEASURE Evaluation, another NGO, conducted update trainings in M&E. All of these inputs contributed to the establishment of routine data collection and Management Information Systems within each of the IAs benefiting from TA through IMPACT/RHAP.

- *Financial management:* Development of capacity in financial management is pivotal for the implementation of effective and efficient programs. IMPACT/RHAP implementing partners received regular on-site and virtual guidance and supervision in the management of the grants. Submission of monthly financial reports increased their skills in financial management.

7. Support of USAID Partner Meetings

At the request of USAID/SA in FY07, FHI used the IMPACT/RHAP mechanism to support the "United States Government Swaziland Partners Technical Workshop" that was held in Mbabane, Swaziland, from October 3-4, 2006. The meeting objectives were to: (1) clarify gaps, opportunities, and priorities in key HIV/AIDS service delivery areas across USG partners; (2) emphasize integration and implementation of the preventive care package and evidence-based prevention strategies across USG/Swaziland partners; and (3) promote further understanding of current priorities and strategies in Swaziland for effective management of HIV-related

opportunistic infections (and reduction of HIV transmission. The key outcome from the meeting was a summary of recommendations that can be easily used and integrated into current USG partner plans for FY06 and proposed plans for FY07.

IMPACT contributed a small amount of funding (about $400) to the USG HIV/AIDS Program (PEPFAR) in Lesotho for the USG Lesotho Stakeholders Meeting, which hosted about 50 attendees on June 6, 2007. The purpose of the meeting was to present the USG PEPFAR program and staff structure to other stakeholders to increase donor coordination and collaboration in Lesotho, which has the world's highest HIV/AIDS rate. There are many funding agencies and programs for which coordination and collaboration is required in this country, and the RHAP funds were applied toward a meeting to bring these groups together. This small monetary contribution helped fill gaps in the local Mission's budget and permitted them to conduct collaborative measures that were important for quality programming in the region.

E) IMPLEMENTATION AND MANAGEMENT

1. Implementation

Following an October 1998 meeting, the USAID Africa Bureau allocated an initial $600,000 to IMPACT and PSI)to support a three-year targeted cross-border HIV/AIDS and STI prevention initiative in southern Africa, initially called the South African Cross-Border Initiative (SACBI). Eventually coined the "Corridors of Hope," this project sought to promote practical regional collaboration on the Durban-Lusaka highway, southern Africa's major transport corridor, which links South Africa, Zimbabwe, and Zambia. In January 1999, IMPACT met with USAID Health, Population, and Nutrition Officers (PHN) from South Africa, Zambia, Malawi, and Zimbabwe in Pretoria to develop the CoH project. The working group designed behavior change interventions (BCI) along the transport corridor from Durban to Lusaka, and identified the need for surveillance and policy support in the region.

From July to November 1999, as a first step in the design process, IMPACT commissioned a qualitative research study to (1) validate the selection of four border sites along the South Africa/Zimbabwe and Zimbabwe/Zambia borders as priority locations for a regional project, (2) identify the key sexual and social networks through which people interact, and (3) identify the key stakeholders and implementing mechanisms that would be an integral part of the prevention program. These data were brought together in a 100-page report, including appendices with detailed ethnographies and site inventories. The assessment not only confirmed the extraordinarily high-risk environment of these four sites, but also highlighted factors that make cross-border communities more vulnerable than other trade towns and urban areas.

FHI submitted the Assessment Report to the Africa Bureau and the USAID Missions in Zimbabwe, South Africa, and Zambia in December 1999. FHI also produced a publication from the assessment titled "*Corridors of Hope in Southern Africa—HIV Prevention Needs and Opportunities in Four Border Towns*" for distribution to USAID Missions and the International AIDS Conference in Durban. In response to a request from the USAID Regional Coordinator, FHI commissioned a similar assessment in Swaziland during 2000, using tools developed under the previous assessment.

In February 2000, FHI convened a meeting with partners PSI and the POLICY Project to reach consensus on the conceptual approach for the project. The POLICY Project was to contribute to the CoH project by developing advocacy activities with policymakers, trucking companies, and the private sector through direct support from USAID's Africa Bureau.

FHI participated in the PHN officers meeting in Maputo, Mozambique, in March 2000, which brought together PHN officers from the USAID Missions in Harare, Pretoria, and Lusaka; the Mission Director from Zimbabwe; the USAID Regional Coordinator, IMPACT consultant; and representatives from PSI and the Futures Group. The work plan and budget for the project were presented at this meeting. The participating Missions requested input into project implementation and, therefore, restricted approval of work plan activities to two strategic planning workshops that will be held in May in two border sites: Beitbridge and Chirundu, Zimbabwe. Following the workshops, the group reconvened to plan implementation.

After a series of meetings with key stakeholders, the CoH project was designed to deliver HIV/AIDS prevention services within high-risk transmission areas in select southern African countries, particularly Lesotho, Malawi, South Africa, Swaziland, and Zambia. The main USG partners of CoH were MEASURE/Evaluation, PSI through its local affiliate Society for Family Health (SFH), the Futures Group's POLICY Project, Johns Hopkins University's Center for Communication Programs, and IMPACT. It was determined that through IMPACT, FHI's role in CoH was to focus on supporting care and support outreach programs, STI control, and community mobilization for BCC among most-at-risk populations as well as conducting strategic information activities and maintaining the CoH project website. What started as a three-year project with FHI eventually lasted close to eight years.

IMPACT/RHAP worked through IAs in five countries to implement HIV/STI prevention activities at 23 sites. The main target groups were mobile populations who frequently cross international borders of 10 countries in southern Africa and vulnerable populations at busy border trade towns. One of the IAs, a faith-based organization, focused on anti-discrimination and stigma reduction among religious communities in South Africa. The IAs were identified through a collaborative process with the key government and community stakeholders in the respective countries. One key criterion was previous work and interest in mitigating the HIV/AIDS pandemic; hence, all the partners had been involved in some prevention activities in their communities.

IMPACT/RHAP worked with the IAs to implement HIV/AIDS BCC and HBC activities through the following funding mechanisms:

i. Subagreements

A subagreement is FHI's most commonly used mechanism for disbursing funds to IAs. Subagreements are legal contractual documents between FHI and organizations that are funded by FHI to implement activities or subprojects. A subagreement not only defines the contractual terms and deliverables, but also serves as the guiding document demonstrating solid technical and programmatic design, including capacity building of the IA by FHI and/or other partners. The subagreement outlines the subproject activities and results to be achieved, the proposed

activities, and the responsibilities of the implementing agency and FHI, and defines the reporting requirements and budget. Most of FHI's partners operated through subagreements that were structured in annual funding cycles renewable following amendments to the original or previous subagreement. Through IMPACT/RHAP, FHI issued subagreements with the following organizations:

- Afribike
- African Network of Religious Leaders with or Personally Affected by HIV and AIDS (ANERELA+), based in South Africa
- CARE/Lesotho and CARE/South Africa
- Center for Positive Care (CPC), South Africa
- Family Life Association of Swaziland (FLAS)
- National Emergency Response Committee on HIV/AIDS (NERCHA), Swaziland
- Project HOPE, Malawi
- Project Support Group (PSG) of South Africa
- World Vision Inc., Zambia

ii. Task Order

FHI helps to achieve its objectives through the use of its IMPACT partners. FHI enters into written agreements with these partners to define their broad statement of work and in some cases to purchase long-term, ongoing personnel services. FHI issues specific task orders linked to partner agreements to authorize specific activities or subprojects within the partner agreement scope of work. The task order is similar to a subagreement in that it is a legally binding agreement and a design document that outlines the activity or subproject objective or results to be achieved, the proposed activities and responsibilities of the partner and FHI, and defines the reporting requirements and budget. For instance, IMPACT used a Task Order in early 2003 to contract PATH to provide 10 days of technical assistance on the facilitation of a BCC training workshop for RHAP implementing agencies in collaboration with PSG of South Africa.

iii. Rapid Response Fund

A Rapid Response Fund (RRF) is a small grant (less than $5,000) for an activity implemented by a governmental, local nongovernmental, or community-based organization. RRFs are intended to provide a quick-response mechanism for funding small projects and discrete activities, or to rapidly make start-up "seed money" available for larger projects that will be implemented through subagreements. Applications for these grants outline the scope of work (SOW) and implementation strategies. These applications then serve as the SOW to be carried out. They may be developed or revised with technical assistance from FHI. IMPACT/RHAP used RRF to fund ANERELA+, an emerging organization for activities with religious leaders who are HIV-positive, before transitioning into a full-fledged subagreement.

iv. Contracts

The contract mechanism is used to engage those organizations that provide a direct service on behalf of FHI. The contract spells out the exact terms and conditions to be met by the subgrantees, including deliverables and payment schedule, and payment is contingent upon the deliverable. FHI plays much less of a capacity-building, technical assistance role for subcontractors than it does for subgrantees. In terms of IMPACT/RHAP, a contract was given to *Sechaba* for research work and to *Into the Limelight* for website development.

2. Management

IMPACT/RHAP was managed by FHI using the internal and external expertise described below.

i. Management and Operational Oversight

At the inception of IMPACT/RHAP, FHI coordinated and supported the activities of its IAs from the headquarters of its Institute for HIV/AIDS in Arlington, Virginia, USA. As the program expanded to include more countries in the region, it became imperative to further decentralize the management and hand over this responsibility to the FHI Regional Office in Nairobi. The need for a closer presence became more apparent, however, as the program grew with demands for provision of technical support and program oversight. As a result, an FHI office based in Pretoria, South Africa, was established to provide more effective coordination and support. With support and oversight from FHI headquarters, the office was managed by a full-time Regional Director. A shared Finance Officer provided financial and administrative support to the office and the IAs. As was required, the Regional Director maintained close collaboration with USAID's RHAP Regional Director and its Cognizant Technical Officer (CTO) in Pretoria and regularly reported on the status of the project.

In July 2001, a part-time Regional Coordinator was hired to manage the project; after her departure in January 2002, coordination of the project was once again temporarily taken over by the Regional Program Officer within FHI/Arlington at 40 percent level of effort. Further coordination of project activities, including assistance with project proposal development, partner capacity building, reporting, and communication, was handled by the program backstop at FHI/Arlington, a Program Officer.

To enhance program coordination and management, FHI hired a full-time RHAP Project Director based in Pretoria in March 2004. This enabled consistent support to implementing partners and responsiveness to USAID/RHAP needs. To assist the Project Director with financial management and granting mechanisms, a Finance Officer was hired at the beginning of the fourth quarter of FY04. An Administrative Assistant was also hired during this period to provide ongoing support to FHI in South Africa. These two new positions were shared between three of FHI's South Africa-based programs (IMPACT/RHAP, IMPACT/South Africa, and the Contraceptive Research, Technology, and Utilization [CRTU] project). Meanwhile, FHI/Arlington provided overall management support to the program with direct backstopping from a designated Program Officer.

The RHAP Director resigned in April 2005 for personal reasons, presenting a significant challenge to project management. As it was difficult to identify a replacement to cover the project for the short duration that the project remained (10 months), FHI's Regional Senior Program Officer (RSPO) based in Pretoria filled the role of Acting RHAP Director from July 2005 to August 2006. Management during the interim period was covered by a consultant, with support from FHI/Arlington; after the RSPO left South Africa and the core RHAP activities ended, the last few months of the project were managed directly by the program backstop from FHI/Arlington.

ii. Technical Assistance

FHI subcontracted an organization with recognized experience in building the capacity of IAs in implementing peer education programs: PSG. In close collaboration with the IAs, FHI determined technical assistance needs, which were outlined in the annual work plans and carried out by the regional office or other FHI staff as well as through local, regional, and/or international consultants. Local technical assistance was often used to conserve resources and assure continuity of services. The Project Director and Finance Officer provided direct support to the IAs in program and financial management to build their capacity in nontechnical areas. FHI also employed the skills of regional technical experts in monitoring and evaluation and management of STI services. In addition, regular technical support and resources were made available, as needed, through in-country visits and virtual communication. Cross-regional collaboration and sharing of expertise was encouraged among the IAs through periodic central workshops.

iii. Financial Management

FHI is fiscally accountable for the program and provides the appropriate level of financial oversight. FHI maintains a cost center accounting system, which separates funding by source throughout the program. The system allows for tracking of both field and home office costs for specific projects and activities. For disbursal and reconciliation of funds to the IAs, each IA submitted a recipient monthly financial report (RMFR) to the regional office for review; once any necessary adjustments were made, it was forwarded to HQ for approval of the reimbursement to the IA. Initially there were exceptions to this, in which international organizations that had their headquarters in the United States reported directly to FHI HQ. The responsibility for checking the accuracy of the financial reports was however decentralized to the regional office with the presence of a finance officer, resulting in rapid follow-up and support for financial reporting accountability.

All project recipients are subject to routine financial reporting requirements, as per USAID regulations, and to internal audits as required by USAID and deemed necessary by FHI and USAID/RHAP. FHI installed a double entry automated accounting system at the regional office as a tool to record transactions and to receive financial transaction information from HQ. This enabled access to more timely data for all levels of FHI (IAs and HQ) and expanded the reporting capabilities. The country office submitted monthly financial reports to FHI/Arlington from which quarterly financial reports were submitted to USAID.

Pre-award questionnaires were conducted for all IAs receiving more than $50,000 while those expending more than $200,000 were subject to external audits.

iv. Project Website and Promotional Materials

FHI was charged with developing and maintaining the RHAP website during the first few years of the project, which it did through a service contract with Into the Limelight. It also developed and distributed promotional materials associated with the website, including a six-panel brochure that summarized the project.

v. Monitoring and Evaluation

Monitoring and evaluation was a core component of program activities to demonstrate the effectiveness of these activities. The regional program designed a database for data capture. The database addressed the key indicators that were identified and recorded on the Performance Indicator Form (PIF) and the database which was populated with current data on a quarterly basis. The IAs were provided with quarterly reporting templates and submitted quarterly reports to the regional office. The regional office, in turn, compiled a report reflecting the activities of the programs in the five countries; this report was submitted to USAID/RHAP and FHI HQ. The regional office submitted semiannual program reports to FHI/Arlington that were collated with reports from other IMPACT projects around the world and submitted to USAID/Global Bureau. Reports on program activities were complemented by regular meetings with USAID/RHAP.

