

# Family Health International

Regional HIV/AIDS Program  
Southern Africa



Annual Report  
October 2003 - September 2004



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## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
BSS	Behavior Surveillance Survey
CBO	Community Based Organization
CDC	Centers for Disease Control & Prevention
CF	Community Facilitator
COH	Corridors of Hope
CPC	Center for Positive Care
CSW	Commercial Sex Worker
FHI	Family Health International
FLAS	Family Life Association of Swaziland
FSW	Female Sex Worker
HBC	Home Based Care
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMPACT	Implementing AIDS Prevention and Care (Project)
KABP	Knowledge, Attitudes, Behaviors and Practices
LAP	Lower Abdominal Pain
LIW	Low Income Women
M&E	Monitoring and Evaluation
PE	Peer Educator
PLWHA	Person Living With HIV/AIDS
PSG	Project Support Group
PSI	Population Services International
RHAP	USAID's Regional HIV/AIDS Program (for Southern Africa)
SFH	Society for Family Health
SHARP!	Sexual Health And Rights Promotion program
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary HIV Counseling and Testing
WVZ	World Vision Zambia

## I. BACKGROUND and INTRODUCTION

Since FY 1999, USAID's Africa Bureau has been providing funding to FHI/IMPACT, PSI and the POLICY Project (among others) to intensify the prevention and care response for mobile populations who frequently cross international borders among ten countries in Southern Africa, and for vulnerable populations at busy border trade towns. The rationale for a regional prevention response includes studies showing increased vulnerability among mobile populations, the continued importance of targeting high-risk groups in high prevalence settings, and providing a means for sharing and transferring project success across borders more efficiently than could be obtained by conventional means.

FHI's approach to HIV/AIDS programming has always been grounded in partnership. In this program FHI works through partners and to date, project activities have been established with partners in 5 countries and implementation of project activities at 23 sites<sup>1</sup>. FHI's