IAs funded through subagreements and contracts submitted financial reports, narrative reports, and process indicator forms to the regional office as specified in their agreements. IMPACT/RHAP determined appropriate reporting formats and assured that evaluation indicators were collected and reported to USAID on a quarterly basis. In addition, IA activities were monitored through regular meetings and site visits. IAs reported directly to the FHI Regional Director. Quarterly meetings were convened at the IA program sites and attended by relevant program staff. Regular monitoring and evaluation training was organized at centrally located venues, providing IAs the opportunity to network and share information and experiences, challenges, and lessons learned across the region.

3. Implementation Challenges

During the life of IMPACT/RHAP, some fundamental developments posed challenges that impacted on implementation in different ways. Many of these issues are not unique to RHAP, as they are simply inevitable challenges encountered when any international development organization implements a regional project such as CoH. The key challenges were as follows:

i. Shift in Focus of Program

HIV/AIDS trends in the southern Africa region continued to be a cause of major concern as the epidemic did not show signs of abating. With such a high HIV prevalence, up to 38.8 percent in Swaziland,[25] the epidemic is considered generalized and not limited to specific target population

[25] UNAIDS 2004.

groups. The governments of the USAID/RHAP countries clearly recognized HIV/AIDS as a health and development crisis and launched various multisectoral responses to fight the epidemic and mitigate its impact. The USG partnered with southern Africa governments through the Emergency Plan and other bilateral and regional initiatives to bring technical expertise and financial support to help southern Africa maximize the quality, coverage, and impact of the response.

In 2004, some of the CoH countries, including Zambia and South Africa, became beneficiaries of the Emergency Plan. For these countries, this development had three major implications: inflow of resources to rapidly expand prevention activities; initiation/expansion of care and treatment activities; and modification of reporting requirements to meet targets set by the Emergency Plan. This brought about an overwhelming need to review, re-prioritize, and strengthen the CoH initiative to achieve maximum yield on investment and complement other USG efforts.

A rapid appraisal for HIV/AIDS program expansion was conducted in Lesotho and Swaziland. Compounded with the generalized HIV prevalence rates in these countries, findings from this appraisal led to a recommendation to rethink the strategy of CoH interventions. It was also observed that the vast majority of new HIV infections could be attributed to a high prevalence of multiple, concurrent sexual partnerships among the general population. This raised doubts about the rationale of interventions targeted at most-at-risk populations.

In April 2004 a five-year joint USAID/CDC HIV/AIDS regional strategy was approved. The strategic objective (SO) is to “strengthen the response to HIV/AIDS in southern Africa.” This SO highlights the priorities the USG has placed on addressing the epidemic in the region through increased resources and the need for all USG agencies and partners to mobilize efforts and scale up response. The strategic objective also reflects the inherent nature of a regional program to assist and support bilateral Missions, facilitate bilateral programming, and fill needs that cannot be met through traditional bilateral approaches. Lastly, the SO statement provides a role for the regional program to serve as a voice for the USG with other donor agencies and policy groups that are looking at needs and programs from a broad, regionwide perspective.

To achieve this objective, three intermediate results (IR) were identified:
IR 1: increased access to select HIV/AIDS services in target populations across the region
IR 2: improved quality of Mission programs to respond to the HIV/AIDS epidemic in the region
IR 3: increased participation of regional networks and institutions in responding to the HIV/AIDS epidemic

In most of the CoH project areas, IMPACT/RHAP projects were the only projects providing HIV prevention activities to communities to the extent that over time, the program became one of the most visible programs in the local communities. This raised a demand from the community that prompted project implementers to continue to stretch available resources to expand activities beyond their original scope in order to meet emerging needs.

All of the above developments initially brought about confusion as to how RHAP should move forward. Initially, USAID directed that the program should refocus on its original mandate (that is, to work with commercial sex workers and truck drivers). This resulted in some sites dropping

certain target groups (such as in- and out-of-school youth in Malawi); CARE Lesotho reduced its emphasis on in-school youth activities. Following further developments, USAID decided to reduce the focus and emphasis on targeted interventions. This presented a slight departure from the original mission and vision of IMPACT/RHAP, again resulting in a change to project implementations. Toward the end of the life of the project, many project sites reported reduced service outputs as a result of project disruption.

ii. Changes in Management

Over the course of the RHAP, there were several shifts in the management of the project. When CoH first began, IMPACT's activities were managed from FHI's headquarters office in Arlington, Virginia. Without a permanent presence in South Africa, it was difficult to conduct ongoing quality assurance and to adequately support the implementing partners on the ground. In an attempt to gradually increase the level of effort, and in response to the growing need for in-country oversight of the project, IMPACT hired consultants, a part-time Project Director, and eventually a full-time Project Director; the Project Director was eventually supported with local staff who split their time between RHAP and other IMPACT projects based in South Africa. FHI was discouraged from hiring additional full-time staff to support the project, which left a large workload for the Project Director to manage. When, toward the end of the project, the Director resigned, it was necessary to use temporary or "acting" staff members to manage the project. These constant shifts in management and support staff did not favor a smooth operation of activities and complicated relations with partners. Nevertheless, IMPACT took the necessary measures to address the situation by ensuring that managerial support was always provided by individuals familiar with the project and the regional activities.

iii. Financial Management of IAs

Financial management required monthly financial reimbursements, which sometimes posed implementation constraints when there were delays. These delays were mostly experienced by IAs who did not receive funding directly from FHI but through their US-based HQ, such as Project HOPE. Many IAs were nascent and lacked strong financial management systems or skills. In some cases (e.g., ANERELA+), the IA did not have its own finance staff, so FHI's CO staff had to play the role of accountant until the IA's institutional capacity grew enough to allow for hiring of finance personnel and managing of money independently, with TA from FHI.

iv. Peer Education Approach

IMPACT/RHAP relied on volunteers who had no other source of income, meaning that the materials, per diem, and incentives provided by IMPACT were considered their salary. This poses a sustainability challenge in any project that depends on volunteers to conduct the work, in terms of volunteers' availability and level of motivation. A lack of promised BCC materials only further hindered the peer educators' efforts. Additionally, as expanded upon in the recommendations section, the use of commercial sex workers to educate general community members was met with resistance and was not a recommended approach for peer education.

v. Data Collection/Reporting of Results

Although the data collection tool was made as simple as possible, it was not possible to control data errors with a high degree of precision. This was due not only to the low literacy levels of the front-line data collectors within the IAs and the nascent nature of the subgrantees, but also to the fact that indicators were not clearly definable and the donor's reporting requirements changed frequently over the course of the project. This allowed for variations in the understanding of the indicators and made it difficult to compare data over time. In addition, behavior change requires a significant amount of time to become sustainable in individuals; therefore, the short duration of the project could not enable the measuring of such outcomes/impact. (See the Results section of this report for more details.)

vi. Clarification of Partner Roles in CoH

At the onset of the project, the roles of the various partners (e.g., MEASURE, PSI, FHI) were defined in stakeholder meetings and project design documents. However, over the course of the project, a lack of communication and/or clarification of roles resulted in few synergetic contributions and ineffective collaboration in some key areas such as outcome evaluation and IEC materials development and distribution.

F) PROGRAM ACTIVITY TIMELINE

FHI fulfilled its role of providing technical assistance and building the capacity of IAs to enable them to implement prevention and care interventions. A comprehensive technical assistance plan was budgeted to provide regular support to accomplish the major program activities outlined in the table below. These activities and the scopes of work of the IAs cited in this table are described in more depth in subsequent sections of this report.

Table 1: Major Program Deliverables

ACTIVITY	FY00: 99-00	FY01: 00-01	FY02: 01-02	FY03: 02-03	FY04: 03-04	FY05: 04-05	FY06: 05-06	FY07: 06-07
Prevention and Care Interventions								
Afribike		X	X	X				
CPC, South Africa		X	X	X	X	X	X	
Project Hope, Malawi		X	X	X	X	X	X	
CARE, South Africa		X	X	X	X	X	X	
CARE, Lesotho		X	X	X	X	X		
World Vision, Zambia		X	X	X	X	X		
FLAS, Swaziland			X	X	X	X		
ANERELA+						X	X	
Capacity Building								
TA to IAs from PSG		X	X	X	X	X	X	X
TA to IAs from FHI		X	X	X	X	X	X	X
BCC Strategy								

ACTIVITY	FY00: 99-00	FY01: 00-01	FY02: 01-02	FY03: 02-03	FY04: 03-04	FY05: 04-05	FY06: 05-06	FY07: 06-07
Conduct training on development of BCC strategy					X	X		
Develop BCC strategy					X	X		
Conduct BCC assessments						X		
Strategic Information								
Baseline surveys at all project sites	X	X						
HIV/AIDS Rapid Assessment Guide		X						
Cross-Border HIV/AIDS Risk Assessments by PSG	X	X	X					
STI Assessments in Swaziland and Lesotho		X	X	X				
Swaziland ANC Sentinel Surveillance		X	X	X				
Peer Education Methodology Assessment					X			
Rapid Appraisal in Lesotho and Swaziland					X			
Mapping of Services at CoH Sites					X			
Rapid Assessment of Community Home-Based Care in Lesotho						X		
BBSS in Zambia			X	X	X			
BSS in Swaziland				X				
BBSS in Lesotho				X				
End-of-project evaluation							X	
Ongoing monitoring (data from IAs)			X	X	X	X	X	
Other Ad Hoc Activities								
Swaziland Health Check by Ernst & Young								X
Regional USAID meeting								X
Lesotho USG partners meeting								X

ACTIVITY	FY00: 99-00	FY01: 00-01	FY02: 01-02	FY03: 02-03	FY04: 03-04	FY05: 04-05	FY06: 05-06	FY07: 06-07
Management								
Project start-up	X							
Project managed from FHI/Arlington and region	X	X	X					
Project managed by part-time Regional Director			X	X				
Project managed by full-time Regional Director					X	X		
Project managed by Acting Regional Director						X	X	
Project managed from FHI/Arlington							X	X
Project close-out								X
Reporting to USAID								
Ad hoc (per request)	X	X						
Quarterly			X	X				
Semiannually					X	X	X	X
Annually			X	X	X	X	X	
Final Report								X

G) PROGRAM RESULTS

The previous section outlined the project inputs FHI contributed and the activities it conducted under the IMPACT/RHAP project in collaboration with its IAs and partners in the southern Africa region. It is also important to consider the overall results of those interventions in terms of their value toward the achievement of USAID's Strategic Objectives, efforts to prevent the spread of HIV/AIDS in the region, and international development in general. This section will outline what was accomplished under the IMPACT/RHAP project in terms of outputs, outcomes, and impact.

1. Program Outputs

i. Capacity Building

FHI is dedicated to capacity building at all levels. Under IMPACT, it was generally achieved through direct technical assistance (TA) by FHI staff or consultants to the subgrantees with whom subagreements were signed. Capacity building is often achieved through conducting workshops and trainings, internships, and exchange visits; providing on-the-job mentoring, supportive supervision, and technical assistance in the development and/or review of guidelines, manuals, tools, and reports; and sponsoring participation in international and national conferences. Imparting skills through training (e.g., trainings of trainers [TOTs] and refresher trainings) is a strong sustainability tool. IMPACT-driven trainings focused mainly on imparting practical skills and enabling their immediate application for maintenance of competencies.

IMPACT/RHAP activities were designed to promote the adoption of safer sexual practices among high risk populations. Through contributions toward the salaries of key staff; provision of transport for volunteers; rental of office space and improvements to structures; supply of furniture and equipment for offices and resource centers; and extensive training and training capacity building, both the number and service delivery capacity of IAs were expanded, thereby increasing access to needed services for the population as a whole.

At the end of the project, IMPACT/RHAP was operational in 23 sites in five countries. At its peak, more than 1,000 peer educators were active. An average of 7,400 peer education meetings were held per month, reaching an average of more than one million men and women with BCC messages and condom distribution.

Figure 5: Training of Peer Educators — Condom Demonstration

PSG, the NGO tasked to provide training technical assistance, conducted a number of trainings for other IAs, as specified in the table below:

Table 2: Number of Staff Trained and Content of Training

Activity	**Date and Venue**	**Content**	**No. trained**
Effective BCI	March 20, Pretoria	• Increasing understanding of BCC • Analyzing existing programs from a BCC viewpoint • Increasing capacity of participants to implement BCC programs	25
HIV/AIDS project planning, management, and monitoring	July 2003, Zimbabwe (Harare and Mutare)	• Planning, managing, and monitoring peer education projects • HIV/AIDS epidemiology • Making health management decisions • Migration issues: youth and women • Mapping and zoning	31
M&E and documenting HIV/AIDS projects	2003, Harare; 2004, SA; 2005, SA	• M&E concepts • Standardization of M&E within RHAP • Roles and responsibilities in M&E • FHI- and PEPFAR-required indicators • Data collection	• 25 • 14 • 20
Integrating HIV/AIDS care and support	October 2004, Lusaka, Zambia	• Integrating HBC and OVC • Field practical	15
Working with FBOs	November 2004, Malawi	• How to work with FBOs • Stigma and discrimination	17

In addition to formal trainings, ongoing technical assistance and mentoring resulted in increased capacity of the IAs in both technical and institutional areas. A total of nine local organizations received technical assistance and mentoring through subagreements with FHI under the IMPACT/RHAP project:

1. ANERELA+
2. CARE/Lesotho
3. CARE/South Africa
4. Center for Positive Care (CPC), South Africa
5. FLAS
6. NERCHA
7. Project HOPE, Malawi
8. PSG of South Africa
9. World Vision Inc., Zambia

One specific success story related to capacity building in institutional development is ANERELA+ (see Attachment C). When FHI first began supporting ANERELA+ through RHAP, the nascent group of religious leaders was not registered as a nonprofit organization in South Africa, and did not have a bank account or a constitution, nor was a management and support structure in place. Because of its limited institutional capacity, a Memorandum of

Understanding was signed between FHI and World Vision, allowing World Vision to manage funds on behalf of ANERELA+. That initial period resulted in a draft constitution, registration, and the gradual growth of a secretariat. The foundations laid by FHI enabled ANERELA+ to apply for additional funding in November 2003, which it received through a subagreement directly with IMPACT/RHAP under which FHI/South Africa's Finance Manager served as accountant for ANERELA+. Eventually, program, administrative, and M&E staff were hired, as well as an accountant whose capacity was built by FHI. With time and organizational development support from FHI, ANERELA+ proved its financial management capabilities and was able to manage its funds independently.

Because of the initial capacity building of ANERELA+, resulting from FHI's technical assistance, other proposals could be developed. At the time of IMPACT close-out, ANERELA+ had established formal partnerships with more than eight other well-known local and international organizations, and their budget grew from $20,000 in the first year to $1,200,000 in 2007. In addition, its initial membership of 40 at its founding retreat has expanded to a network of 15 country chapters and 3,400 members in southern Africa as well as Bolivia, Brazil, Jamaica, USA, Canada, United Kingdom, Denmark, and Sweden. Participation of its representatives in two International AIDS Conferences has meant a growing interest outside of Africa, and an international expansion steering committee has been set up to develop a strategy to expand into the International Network of Religious Leaders Living with or Affected by HIV/AIDS (INERELA+) with a permanent staff member based in London. At the time of IMPACT close-out, the network was in the process of appointing an Executive Director who will lead it into new areas of depth and reach.

ii. Strategic Information: Assessments, Evaluation, and Surveillance

For a recap of assessments, evaluations, and surveillance surveys conducted with funding and/or technical assistance from FHI under IMPACT/RHAP, see Section D1 above or the detailed reports produced for each individual Strategic Information (SI) activity.

iii. USAID/Partner Meetings

Funding from IMPACT/RHAP enabled two important meetings to be held by USAID and partners in the southern Africa region:

- "United States Government (USG) Swaziland Partners Technical Workshop" in Mbabane, Swaziland, October 3-4, 2006.
- USAID Partners Meeting in Lesotho in June 2007.

2. Service Outputs

The aim of the program was to reach as many people as possible with behavior change messages. All the projects met their annual targets in terms of the number of people reached through group education and one-on-one interactions. In fact, the Zambia project reached nearly 75 percent of permanent female sex workers or high-risk women, long-distance truck drivers, and uniformed personnel in targeted sites with peer education, condoms, and/or STI services.

Although the number of peer educators fluctuated, all the IAs trained and worked with the desired number during most the project. After streamlining the number of peer educators, a total of 431 (see Table 3 below) contributed to the achievement of project objectives.

Table 3: Number of Peer Educators

Implementing Agency	**Average number of Peer Educators**
CARE Lesotho (including South Africa)	142
Center for Positive Care	99
Family Life Association of Swaziland	59
Project HOPE Malawi	70
WVI Zambia	61

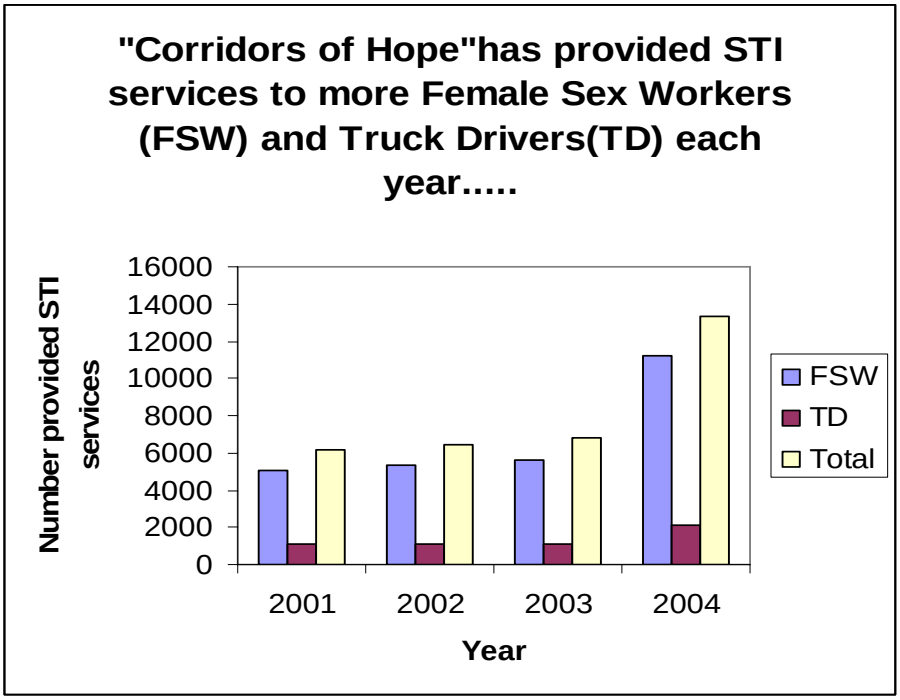
Peer educators captured data using process indicator forms; below are the total estimates for the life of the project.

Table 4: Key Process Indicators and Outputs over LOP

# of people reached with peer education	1,000,000
# of condoms distributed	3,000,000
# of individuals provided with STI management	3,000
# of individuals referred for STI management	3,000
# of peer educators trained	500 (431 active)
# of IEC materials distributed	2,800
# of facilities supported to provide STI management services	11
# of VCT sites supported	11
# of households served by community and home-based care programs	5,000

In Zambia alone, a total of 597,991 one-on-one meetings were held with males and females in the 10 sites to address HIV prevention interventions; about 54 percent of these contacts were with females. In addition, more than 200,000 face-to-face meetings were held with long-distance truck drivers and a total of 533,551 condoms were distributed (of which 97 percent were male condoms). The project established drop-in centers as focal points for activities. From these centers the project personnel were able to plan outreach activities, provide prevention communication and "edutainment," offer STI services, and most recently provide HIV counseling and testing services. In FY04 alone, the program reached more than 140,000 men and women with one-on-one behavior change discussions, provided STI services to more than 11,000 women at high risk for HIV, and provided STI treatment to more than 2,000 symptomatic truck drivers. The project also provided HIV counseling to more than 500 people, and tested for HIV and post-counseled nearly 400 people. The figure below shows how many female sex workers (FSW) and long-distance truck drivers (LDTD) were provided with STI services in Zambia.

Figure 6: Number of FSW and LDTD provided with STI services in Zambia (2000–2003 World Vision, Zambia)



The above service outputs demonstrate the high coverage of IMPACT/RHAP in the region.

3. Outcomes

i. Image of CoH Project

The IMPACT/RHAP worked largely in resource constrained settings and, in many sites, was the only program providing HIV/AIDS and STI messages to mobile populations at cross-border sites and towns along the transport corridor. This section presents anecdotal information on the image of the CoH Project, to which RHAP contributed.

Some projects, like FLAS, were recognized by the government as “an authority in working with mobile populations.” In Zambia, one stakeholder described CoH as follows: “CoH is like a conscience. It is like a voice inside you. It tells you when you’re doing something wrong.” Project staff demonstrated unique communication skills as explained by one staff member: “Here they receive quality treatment and they are met with smiling faces. This project has a human face.” Peer educators were also appreciated by the community.

In Swaziland, because of the use of commercial sex workers as peer educators, the image of the project was initially negative. But with time, and after observing the value of the messages, the peer educators became very popular and served as key change agents in the community.

ii. Improved Access to STI, HIV/AIDS, and Counseling Services

An important aspect of improving access rests in the changed attitudes of providers and communities toward HIV/AIDS. All the IAs reported significant improvements in the quality of services due to increased knowledge and skills of staff and volunteers (peer educators) who were involved in direct project implementation

Training and technical assistance had several positive results, as reported by the beneficiaries. Staff expressed more confidence in their skills, as evidenced by the following quotations from training evaluation forms:

- "I have really improved my counseling skills, and I went to computer training."
- "In this project we got a lot of support in terms of training. We interacted with other countries and learnt from their experiences. We had internships in other countries like Zambia and Malawi and learnt some best practices of peer education."

The skills and confidence of peer educators to interact with people and discuss behavior change was increased. Peer educators were reported to have "shown personal growth economically and socially." A community member reported that "they are recognized in the community and stigma has been reduced."

Barriers to services for youth were also reduced. A 19-year-old commercial sex worker reported, "If it wasn't for CoH, we would be dead by now because most of us feared people staring at us at the clinic, so we never used to go."

iii. Improved Behaviors and Attitudes

The increase in access to the above-mentioned services facilitated people's behavior to seek health services in a timely manner and increased their awareness of HIV and AIDS. Behavior change was anecdotally observed, with more and more people becoming interested in knowing their HIV status and using condoms for prevention of infection.

Through peer educator outreach sessions, training, and encouragement of HBC volunteers, as well as anti-discrimination and stigma-reduction efforts within religious communities, attitudes toward PLHA and health-seeking behaviors were improved. For example, individuals with symptoms of STIs were recommended to "go and seek medical help" immediately rather than ignoring the warning signs and seeking help in the late stages of the disease. The presence of caregivers in the community reduced the stigma around HBC and encouraged relatives to look after their own sick relatives or friends, as evidenced by this statement: "Relatives of patients have also been encouraged to care for patients. The relatives eventually started to come and support these patients, because if somebody who is not even our relative is able to come and support this person, then let us also support them."

In a way, the HBC component of the project complemented the cultural norm of taking care of the sick at home, particularly those who were shunned for having AIDS. The work of counselors also dispelled the myth about witchcraft causing HIV/AIDS. "People in the area think that we are helping them with a lot of things because they used to think that there were acts of witchcraft

when there is an outbreak of diseases. After they got counseled they realized the truth," said one volunteer.

According to some caregivers, the major achievement was the knowledge they gained and the reduction of stigma and discrimination. They felt empowered enough to be self-reliant; therefore, the project helped not only the beneficiaries but the IA participants themselves.

At the CoH in Zambia, the two rounds of BBSS (in 2000 and 2003) showed changes in behavior, including reduction of partners and increase of condom use. The only target group surveyed in the Round One surveillance survey was truck drivers; therefore, the following comparisons between the 2000 and 2003 BBSS concern that target group only.[26]

- *Condom use:* The results showed that the truck drivers in all surveyed sites had fewer regular partners in 2003 than they did in 2000, with the larger proportion of truck drivers reporting having no regular partners in the past 12 months. The truck drivers in Chirundu reported having fewer commercial partners and non-regular partners in the past 12 months. These decreases are statistically significant ($p<0.001$). The findings also showed that condom use at last sex with a commercial partner decreased by 7.2 percentage points in Livingstone; similarly, consistent condom use for 30 days with a commercial partner decreased significantly in Livingstone. The findings also show that both condom use at last sex and consistent condom use with a non-regular partner increased in both sites between surveys, keeping in mind that there was only one respondent in Livingstone in 2003 who had reported sex with a non-regular partner.

- *STIs:* The findings show that the proportion of respondents who could correctly identify more than two STI symptoms in men increased in Livingstone, while remaining stable in Chirundu. However, along with the increase in knowledge came the increase in those reporting a history of genital discharge and genital ulcers. The increase in reported STIs could, perhaps, be due to the fact that the increased awareness led to increased acknowledgment and diagnosis of existing STIs, which is the first step toward seeking treatment.

- *VCT:* Although the number of people claiming to have access to VCT actually decreased between 2000 and 2003, the proportion of people being tested and obtaining their test result increased, with approximately 96 percent and 92.6 percent of respondents in Livingstone and Chirundu, respectively, having received the result of their HIV test.

iv. Strengthened National Systems/Priorities

After conducting two BBSS in Zambia and one BSS each in Swaziland and Lesotho through IMPACT/RHAP, the Ministry of Health in South Africa recognized the importance of conducting behavioral surveillance and took the initiative to conduct its own, with technical assistance from FHI through a different funding mechanism (the Center for Consulting Services) in 2006. This demonstrates that FHI's surveillance efforts, which have all been conducted in

[26] Please contact FHI for more information about the BBSS.

close collaboration with government, have not only strengthened national-level sentinel surveillance but also have brought more attention to the importance of conducting behavioral surveillance on a regular basis, and have directly influenced national-level policies and priorities related to public health.

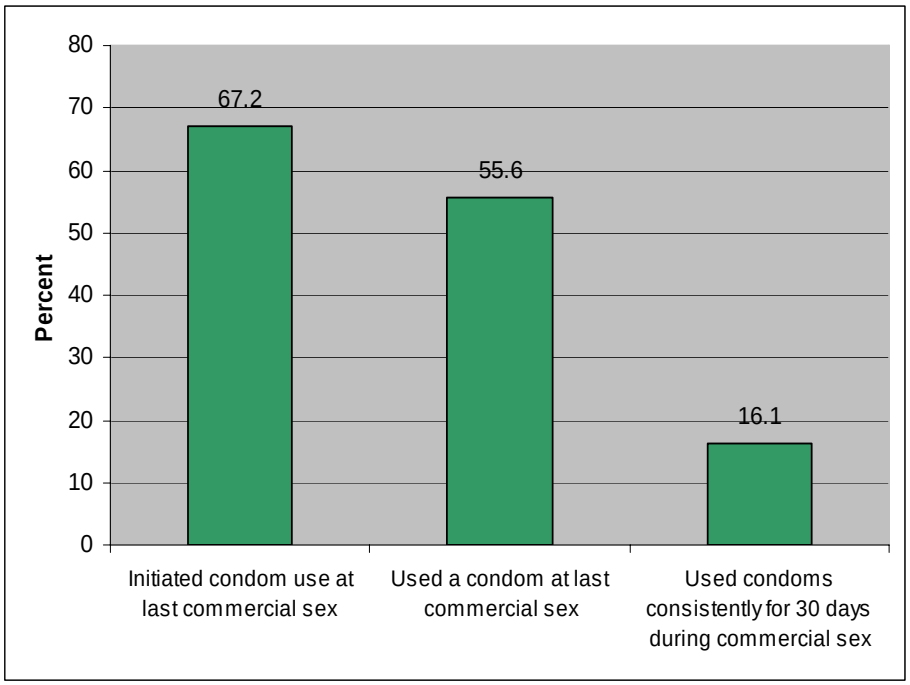
As a result of the "Swaziland Health Check" conducted by Ernst and Young, with financial support from FHI, the Swazi Prime Minister's office instructed the Ministry of Health in Swaziland (MOHSW) that its top priority for 2007 must be resolution of the drug crisis related to HIV/AIDS. This resulted from conducting a vulnerability review of the MOHSW's internal controls in FY07.

4. Impact

The impact of IMPACT/RHAP may not be easily determined because the programs were not national in scope and the project duration may not have been long enough for demonstrable impact. However, the changes at the outcome indicator level discussed above could serve as a good indicator of the program's contribution, especially as there were not many other players in the project target areas.

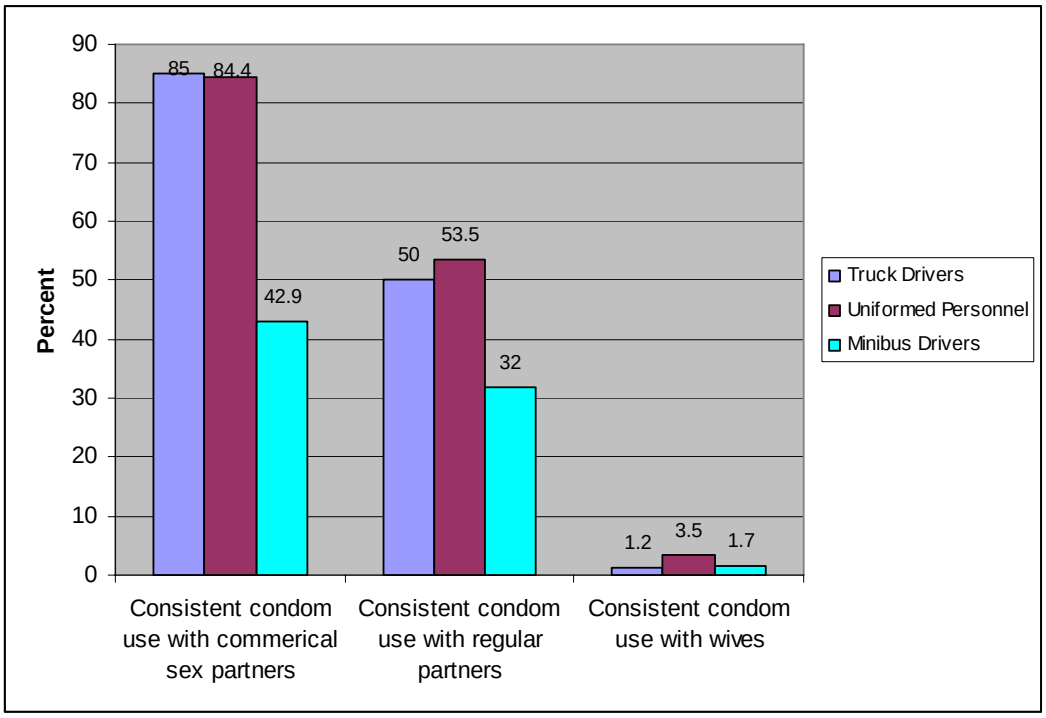
Between 2000 and 2003, STI rates among target groups had not changed; yet the number of sex workers frequented by long-distance truck drivers had decreased, and there was an increased awareness of basic HIV/AIDS information. Round II of the BBSS revealed that female sex workers (FSWs) were aware of the importance condoms play in HIV prevention and a high proportion of the FSWs initiated condom use at last sex with their clients (slightly more than 67 percent); see figure 7 below. On a more discouraging note, the study found that only 16 percent of female sex workers interviewed had used condom consistently in the previous 30 days, with the main reason being that the partner objected or a condom was not available. (No information is available on whether the rate of condom use had increased since 2000, because the Round I survey did not include FSWs.) These findings led to improvements in programming, such as increased emphasis on making female condoms available and affordable; more intensive efforts to reach clients of sex workers with BCC messages; and focus group discussions to determine other causes of unsafe behavior and solutions for promoting increased condom use.

Figure 7: Proportion of FSW Using Condoms (Round II BBSS)



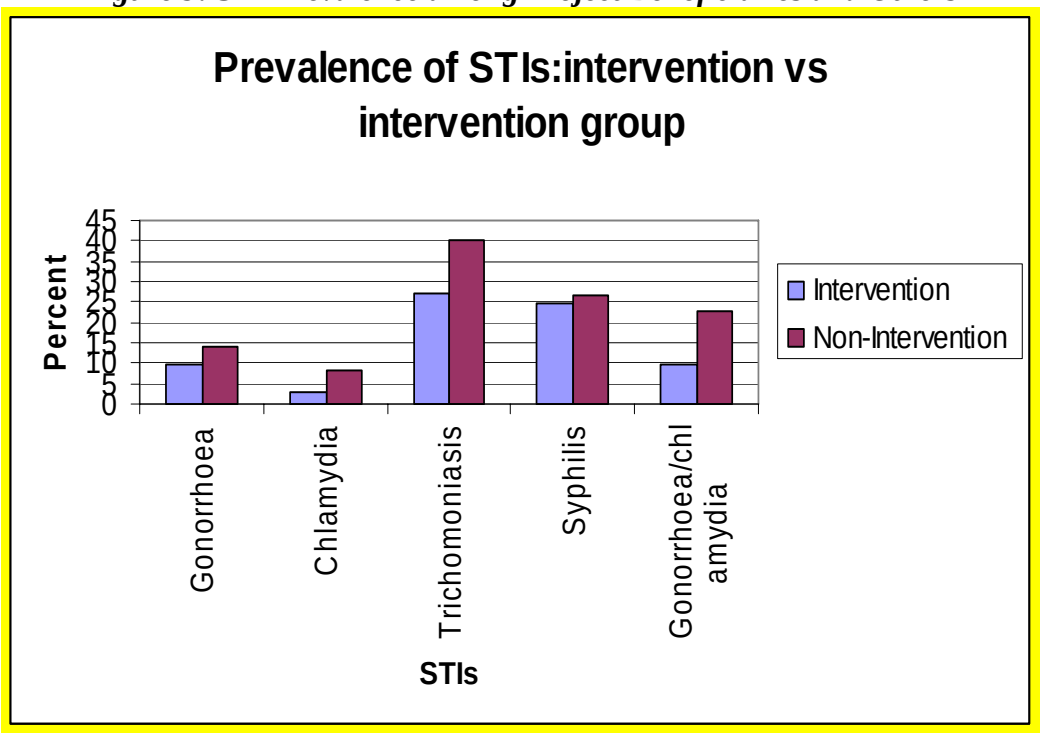
Additional survey data indicated the effectiveness of RHAP/CoH interventions, in that reported condom use was lower among the truck driver groups that were not targeted by the project (e.g., minibus drivers), as indicated in the figure below.

Figure 8: Proportion of Truck Drivers, Uniformed Personnel, and Minibus Drivers Using Condoms (Round II BBSS)



The figure below presents prevalence of STIs among FSW who registered and received STI services at least once before the 2003 survey, as compared with those who never received project services or visited the project's drop-in center. Overall prevalence of STIs was lower among those who were not reached by RHAP/CoH; therefore, it can be inferred that IMPACT interventions did, in fact, have a positive impact on behavior change and STI prevalence rates.

Figure 9: STI Prevalence among Project Beneficiaries and Others



III. LESSONS LEARNED AND RECOMMENDATIONS

Many lessons have been learned from the implementation of the IMPACT/RHAP project, and each IA has generated its own lessons, best practices, and innovations that can help guide future HIV/AIDS and STI prevention programming for mobile populations in the region. This final RHAP report focuses on a few of the most noteworthy examples.

1. Project Focus

The change of program focus midway through the project had a negative impact on attainment of project targets. After the decision by USAID/RHAP to streamline the target groups, some projects dropped interventions for certain target groups and scaled down the number of peer educators with whom they were working. In addition, all IMPACT/RHAP interventions in Zambia were removed from the regional project and taken on by the USAID and FHI bilateral teams in Zambia. Such major changes in the focus and geographic coverage of the project during implementation can introduce confusion and result in loss of confidence by project implementers as well as reduction in achievement of service outputs. It is recommended that shifts in strategy

imposed by the donor be phased in gradually to allow projects to adequately adapt to the new strategy and to work with communities to design alternative approaches, thus avoiding the disruption of project activities and the abrupt termination of initiatives in progress. The beneficiaries and implementing agencies should be fully briefed and sensitized on such strategic decisions to promote their full understanding and buy-in of the new programming, as well as the replication of model approaches.

2. Peer Education Approaches

Peer education can serve as a model for reaching the wider community with BCC messages for HIV and STI prevention. If supported with the necessary resources and financial incentives, this cadre of volunteers (despite often being illiterate or semi-literate) can develop a strong sense of ownership that promotes commitment to the project. The regular provision of appropriate IEC materials should be ensured to complement the work of peer educators.

One of the project's main weaknesses was the use of CSWs to educate other target groups (such as migrant laborers and truck drivers) about HIV/AIDS and behavior change. All of the IAs reported initial community resistance to being educated by known CSWs in the community, who not seen as model citizens with behavior to emulate. General community members did not consider themselves "peers" of the CSWs, and some communities labeled RHAP a "CSW project." For a peer education program to maximize its effectiveness, peer educators must restrict their BCC interventions to individuals within their target group. It is recommended that sex workers limit their education to their true "peers" rather than extending it to truck drivers, youth, and/or the general population; in fact, this recommendation applies to any such target group.

3. Community Buy-in and Ownership

Commitment and buy-in from the larger community is paramount. At the planning stage and throughout project implementation, more time and effort must be invested to enable increased community involvement so that target populations will fully appreciate the project.

It is recommended that peer educators be recruited within their own peer group first. Other peer educators within the same geographic area can be accessed to complement communication interventions as needed. However, to provide effective prevention services, the context and makeup of the target population should be considered when matching peers from non-peer groups.

The use of CSWs as peer educators for a behavior change project, in particular, requires concerted efforts and increased support to obtain community buy-in. However, IAs observed that maintaining the involvement of the community in project activities increased acceptance and sustainability. As reported by one stakeholder, "Commercial sex workers are human beings. We try to give them self-worth so they feel good about themselves."

4. Income-Generating Activities

The importance of promoting income-generating activities and alternative means of income for CSWs cannot be underestimated. Efforts must be made to provide complementary BCC messages to support a shift from sex work to other means of employment that can serve as a primary source of revenue. When the project cannot directly fund income-generating activities or micro-enterprise projects, it should foster linkages with other organizations already involved and experienced in these activities.

5. Increased Access to Key Target Groups

Often the involvement of males in prevention and care services, and VCT in particular, is significantly lower than that of females. To address men's risk behavior and promote increased use of VCT by men, programs should advocate for HIV prevention in the workplace and encourage female clients to refer their partners to access VCT services. To increase accessibility of prevention services — education, condoms, STI, and VCT — for truck drivers and female sex workers, the hours of operation for drop-in centers, clinics, and other resource centers should be extended up to 7 pm or later in the evening. Extending operating hours of key health services proved to be successful for reaching greater numbers of people in these target groups, particularly in Zambia. Along the borders and in areas surrounding STI clinics and VCT drop-in centers, outreach activities involving referrals and demand creation messages play a crucial role in actively promoting VCT entry points for care and prevention, including risk assessments and STI management.

6. Target Groups Versus General Population

The HIV/STI risks associated with sex work are not confined to sex workers and their clients. Male clients of sex workers are a bridge population linking HIV among high risk populations to the general population, since the male clients have girlfriends and wives who, themselves, may not engage in high-risk behaviors. Prevention of HIV in sex workers prevents transmission from clients to their other sexual partners and therefore to the general population. Improving access and availability of preventive and curative services for sex workers is a significant means of reducing the transmission of HIV and/or other STIs in the community. The impact of this intervention is linked to the sexual networks within the community and country. Understanding how sexual networks are organized and operate within a community deserves further research.

7. Monitoring and Evaluation

A behavior change project that deals with hard-to-reach target groups and nascent IAs requires clear and simple performance indicators as well as rigorous supervision and support of the community-based volunteers and/or staff who collect the monitoring data. In this project, data collection tools underwent several revisions to address new indicators for PEPFAR requirements.

The continual changes in USG/PEPFAR reporting requirements and revisions of indicator definitions created major challenges in obtaining timely, accurate, and meaningful data on process indicators. Low-literacy community-based volunteers conducting day-to-day frontline

data collection were frustrated and confused by this situation. Repeated M&E trainings and technical assistance had to be offered to the IAs, and collection of data required rigorous monitoring and quality data checks. In addition, the data collection and reporting tools had to be revised several times midway through the project. The shifting reporting requirements and changing definitions of indicators caused difficulties in documenting consistent results and comparing project data over time. An effective M&E system must comprise clearly specified targets from the onset of the project as well as regular spot checks for data quality among the IAs. Efforts should be made to maintain constant indicators and data collection tools throughout the life of the project.

8. Branding and Packaging

It is beneficial for a model program to produce its own unique behavior change communication materials, including slogans and logos that both distinguish it from other, lower quality services and target the desired audiences. The branding strategy and BCC materials should be designed through a participatory approach to ensure that messages respond specifically to the target group's needs and that logos and slogans appeal to their emotions and style. The principles of marketing and advertising need to be applied to create messages relevant to the local context and, therefore, effective for behavior change promotion. What ensures relevance is that the communication is audience-driven and the result of a participatory process. Branding is a key marketing principle that helps us distinguish one product or service (or in this case, behavior) from that of the competition (or from nonexemplary, unsafe behaviors). Branding is a promise to the target audience that must be delivered consistently and centered on the beneficiaries' needs and wants. One example is from WVI Zambia, which used the theme "Together we win" to form the overarching structure for its BCC efforts.

9. Partnerships/Regional Collaboration

The trainings and meetings conducted at central locations provided opportunities for IAs to share experiences and learn from each other. The motivating and rejuvenating nature of these exchanges appears to have contributed to the retention of project staff/volunteers. This is just one of the benefits of a regional project, and it is recommended that exchange visits and internships be a regular feature of programming.

It is recommended that partners work in close collaboration to complement each other's work and fill gaps where they exist, yet in such a way that no one partner is dependent on another for a service or product that is critical for implementation of its own project. Effective collaboration can prevent delays and disruptions in project activities if a partner is unable to meet deadlines or provide materials. The issue of collaboration should be addressed in the design phase of the project, in consultation with the donor. In addition, regular partner meetings should take place over the course of the project, with all prime partners and donor representatives, to discuss challenges and find joint solutions. This may occasionally involve a revisiting of partner roles, budgets, and scopes of work.

Peer education interventions caused confusion regarding partnerships and prime partner roles. In some sites, different partners used the same individuals for their respective peer education and

BCC interventions. As a result, the beneficiaries and even the peer educators themselves did not have a clear sense of the partners' roles in the RHAP project and were therefore unable to appropriately represent each organization. Furthermore, the messages and BCC approaches of the two partners were not always consistent. From the onset of the project, at the design phase, the scopes of work and geographic coverage of each prime partner should be clearly defined and planned to ensure that the target groups are different, the geographic areas chosen respond to gaps in coverage, and the messages and approaches used are complementary.

10. Funding Allocation

Projects of limited duration are less likely than longer programs to achieve positive, sustainable impact. In particular, short funding cycles do not allow for the strategic long-term planning and continued implementation that is necessary for the promotion of positive behaviors and attitudes, a process that requires time to take people through the stages of behavior change and attitude transformation. Funds for the RHAP project were approved and allocated on an annual basis, and funds were not always guaranteed to IAs for the following fiscal year. This occasionally caused anxieties that resulted in losing experienced IA staff toward the end of each funding cycle. Where possible, funding should be allocated on a multiyear basis.

11. Biological and Behavioral Surveillance

Since the beginning of the HIV epidemic and reports of early cases of AIDS in the 1980s, much has been done and multiple resources have been directed to prevention programs. The vast majority of these programs have focused on encouraging people to adopt safer sex behaviors. But very few of these programs and resources have been directed toward tracking those behaviors over time; instead, most of them track cases or the spread of HIV itself. While this is important, it is not enough without monitoring the behaviors that facilitate the spread of HIV. Rising HIV prevalence may be an indication that prevention programs are failing, but it does not indicate the causes. A stable or falling HIV prevalence could mean fewer new infections or it could mean more deaths.[27] And because a person can live with HIV for many years, especially in this era of antiretroviral therapy, HIV prevalence figures alone may reflect a mix of old and new infection that may not be useful for documenting recent changes in new infection rates.

The Behavioral Surveillance Survey (BSS) is a tool designed by UNAIDS, WHO, and FHI to solve this problem and gather information on the state of the epidemic in a given country. The emphasis of BSS is on the use of behavioral data to inform and explain trends recorded in HIV infection in given populations and use the data for planning and evaluating responses to interventions. By providing understanding of risk behaviors within the general population or select target groups, the BSS can serve as a valuable tool for design of new and more effective approaches and planning interventions. Surveillance of biomarkers (STIs) in combination with behavioral surveillance can provide evidence of relative response to the epidemic, as the rates of curable STIs can be used as proximal indicators of prevalence of risk behavior in the population. The information collected through Biological and Behavioral Surveillance Surveys (BBSS) can be used as an early warning on risk behaviors and, therefore, can be used to plan prevention activities and measure the effectiveness of the national response to HIV interventions over time.

[27] Behavioral Surveillance Surveys, Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV.

The following table was developed by stakeholders in Zambia to present the conclusions and recommendations from two rounds of BBSS, conducted in 2000 and 2003:

Table 5: Recommendations of the Dissemination Working Groups

ISSUES EXPLORED	**WORK POLICY GROUP**	**STI SERVICES GROUP**	**BEHAVIOR CHANGE GROUP**	**HIV VCT GROUP**
What does data tell us about the target group?	Majority is married; therefore, spouses should be targeted.	STIs still high. Many are not being reached. Broaden target group.	Long-distance truck drivers use more drugs than alcohol; few men receive STI treatment	They are well sensitized on HIV and AIDS prevention.
What are the main problems facing these target groups?	Need for economic empowerment. Delay in clearance of trucks. Low condom use.	Poverty. Age difference between peer educators and target group members. Delay in accessing STI services. Female condoms not easily acceptable and not available. Language barrier is an issue.	Condom use is low despite high knowledge level.	Low uptake of VCT services. Low condom use. FSW are of low economic status.
How can this data be used to address the problems faced by the target groups?	Create linkages for sex workers with IGA component. Mobile STI clinics along truck corridors. Strong referral system to ensure treatment and care. Truck companies' policy to allow spouses to accompany husbands. Include condom distribution within workplace.	Improve referral system. Review STI management approach. Train peers as peer educators. Work with traditional healers because CSW often consult them. Introduce mobile VCT services. Capacity building for staff and peer educators.	Give condoms to truck drivers. Continue with sensitization.	Lobby to promote HIV VCT. Improve M&E of the project. Have focused interventions.
How can we use this data to improve the service?	Carry out focus-group discussions to explore reasons for low condom use. Step up workplace intervention.	Work on gaps. Make female condoms more available and at less cost.	Carry out skills training in condom use. Drop-in centers should be open until 18h.	Strengthen referral system and open more VCT centers. Have management plan for staff.
What additional data do we require?	Data on what is being done about management—they should be targeted.	Issues of testing males. Benchmarks from countries that have succeeded.	Research study on stimulants and other drug use.	What other organizations are involved with similar projects and how are they doing?

IV. IMPLEMENTING PARTNER ACTIVITY HIGHLIGHTS

A. IMPLEMENTING PARTNER MATRIX

Table 6, below, summarizes the program focus of the various IAs to which FHI provided subgrants and technical assistance in the southern Africa region through this project.

Table 6: IMPACT/RHAP Subgrantee/Subcontractor Summary

IA	Sub-grant Type	Dates	LOP Award	Technical Area(s)	Project Sites	Target Populations	Strategies/ Activities
Afribike	Sub-agree-ment	8/15/01 – 5/31/03	$173,915	Community mobilization	All	Community-based workers	Procurement of bicycles
ANERELA+, South Africa	Rapid response fund; sub-agree-ment	12/15/04 – 3/31/06	$125,036	Anti-stigma and discrimination reduction	South Africa/regional	HIV-positive religious leaders, members of the religious communities; networks	Institutional support; organizational development capacity building; BCC in religious sermons; networking
CARE, Lesotho	Sub-agree-ment	10/15/00 – 9/30/05	$1,356,500	BCC, HBC	Maputsoe and Maseru in Lesotho	Sex workers, migrant laborers and their partners, youth, low-income women, long-distance truck drivers, and taxi drivers	Peer education, referrals for STI services, and hospice-based home-based care (in SA)
CARE, South Africa	Sub-agree-ment	10/15/00 – 3/31/06		BCC	Ficksburg and Ladybrand in SA	Sex workers, migrant laborers and their partners, youth, low-income women, long-distance truck drivers, and taxi drivers	Peer education, referrals for STI services
Center for Positive Care (CPC), South Africa	Sub-agree-ment	11/1/00 – 11/30/04 and 5/1/05 – 3/31/06	$347,725 and $137,410	BCC	Four border posts and workplaces: Pondrift, Platjan, Zanzibar, and Groblersbrug - Musina,	Men in workplaces and farming communities, truck drivers, sex workers, and uniformed men in	Peer education, condom distribution, and referrals for STI services

Table 6: IMPACT/RHAP Subgrantee/Subcontractor Summary

IA	Sub-grant Type	Dates	LOP Award	Technical Area(s)	Project Sites	Target Populations	Strategies/ Activities
					Groblersbrug and Martins Drift areas	Musina, Groblersburg, and Martins Drift areas	
Ernst and Young	Letter of Engage-ment	October 26, 2006	$57,075	Strategic information/ financial audit	Swaziland	Swaziland government (Department of Health)	Desk review and financial assessment/ audit; participatory meetings with government officials
Family Life Association of Swaziland (FLAS)	Sub-agree-ment	5/1/02 – 9/30/05	$317,457	BCC	Lavumisa, Lomahasha, and Ngwenya	Sex workers, truck drivers, low-income vulnerable women, and members of the community the sex workers are having sex with	Local advocacy, reaching out to men through community meetings and making sexuality information and condoms available in bars, shebeens, and night clubs; peer education through community volunteers; condom distribution; and referral to STI care
	Sub-agree-ment	9/1/01 – 2/28/03	$59,801	Behavioral Surveillance Survey	Swaziland	Seasonal workers, factories, tertiary institutions, out-of-school youth, military, watchmen, and CSWs	Surveillance
Into the Limelight	Contract	4/2/01 – 4/1/02	$1,499	Media	All	RHAP/CoH stakeholders (donor, partners, IAs)	Public relations and media: web page design and

Table 6: IMPACT/RHAP Subgrantee/Subcontractor Summary

IA	Sub-grant Type	Dates	LOP Award	Technical Area(s)	Project Sites	Target Populations	Strategies/ Activities
							promotional brochures
Karen Doll Manda Services	Contract	3/15/00 – 6/15/00	$13,835	Management and strategic planning	N/A	CoH stakeholders	Initial SA cross-border initiative workshop
NERCHA	Sub-agree-ment	10/1/02 – 7/31/03	$20,820	ANC sentinel surveillance	Swaziland	ANC clinics; pregnant women	Surveillance
PATH	Task order	Special ongoing work order	$30,579	BCC	All	All	Technical assistance
Project HOPE, Malawi	Sub-agree-ment	7/1/01 – 10/31/05	732,976	BCC; STI and HBC services	Border town of Muloza Mwanza border (last six months of the project)	Traders, bicycle riders, customs personnel, commercial sex workers, in- and out-of-school youth, truck drivers	Peer education, road shows — edu-entertainment, evening shows, BCC materials, development/ revision, resource center and STI services, community outreach
Project Support Group (PSG), South Africa	Sub-agree-ments	Various between 8/31/1999 and 4/30/06	$476,750	Capacity building; evaluation; assessments	Support to implementing agencies; implementa-tion of evaluations for FHI	FHI, CPC, Project HOPE, CARE Lesotho, FLAS, ANERELA+	Training, on-the-job follow-up and support, internship, exchange visits, survey and evaluation methodologies
Sechaba Consultants, Lesotho	Contract	2/19/01 – 12/31/02	$93,256	Behavioral Surveillance Survey	Lesotho	In-school youth, out-of-school youth, female sex workers, low-income migrant women, and the military	Surveillance

World Vision Inc. (WVI), Zambia	Sub-agree-ment	12/1/00 – 5/20/04	$562,605	BCC; STI services	Border towns and some inland high transmission sites in Chirundu, Kapiri Mposhi, Kasumbalesa, Livingstone, Nakonde, Chanida/ Katete, Lusaka, Ndola, and Kazungula	FSWs and their clients (primarily truck drivers and uniformed personnel), and secondary targets such as school-age youth and patrons of high risk settings in border areas	BCC interventions (peer education, outreach work, drama, community discussions, individual and group counseling at drop-in centers), treatment of STIs, referrals to VCT services, integration of reproductive health and advocacy activities, workplace initiatives

B. SUBPROJECT HIGHLIGHTS

The details of interventions conducted by each of IMPACT/RHAP's subgrantees, listed in alphabetical order, and their coverage zones are described in the paragraphs below. As specified in the table above, some were subcontractors, but most were subpartners through subagreements.

1. AFRIBIKE

The history of Afribike dates back to the 1939 Swedish army bicycle design, a simple, robust, and low maintenance bike. In 1999, Afribike, in conjunction with its Dutch and Swedish partners, introduced the African version of the original design and labeled it Afribike. The bicycle is built with basic features and suitable for daily use in rural and peri-urban locations. The life expectancy of the bicycle with proper care and maintenance is 30 to 40 years.

FHI signed an agreement with Afribike for a project to run from August 2001 to April 2002 for $96,148. The goal of the Afribike project was to enhance the mobility of peer educators in three border project sites resulting in an increased number of beneficiaries being reached. Afribike had the responsibility of distributing bicycles to peer educators at three FHI-funded projects in existence at the time: The Center for Positive Care, World Vision, and CARE Lesotho.

The strategies to be employed included establishing partnerships between Afribike and each of the three projects and determining the skills needed for a long-term bicycle promotion and

maintenance program. Selected peer educators from each site were trained and provided with bicycles, tools, spares, parts, and accessories.

The Afribike bicycles were supplied in a 20-foot shipping container that provided safe storage for the bicycles and maintenance equipment. Each of the other IAs received 80 bicycles from Afribike (for a total of 240), and peer educators were instructed on their use.

This was a worthwhile endeavor in project sites with serious transport challenges. However, it would seem the project met with insurmountable management obstacles that prevented the attainment of its original intentions. One of the challenges was related to lack of commitment in the care of the bicycles when the peer educators did not feel ownership of the commodity. In some sites, such as CARE Lesotho-Ladybrand, the option of selling bicycles to the peer educators was explored.

2. ANERELA+

ANERELA+ (the African Network of Religious Leaders Living with or Personally affected by HIV and AIDS) was founded in November 2002 with a vision of an African region where religious leaders living positively with and affected by HIV and AIDS are empowered to live openly as witnesses to hope and be forces for change in their congregations and communities. The goal of ANERELA+ is to found a highly effective network that links HIV-positive or personally affected religious leaders for fellowship, mutual support, and empowerment. ANERELA+ is an international body with national chapters and an elected Steering Committee to see it through the first three years. The three years were divided into a six-month set-up period; 30 months to build the basic network, initially involving 12 countries within the Africa region, and a mature phase.

FHI supported the initial six-month set-up period from November 2003 to May 2004, using rapid response funds. During this period most of the project activities were accomplished. These included the recruitment of a coordinator, registration of the organization, purchase of office equipment, production of a newsletter, and formation of a national network. At this time, ANERELA+ was a very nascent organization without an administrative structure to manage funding. For this reason, the seed funding was obligated to ANERELA+ through World Vision Inc. in South Africa. The first subagreement (FCO # 85719) was, therefore, between FHI and WVI Inc. After the end of this initial agreement, FHI and ANERELA+ entered a second subagreement that focused on strengthening project management and the formation of a South African network.

FHI provided ongoing technical assistance in organizational and financial management and training in M&E. The capacity of ANERELA+ was strengthened through the addition of an administrative secretary, an accountant, an M&E officer, and a project coordinator. Because of this strengthened administrative structure, the organization was capable of managing its own finances in this second round of funding.

The organization was successful in increasing its network of religious leaders who are affected by or infected with HIV. Toward the end of the funding period, a South African Network was

being formed (SANERELA+). ANERELA+ continued to gain recognition as evidenced by requests from several countries. One of the highlights of this organization was a national workshop in Kenya that received extensive press coverage in East Africa and was the subject of extensive public discussions. A representative of ANERELA+, Reverend J.P. Heath, participated in the final IMPACT event organized by FHI in Arlington, Virginia.

3. CARE/Lesotho and CARE/South Africa

IMPACT/RHAP funding to CARE started in October 2000 to support HIV/AIDS activities at the border sites of Maseru and Maputsoe in Lesotho as well as Ladybrand and Ficksburg, which are respective adjacent border towns in South Africa. IMPACT/RHAP supported CARE's Lesotho-based activities until September 2005; CARE/South Africa activities continued until March 2006.

The CARE project, dubbed the Sexual Health and Rights Program (SHARP!), was a cross-border initiative implemented by CARE with offices in Lesotho that managed both Lesotho and South Africa border sites. IMPACT/RHAP enabled SHARP! to work with priority groups in the selected border area including sex workers, migrant laborers and their partners, youth, low-income women, and long-distance truck and taxi drivers.

Through its community development approach, the project also supported local communities living in and around these border areas and worked with youth (10 to 25 years old) and health service providers for effective service provision and use. Resource centers were developed to serve as the community's coordinating center for HIV/AIDS activities such as training and information, and were envisaged to evolve into facilities that can serve as the community's counseling and voluntary testing center. FHI/USAID support will also be used to strengthen activities of community-based organizations, including their capacity to offer home-based care services.

The goal of the SHARP! Program was to protect and promote the livelihood and security of individuals and households that are affected by HIV/AIDS. It aimed to reduce the vulnerability of households to HIV/AIDS and contribute to the mitigation of HIV/STI's devastating effects by promoting safer sex among priority groups and facilitating skills empowerment for communities.

CARE relied on the use of volunteer peer educators to conduct BCC activities for HIV and STI prevention, condom distribution, referrals for STI prevention/treatment, and home-based care activities. All of these activities were conducted in Lesotho, but home-based care was not conducted in South Africa.

SHARP! peer educators were recruited with involvement from the community and trained. More than 200 peer educators were trained over the course of the project, and 60 were active at the end of the project. The training curricula for peer educators included content on HIV/AIDS transmission and prevention, reduction of stigma and discrimination, and demand creation for HIV testing. Weekly update meetings and sharing of experiences enabled peer educators to execute their duties with confidence and sustain their motivation to do so.

- **BCC interventions:** These were carried out by peer educators through one-on-one discussions and group education sessions that reportedly reached more than 900,000 people. Activities were carried out at resource centers and at outreach events in the hot spots (e.g., bars, border crossing sites, and taxi ranks). With supervision from project staff, the peer educators staffed the resource centers, which were well patronized by youth for information and education on HIV/AIDS and STIs. A variety of activities were carried out at the resource centers, including video shows, talks, and drama. More than 200,000 BCC materials were distributed at the centers.

- **Condom distribution:** This formed an important component of the program, as condoms were part of the peer educator's kits. In each of the peer education outreach activities, distribution of free condoms was encouraged. Condoms were distributed at one-on-one and group meetings. Peer educators also resupplied and stocked condoms at formal and informal bars, clinics, and truck stops. Condom distribution was accompanied by education and demonstrations on their correct use. Over the life of the project, the CARE peer educators distributed more than a million condoms in Lesotho and South Africa.

- **Referral for STI:** To encourage adoption of health-seeking behaviors, peer educators referred clients to government clinics for diagnosis and treatment of STIs; sometimes 50 to 100 referrals per week were reported per site. As an effort to strengthen the referral system, CARE introduced referral vouchers cards to track referrals and treatment follow-ups.

- **HBC/care and support:** As a complementary component added in the last year of the project (FY05), CARE trained 120 volunteers as HBC caregivers in Lesotho. To avoid caregivers traveling long distances, recruitment was conducted per zone. Caregivers' primary role was to visit PLHA in Lesotho to provide basic care and support, including assisting with household chores like cleaning and cooking. Care supporters also encouraged HIV testing and positive living. Each caregiver saw an average of five to 20 different patients per month; patients were visited two to three times per week and as needed. Caregivers met once a month to share their challenges and suggestions for overcoming them. This component was later expanded to include palliative care, for which 79 additional volunteers (including peer educators) were trained. They served a total of more than 2,000 households in the communities of the coverage areas. The HBC component of the project necessitated the inclusion of orphans and vulnerable children in the project.

- **Capacity building of CBOs:** SHARP! continued to mentor and provide capacity building to CBOs including resource mobilization and fundraising to support its volunteer efforts. This component included organizational development training and monthly meetings to strengthen networking among CBOs. SHARP also established a referral link with service providers who met with CBOs regularly to discuss case studies, referrals, new interventions, and standards in care and prevention.

4. CENTER FOR POSITIVE CARE (CPC), South Africa

Through IMPACT/RHAP, FHI supported the CPC from November 2000 to March 2006. CPC is a nonprofit organization based in Thohoyandou in the Vhembe District of South Africa's

Limpopo Province. The project coverage area ran along the border of South Africa with Botswana and Zimbabwe. The busiest border site is Musina, South Africa, which borders Beitbridge in Zimbabwe; the second busiest is Groblersbrug, which borders Botswana. Therefore, the CPC subproject with FHI targeted truck drivers, but it also dealt with the highly fluid population of refugees and illegal immigrants who crossed the borders of Zimbabwe and Botswana to enter the more lucrative country of South Africa. Typical of busy borders in southern Africa, the sites covered by CPC were characterized by truckers who wait for long periods, often overnight, before they are cleared to cross into other countries. An additional attraction to the country is the presence of farms that seek seasonal labor along the Limpopo border areas; thus, a key target group was migrant farm workers.

The aim of the CPC subagreement under IMPACT/RHAP was to create an enabling environment for behavior change that would reduce the transmission of STIs and HIV. This meant promoting safer sexual practices amongst the mobile communities, vulnerable women and, where possible, uniformed services at border sites.

The project used peer education to conduct community-based STI/HIV/AIDS intervention strategies that targeted highly vulnerable groups such as women at high risk, truckers, and migrant laborers. CPC's peer educators are community-based volunteers recruited at each site and intensively trained and supported to deliver outreach activities to communities using a variety of participatory methods of facilitating discussions on social issues that impact on HIV and AIDS. To achieve their objective of preventing HIV/AIDS, CPC offered services in three main program areas: BCC activities and distribution of IEC materials; condom distribution; and STI referrals.

Equipped with IEC materials and condoms, peer educators conducted the above interventions during outreach activities. Outreach sessions conducted by peer educators were often under the supervision of a staff member. Typical peer education interventions consisted of one-on-one sessions, door-to-door discussions, and public meetings at border posts and truck stops. Outreach messages focused on HIV/STI education, modes of transmission, recognition of common STI symptoms, and where to seek treatment. Detailed information on the use of condoms for prevention of HIV and STI was also provided together with a demonstration on proper condom use.

At group sessions, peer educators employed other participatory and entertaining methods of simultaneously educating and entertaining the communities, including drama, singing, role plays, and question-answer games. Some large, open-air edutainment activities were conducted with the assistance of the Society for Family Health (SFH), PSI's local affiliate organization, which had the capacity to conduct mass media communication. In addition to such outreach activities, peer educators resupplied condoms to various sites including clinics and common drinking places characterized by high-risk activity, such as formal and informal bars and spaza shops.

The following are estimates of specific project achievements:

- Ninety-nine male and female peer educators were recruited and trained. Following the initial 10-day training, the peer educators received annual refresher trainings and ongoing

on-the-job supervision and support. They were provided with peer education materials, including uniforms, BCC pamphlets, condoms, and demonstration materials.
- More than 2 million condoms were distributed.
- More than 800,000 people were reached with behavior change interventions.
- An estimated 200 clients were referred to local clinics for examination and/or treatment of STIs.

5. ERNST AND YOUNG (E&Y)

In a meeting on September 20, 2006, with USAID/SA, Ernst and Young (E&Y) in South Africa was informed of concerns about the internal control environment within the Pharmaceutical Services at the Ministry of Health and Social Welfare in Swaziland (MOHSW), specifically with regard to the procurement of medical supplies and pharmaceuticals. In addition, they were advised that USAID, through the Global Fund, was providing support to the MOHSW by providing funds to NERCHA, which, in turn, purchased antiretrovirals for distribution to the MOHSW.

E&Y was commissioned to conduct a "vulnerability review" of the Pharmaceutical Services Department and, based on the findings, make recommendations to meet the standards of best practice within the MOHSW with regard to the procurement of medical supplies and pharmaceuticals. Through a Letter of Engagement dated October 26, 2007, between Ernst and Young and FHI under IMPACT/RHAP, Ernst and Young was able to conduct what was called the "Swaziland Health Check" during the first and second quarters of FY07.

The methodology used to conduct this internal control environment review is designed to highlight vulnerability areas to increase the awareness of potential vulnerabilities, the typical warning signs or red flags of fraudulent activity, and appropriate responses to fraud and corruption. The methodology was designed through a co-development process, combining Ernst and Young's general accounting and auditing experience with each client's unique circumstances. The specific approach used for this situation was as follows:
- The existing internal control environment in the Pharmaceutical Services Department of the MOHSW was compared with best practice controls, and deficiencies with resultant exposures were highlighted.
- Supporting recommendations were provided to mitigate and manage identified vulnerabilities. In addition, recommendations were provided to assist management in strengthening the internal control environment to meet the standards of best practice.
- Once the detailed review was completed, a formal report was submitted to USAID/SA in which the results of the assessment were addressed and weaknesses were identified along with supporting documentation.

The activity took approximately one month to conduct, and USAID/SA was satisfied with the work done by Ernst and Young. This initiative assisted the Swazi Ministry of Health (MOHSW) to assess critical issues related to their internal controls; it included a final debriefing trip by Ernst and Young staff to present the Vulnerability Review findings to the Principal Secretary and the MOHSW senior staff. As a result, the Prime Minister's office instructed the MOH that its top priority for 2007 must be resolution of the drug crisis related to HIV/AIDS.

6. FAMILY LIFE ASSOCIATION OF SWAZILAND (FLAS)

FLAS is a not-for-profit nongovernmental organization established in 1979. It has won the governments recognition as the largest and leading organization in Swaziland in the provision of innovative sexual and reproductive health services.

FHI and the FLAS signed a subagreement to implement HIV infection prevention activities from May 2002 to September 2005. Project site interventions were staggered to start with one project site after another. In July 2003, activities were started at the first intervention site in Swaziland, the Ngwenya border post and the surrounding communities along the edge of South Africa. This was followed a month later by Lavumisa, Swaziland, which borders Mozambique. The project then expanded to two more sites, Lomahasha (another border site with Mozambique) and Manzini, an urban transient city in central Swaziland.

The subproject goal was to promote behavior change among high risk groups. The objectives were to:

- Promote behavior change among high-risk groups with particular attention to sex workers, truck drivers, low-income vulnerable women, and other members of the community.
- Contribute to the increase of knowledge on STI/HIV/AIDS, modes of transmission, and prevention methods among mobile populations in the project sites.
- Increase the number of STI clients receiving quality STI treatment and care within the project sites.
- Increase the number of chronically ill people that receive external quality care and support within their families in the project sites. This objective was added toward the end of the project to respond to the demands for care and support.

The project used peer education with an emphasis on the ABC approach (Abstain, Be faithful, and use Condoms). Male and female peer educators, the cornerstone of project interventions, conducted BCC, referrals to clinics for STI treatment and VCT, condom distribution, and HBC. Peer educators were recruited through a “snowball” method. Standard selection criteria were based on age, sex, minimum level of education, residence, acceptability in the community, and commitment to volunteerism. Peer educators received an initial 10-day training that covered HIV/AIDS/STI transmission and prevention, family planning, gender issues, and human rights. Skills imparted included facilitation, counseling, group dynamics, volunteerism, negotiation, and referral. The prevention component included the role of condoms and detailed instructions on their use; the training provided a strong knowledge and skills base for peer educators to effectively influence behavior change both among their peers and for themselves. To ensure quality provision of services and information, weekly update meetings were facilitated by project staff in all the project sites.

Peer educators conducted the following community outreach activities:

- **BCC meetings:** These were conducted through individual and group talks applying participatory methodologies such as role plays, discussions and use of picture codes. Over the course of the project, the peer educators held a cumulative total of more than 16,000

meetings and reached approximately 96,000 males and 135,000 females with HIV/AIDS and STI messages for adoption of safe sexual practices.

- **Condom distribution:** Peer educators promoted the use of condoms for prevention of HIV and STIs. Condoms were distributed to individuals and groups during outreach activities, and condom cans were placed in strategic areas. More than 1,200,000 million condoms were distributed throughout the life of the project.

- **Development and distribution of IEC materials:** To enhance BCC efforts, FLAS produced a booklet on HIV/AIDS that was highly popular, with more than 6,000 copies in the local language, Siswati, distributed in just one quarter. The booklet covers information on HIV, STIs, positive living, and family planning. In addition, peer educators distributed IEC materials received from PSI.

- **Referrals:** Part of the peer educators' mandate was to refer clients in need of services that could not be provided during the outreach sessions. A total of 4,000 referrals were recorded for STI management and other services including VCT and antiretroviral therapy. Some of the referrals were made to FLAS' mobile clinics in Lavumisa and Ngwenya, which were not directly supported by IMPACT/RHAP.

- **Home-based care:** In line with the extent and demands of the epidemic, FLAS began the implementation of HBC activities in the last subagreement quarter, April to September 2005. All peer educators were trained in HBC after contracting another local NGO, Swaziland Hospice at Home. This training enabled the peer educators to provide care and support to terminally ill patients in the various homesteads in the project sites.

Another agreement was put in place between FHI and FLAS to conduct the Swaziland Behavioral Surveillance Survey (BSS). In Swaziland, the BSS targeted seasonal workers, factories, tertiary institutions, out-of-school youth, military, watchmen, and CSWs. FLAS was responsible for completing the protocol; recruiting and training survey personnel; adapting and translating the BSS questionnaire; mapping, collecting, and cleaning the data; and analyzing and disseminating the findings, all with TA from FHI. The results were disseminated in January 2003 by the Government of Swaziland and FLAS.

7. Into the Limelight

Into the Limelight is a young, dynamic communications and design house established in 1999 to enhance the profile of organizations by providing high quality communications media. The organization has a good reputation in the NGO field.

In 2001, a service contract was entered into with Into the Limelight to develop and maintain a website for RHAP, and to develop promotional materials associated with the website. The website (www.rhap.org.za) was updated regularly throughout the CoH Project and contained links to RHAP-supported reports and tools that could be directly downloaded. In addition to extracting data and information from project reports, the organization made visits to project sites to understand project activities and capture highlights for the website. At regular intervals, Into

the Limelight populated the website with up-to-date information on the achievements of the regional program, increasing the sharing of best practices region and worldwide.

A six-panel brochure summarizing RHAP was designed and distributed. The brochure promoted the website and included information on

- geographical concentration
- HIV epidemic
- cross-border site activities, "Corridors of Hope"
- regional policy activities
- networking and information sharing
- consistency and comparability of data
- non-presence countries

This service contract ended on April 1, 2002; per USAID's request, the contract was not renewed with FHI but was taken over by another RHAP partner.

8. National Emergency Response Committee on HIV/AIDS (NERCHA)

USAID asked IMPACT to support some costs associated with the Swaziland Antenatal Clinic surveillance survey, and to provide limited technical assistance. This assistance was provided by a consultant from Zimbabwe with extensive expertise in antenatal clinic HIV surveillance, and a subagreement was developed with NERCHA to support the Government of Swaziland on the survey. The report was finalized and shared by the Government of Swaziland in December 2002 and final dissemination activities were completed in July 2003.

9. Project HOPE, Malawi

RHAP's support to Malawi started in 2001 and ended in September 2005. Before RHAP funding, Project HOPE had been involved in HIV/AIDS activities with in- and out-of-school youth, and this was seen as one of the reasons that attracted RHAP funding, to complement already existing efforts. The objectives for this project were to

- contribute to the reduction in the prevalence of HIV/AIDS and STI in the impact area
- contribute to an increase in health-seeking behavior for STI treatment and adoption of risk reduction behavior
- increase awareness and demand for VCT and STI treatment

As with other CoH projects, the main interventions were peer education with target groups including commercial sex workers, youth in and out of school, and bicycle riders. Clients with STI were either treated at the project clinic or referred to health facilities, and VCT was promoted. Project HOPE operated at Mulanje, a border town characterized by human traffic on foot and bicycle. HIV/AIDS activities were held in Mulanje at the Muloza border post, which borders Mulanje District in Malawi and Milange in Mozambique. The Mulanje District forms part of the major transport corridor of Blantyre-Quelimane. The project targeted the community residing around the border post and trading areas of Limbuli and Muloza. Most of the residents of this area are employed in the nearby tea and coffee estates. RHAP project activities did not cover the tea estates. Commercial sex activities are carried out in bars and restrooms within

Muloza; other sex workers come from Mulanje town, Mozambique, and the surrounding villages.

Muloza is a recreational area for people from Malawi and Mozambique. On weekends, intense trading activities during the Sunday market are combined with fervent recreational activities in and around the numerous bars and adjacent rooms. It is also during weekends that numerous "freelance" sex workers from surrounding villages in Malawi and Mozambique join permanent sex workers.

Initially 220 peer educators were trained, 131 in Mulanje and 79 in Mwanza. This number of peer educators dropped drastically following the streamlining of project activities according to USAID/RHAP's realignment with recent HIV prevalence findings and efforts to revert to the original RHAP mandate. In- and out-of-school youth activities were discontinued because the original RHAP was to focus on commercial sex workers and truck drivers — cross border populations who were engaged in high risk activities. At the end of the project, Project HOPE had 62 active peer educators.

Peer educators disseminated BCC messages aimed at promoting the prevention of the spread of HIV. They conducted community outreach providing education on the use of condoms and supplying free condoms. They targeted hot spots such as beer drinking places where high risk sexual behaviors took place. They also held HIV/AIDS awareness group meetings in public places.

Condom distribution
By the end of the project, more than 200,000 condoms had been distributed. The project achieved this high distribution mostly through peer educators, while fewer condoms were distributed from the drop-in center. Condom distribution included demonstration of instructions on the proper use for prevention of STI and HIV infection.

BCC materials
For community education and communication, the project obtained BCC materials from the National AIDS Commission. These materials were mainly distributed by the peer educators, and a few others were issued directly to the clients who visited the drop-in center. The project also held community health education campaigns, displayed messages on billboards and peer educators T-shirts and caps, and distributed brochures with information about the project and HIV/AIDS.

Drop-in resource center
Project HOPE had a drop-in center close to the border. This center was highly patronized and often packed to capacity by young people and adults interested in BCC. This high attendance could be largely attributed to the fact that the site is within a poorly resourced rural area of Malawi with meager, if any, recreation facilities. The center provided a variety of activities including STI/HIV/AIDS education through video shows, talks, and drama as part of their health education activities. Condom availability was a feature at the center, which also hosted a PLHA support group. In March 2005, the resource center was certified to provide VCT services according to national protocols and standards.

Care and support
Project HOPE ran an HBC program in which 18 HBC caregivers were trained; 17 were active at the end of the program. Targeting a few villages in the impact area, the project served about 50 to 60 clients per month. A visit was primarily characterized by taking part in household chores like cleaning, cooking, and bathing the sick. Some caregivers donated their own meager earnings from part-time jobs to provide food for the sick.

Referrals for STI services
Project HOPE was one of the few projects to run an RHAP-funded clinic that provided STI services since 2002. Peer educators referred clients to this clinic and to nearby government and mission health centers. About 1,500 clients were treated at the clinic.

10. PROJECT SUPPORT GROUP (PSG)

PSG is a regional nonprofit organization/trust with branches in Zimbabwe, Zambia, and South Africa and emerging branches elsewhere in the region, under the stewardship of its South African branch. The PSG has a strong academic collaboration with several southern African universities and research institutions. The organization has received support from the Netherlands Government since 1985. PSG supports approximately 360 community AIDS prevention and mitigation projects throughout southern Africa. PSG's support to projects is primarily through the provision of technical assistance intended to increase the scope, coverage, and impact of RHAP partners' activities. In particular, PSG seeks to transfer its effective program approaches and skills developed in the region to RHAP partners. The interactions also foster effective cross-learning between RHAP partners.

As part of its mandate with USAID/RHAP to provide continued technical and financial support to partners in southern Africa, FHI entered into a partnership with PSG to deliver part of this support. PSG had previously assisted USAID and FHI in providing technical support to the regional program since 1999. In 2003, FHI and PSG signed an agreement to expire on February 28, 2005, for an initial amount of $279,000. Thereafter the agreement was amended with additional funding to April 30, 2006 to allow PSG to conduct additional end-of-RHAP project evaluations and report writing.

The goal of this PSG engagement was to provide training and technical support to partner NGOs in the RHAP program, in partnership with IMPACT. Strategies included training and technical assistance, with specific training including HIV/AIDS project planning, management and monitoring; effective behavior change interventions; monitoring, evaluation, and documenting HIV/AIDS projects; integrating HIV/AIDS care and support; and working with faith-based organizations.

PSG employed a variety of strategies for the provision of training and technical assistance to RHAP partners. The strategies were effective in promoting regional transfer and coordination because all the partners were often brought together in centrally located workshops. This presented numerous opportunities for sharing of lessons, challenges, and practical examples for

solving problems. Training strategies included training in workshops, exchange visits, field support visits, and internships.

Training
FHI identified the training needs of its partners and requested PSG to conduct relevant training primarily to strengthen peer education through updates and integration of pertinent thematic areas. PSG is recognized for its peer education model, which is grounded on social development theories and supported by adaptable training modules.

Since the RHAP partners are regional, to maximize the diffusion of best practices and learning across the region, the location of the trainings was varied depending on the type of training and availability of opportunities for learning. For example, trainings that required field practical and observation were taken to model sites that enabled such practical learning. Mutare, in Zimbabwe, was often used as a practical site because of its strong peer education program. PSG has a partner organization that implements a strong peer education and care and support program in Lusaka, Zambia, which rationalized the selection of this town as a venue for training. Training was conducted in Malawi to demonstrate approaches for working with faith-based organizations. This training took participants to a Catholic-run mission that implements comprehensive HIV/AIDS activities.

PSG conducted a variety of courses and completed all of its training activities as planned:

- HIV/AIDS project planning, management and monitoring
- effective behavior change interventions
- monitoring, evaluating, and documenting HIV/AIDS projects
- integrating HIV/AIDS care and support
- working with faith-based organizations
- monitoring and evaluation

Technical assistance
FHI and PSG consulted on how to plan and manage the technical assistance to partners. They classified the partners according to the level of technical assistance and guidance that was needed for peer education programs. Project HOPE, CARE Lesotho, and FLAS were considered more nascent than the CPC, which had previously received substantial support from PSG in running effective peer education programs. World Vision Zambia, which was placed in different category because it was a more mature program with a different cadre of peer educator, needed less support from PSG. CARE Lesotho, however, ended up receiving minimal support because it was undergoing structural changes that made it difficult to schedule timely technical support during the funding period.

- **FLAS** received substantial assistance in setting up its peer education prevention activities using the PSG model. PSG assisted in the mapping, recruitment, and training of peer educators. The assistance was provided on-site and through an internship at a mature program in Mutare, Zimbabwe. Through this capacity building, FLAS was able to develop its own picture codes and a quality checklist, and adapt a 10-day training program to suit its local conditions.

- **Project HOPE** was guided to develop systems to enumerate target populations in the project coverage area, and develop monitoring instruments for use by peer educators and a training and motivation plan for peer educators and adaptation of the PSG peer educator curriculum. With these skills, Project HOPE was able to develop its own counseling materials and expand the project to another border site.
- **CPC** received technical visits for updates and enforcement of quality peer education approaches. The center remapped its sites and retrained its peer educators. With the competency that was gained, CPC expanded its project coverage.

PSG visited each of the NGOs it supports twice a year and provided intensive on-the-job follow-up training. PSG also provided technical assistance in the form of internships and exchange visits. The internships involved assigning nascent partners to more experienced sites to help them learn the development and implementation of peer education programs. Two internships were carried out involving partners from CPC, FLAS, and Project HOPE.

Exchange visits were conducted when selected peer educators from the above partners visited more experienced projects in Zambia and South Africa. This exercise boosted the morale and motivation of the peer educators who visited a stronger program in a different country. Most of them were traveling outside of their own country for the first time.

FHI commissioned PSG to provide technical assistance in conducting end-of-project evaluations. The research skills of the partners in developing evaluation tools, collecting data, and writing reports were strengthened through PSG's use of a consultant who was highly experienced in conducting research work in resource constrained settings. In a peer education review it was reported that "the four NGO partners contacted for this review uniformly said they were very satisfied with the technical assistance provided by the PSG team and the effectiveness and utility of the model."[28]

11. SECHABA CONSULTANTS

The Behavioral Surveillance Survey (BSS) conducted in Lesotho in 2001-2002 was implemented through a contract between FHI and Sechaba Consultants. The target populations were in-school and out-of-school youth, female sex workers, low-income migrant women, and the military. The survey captured information on sociodemographic characteristics of the respondents; sexual behavior; self-reported number of sexual partners; self-reported patronage of CSWs; self-reported condom use with different partners; knowledge and use of condoms; knowledge, attitudes, and opinions about HIV and AIDS; knowledge about STIs and STI treatment-seeking behavior; knowledge of voluntary testing and counseling; exposure to HIV prevention interventions; self-reported STI symptoms and treatment-seeking behavior; self-assessment and assessment of others' risk of contracting HIV; and the ability to identify effective methods to prevent HIV transmission. The Lesotho BSS was disseminated in December 2003 by the Government of Lesotho in collaboration with Sechaba Consultants, the US Embassy, and USAID. The dissemination was successful and contributed to public debate on HIV/AIDS.

[28] Peer Education Review, Iain McLellan, 2004.

12. WORLD VISION INC., ZAMBIA

The Cross Border Initiative (CBI) was a project jointly implemented by the Society for Family Health and World Vision Zambia, funded by USAID and the Japanese International Cooperation Agency (JICA), and supported by FHI with technical assistance through RHAP/CoH. The overall aim of the CBI is to reduce the transmission of HIV among high risk groups at multiple Zambian sites with particularly high HIV prevalence rates. The primary targets of the project are sex workers and their partners; the secondary targets are bridging populations, school-age youth, truck drivers (who may not be clients of sex workers), and patrons of high risk settings in border sites that CSWs patronize. The sites at which the Cross Border Initiative operates are Chirundu, Livingstone, Kazungula, Chanida/Katete, Kapiri Mposhi, Kasumbalesa, and Nakonde.

USAID and JICA began supporting the CBI in 1999. In 2001, JICA began to assume responsibility for funding the core components of the program while the USAID funding through IMPACT/RHAP supported community mobilization for youth and enhanced STI control services. JICA continued to cover general peer education and STI treatment targeting CSWs and truckers, while the add-on “plus-up” activities covered by IMPACT included youth activities, the Blue-House Drop-In Center, physical expansion to Jordan and Masstock Farm, company focal point persons, and the involvement of money changers, clearing agents, and men in uniform. The RHAP/CoH funding to World Vision Zambia’s CBI ended in December 2004—the local USAID/Zambia Mission bought into the project and took over because Zambia is a PEPFAR country featuring its own USG bilateral project involving FHI/Zambia. CBI continues to receive technical support from FHI.

Zambia hosts a major component of the Durban-Lusaka transport corridor, which transects South Africa and Zimbabwe. This is also a major corridor for trucks passing through to Tanzania. The findings of the first assessment in 1999 demonstrated the need for interventions in HIV prevention. To monitor and assess the progress of the prevention interventions provided to the target groups in the project sites, repeated rounds of cross-sectional behavioral and STI prevalence surveys (BBSS) have been conducted. The first BBSS was conducted among female sex workers, truck drivers, uniformed personnel, and minibus drivers in 2000, and the second round in 2003.

The aim of the CoH project under RHAP was to reduce the transmission of HIV among high-risk groups at multiple Zambian sites with particularly high rates of HIV transmission. This involved highly targeted interventions primarily aimed at CSWs and their partners. The secondary target group members were bridging populations, school-age youth, truck drivers, and patrons of high risk settings in border sites that CSWs patronize. Similar to other CoH projects, the three primary foci of the project are condom promotion, STI service provision, and BCC.

Zambia is surrounded by countries that have a high HIV prevalence: Botswana, Zimbabwe, Malawi, The Democratic Republic of Congo, and a small piece of Namibia. The CBI project is implemented in 10 sites, seven at the borders and three along the major transport route. The border project sites are Chipata, Chirundu, Katete, Kasumbalesa, Kazungula, Livingstone, and Nakonde, and the inland sites are Kapiri Mposhi, Ndola, and Lusaka.

Peer education
As in other CoH projects, peer education formed a major component of the interventions. CoH Zambia applied a similar peer education strategy as the other IAs but had difficulty identifying and maintaining its outreach workers. WVI Zambia therefore decided to engage fewer peer educators who work full time and are paid a salary, under the assumption that the greater the financial incentives, the greater the commitment of the peer educators. In mid-2003, World Vision completely relaunched the Cross-Border Initiative and the technical approach shifted from focusing on volunteer peer educators to focusing on the use of professional outreach workers. The CBI project trained a core group of peer educator trainers in each site. Then a comprehensive team was created, consisting of a detailer (a person in charge of condom social marketing), a BCC coordinator, a healthcare provider, and a VCT counselor to impart technical content and skills in the peer educator training manual. A total of 37 peer educator trainers were equipped with knowledge and skills to apply participatory methodologies in training peer educators on BCC, including condom distribution and referrals for STI management. At the end of the funding period, the project had 61 peer educators.

BCC
Peer educators disseminated BCC messages aimed at promoting the prevention of the spread of HIV infection. Peer educators conducted community outreach providing education on the use of condoms and supplying both free and socially marketed condoms. Peer educators targeted hot spots, such as beer drinking places, where high risk sexual behaviors took place. They also held HIV/AIDS awareness group meeting in public places, drama sessions, and one-on-one sessions.

Mass media campaigns
The CBI employed vigorous mass media methods in addition to the use of public address systems. The initiative contracted a media group to erect 23 bus shelters throughout the 10 CoH sites. Each bus shelter carried one of the CoH messages and a list of all the CoH services.

IEC materials production and distribution
This project had the capacity to produce its own target-specific IEC materials, which complemented the ones the project obtained from other sources like the District Health Management Team and other NGOs. In addition to print materials to hand out to clients, project staff wore T-shirts with BCC messages as uniforms. The project used framed mirrors that carried CoH logos, reinforcing its messages on calendars and danglers. The expertise of SFH in producing IEC materials rendered this project superior in some of its BCC innovations.

Condom promotion and distribution
Unlike in other CoH projects, socially marketed condoms were a major part of the peer educators' responsibilities, because this project was implemented in partnership with SFH. CoH strategically promotes social marketing of condoms to increase their use among high-risk groups in the prevention of HIV and STI infection. The project conducted condom promotions for both free and socially marketed products by using innovative strategies like the "maximum night," a combination of edutainment and HIV/AIDS/STI messaging through the use of music and drama during the night at hot spots. More than 400,000 condoms were distributed.

Resource center activities
STI service provision remained a primary activity in this program. Recognizing that high impact interventions reduce the risk of infection, the project continued providing presumptive treatment to new CSWs. Additionally, syndromic treatment was provided to CSWs who were revisiting the drop in-centers branded the “Blue Houses.” The treatment was also extended to truck drivers and their partners. JICA continued to support the purchase of drugs and other related consumables like gloves, needles, and syringes.

Voluntary counseling and testing
A milestone in the history of the CoH was the introduction of voluntary counseling and testing linked to the district health management teams at all CoH sites in Zambia.

V. ATTACHMENTS

A. COUNTRY PROGRAM FINANCIAL SUMMARY

The table below presents the Life of Project (LOP) obligations and expenses for the RHAP portion of IMPACT funds as of the end of September 2007. The remaining balance was returned to the overall pool of IMPACT funds to make up for slight over-expenditures in other countries.

FUNDING TRACK	**LOP OBLIGATION**	**LOP EXPENSES**	**REMAINING BALANCE**
Field support, COP05 funds combined	7,129,000	6,995,486	133,514
CDC/LIFE	200,000	200,000	0
TOTAL	7,229,000	7,195,486	133,514

B. PUBLICATIONS PRODUCED

- Cross-Border HIV/AIDS Risk Assessments by PSG, 1999–2002
  - *Lesotho and Swaziland: HIV/AIDS Risk Assessments at Cross-Border and Migrant Sites in Southern Africa*, 2001
  - Caprivi, Namibia HIV/AIDS Risk Assessment report, 2002
  - Botswana HIV/AIDS Risk Assessment report
- Baseline surveys at all project sites, 1999/2000
- HIV/AIDS Rapid Assessment Guide, by PSG and FHI, 2001
- Biological and Behavioral Surveillance Surveys (BBSS) in Zambia: 2000–2003
- Behavioral Surveillance Surveys (BSS) in Swaziland and Lesotho, 2002
- STI Assessments in Swaziland and Lesotho, 2002
- ANC Sentinel Surveillance, 2003
- Peer Education Methodology Assessment, 2004
- Rapid Appraisal in Lesotho and Swaziland, 2004
- Mapping of Services at CoH Sites, 2004
- Rapid Assessment of Community Home-Based Care in Lesotho, 2005
- Final Evaluations at all project sites, 2006

C. IMPACT CLOSE-OUT EVENT ADDRESS BY FATHER J.P. HEATH OF ANERELA+

Presented in Arlington, Virginia, June 28, 2007

Members of the FHI Board, staff, partners, invited guests,

It is impossible to speak about the history of ANERELA+ without speaking about the integral role which FHI played in our formation. Many of you might well know where ANERELA+ came from. In August 2001 three Anglican clergy got together during the All African Anglican consultation on HIV and AIDS. These three clergy were: Canon Gideon Byamugisha from Uganda; Reverend Francis Karemera from Rwanda; and me, Father J.P. Heath from South Africa. In that first impromptu meeting a dream was born, a dream to hold just one retreat for clergy living with HIV to offer mutual support.

This meeting was eventually held in Mukono, Uganda, in November 2002; and in that meeting ANERELA+ was born. There are, however, two lesser known facts about that first meeting. Canon Gideon, in one of his less inspired moments, had asked me to facilitate that first meeting. Secondly, Mr. Buck Buckingham III from USAID attended the meeting as a founding member of ANERELA+. At that meeting, Buck pledged that he would assist ANERELA+ in finding seed funding. I was also asked to coordinate this new network.

In ANERELA+, we usually try to highlight the situation on the ground which led to the need for ANERELA+ being formed:

1. AIDS being seen as God's punishment for sin.
2. Faith communities saying "This is not our problem, this is a medical issue, this is a government issue, this is not a church or faith community problem."
3. Faith communities being caught in the denial which said "No one in our faith community is living with HIV."
4. Responses like the previous one, which lea to a very strong *them* and *us* syndrome simply because when faith communities did get involved in an HIV or AIDS response, it was mostly for "those people out there," not for those of us who are in here.
5. Stigma linked to HIV being equally prevalent in all faith communities.
6. HIV being linked to immorality.
7. Because religious leaders are seen as "bastions of religious living," it is even more difficult for them to become open about their HIV status.

All of these are good, sound reasons for getting involved in forming a support group for religious leaders from all faith communities. But perhaps a word about this person who had been asked to not only facilitate this first meeting but also coordinate the new network:

- He was a simple priest who had no experience in facilitating workshops but rather had simply been a participant in one workshop where aims, objectives, mission statements, action plans, and strategic plans had been developed for his home diocese;
- He had no experience whatsoever in writing funding proposals; and
- Setting up and starting a network was as foreign to him as developing the technology to take a human being to the moon!

I can only say to you that God, however, wanted this network to succeed. Regardless of my many levels of unsuitability, God put the right people in my path to make this process happen. Buck Buckingham put me in touch with Lee Pyne-Mercier from FHI. Very patiently, he walked me through the process of applying for ANERELA+'s first funding. In addition to this, while addressing a session to the International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa (ICASA) in September 2003, Lee worked with me in getting everything else that was necessary for implementing this dream of getting ANERELA+ off the ground. ANERELA+ was not registered and did not have a bank account or constitution, etc. This meant that, at very short notice, a Memorandum of Understanding was signed between FHI and World Vision South Africa, in such a way that World Vision managed all the funds for us. And so ANERELA+ was brought into being.

The initial funding we received from FHI not only saw a constitution being drafted and ANERELA+ being registered as a nonprofit organization in South Africa, but also saw the slow growth of a secretariat. The foundations laid by FHI allowed us to apply for further funding and eventually expand the secretariat to include a Programs Manager, accountant, administrative person, and most recently a monitoring and evaluation specialist. But you would be wrong if you thought that the only growth that has been experienced since that first FHI grant in November 2003 was a growth in staff at the secretariat. Because of that initial capacity building, other proposals could go out.

Today we count as funding partners: Christian AID, ICCO, Bread for the World, SIDA, Southern African AIDS trust, Norwegian Church AID, PACT SA, and World Vision.

Our budget has grown from $20,000 in the first year to $1,200,000 this year.

An initial membership of 40 at our founding retreat has expanded to a network of 15 country chapters and 3,400 members.

Participation in two International AIDS Conferences has meant a growing interest outside of Africa. Today we have international members in Bolivia, Brazil, Jamaica, USA, Canada, United Kingdom, Denmark, and Sweden.

An international expansion steering committee has been set up, which is developing the expansion strategy into the International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA+) with a permanent staff member based in London.

Four world regions have now been identified: Africa, Pan America, Europe and the Middle East, and Asia and the Pacific.

We have now advertised for and are in the process of appointing an Executive Director, who will lead the network into the new areas of depth and reach.

Much still remains to be done. There are still millions of people living with HIV who have no access to care, support, treatment, and effective prevention strategies. The stigma, shame, denial,

discrimination, inaction, and mis-action around HIV and AIDS still remain a real threat to effective responses and the achievement of the Millennium Development Goals. But a small seed planted and first nurtured by FHI is growing, and through faith communities internationally our reach is being felt by ever more people.

I stand here today not only to thank you profoundly for the trust which was first shown by FHI, but also to pledge our willingness to continue to work with FHI into the future to meaningfully impact the negative effects of HIV and AIDS on humanity. Together we will achieve so much more.

I thank you.
Father J.P. Heath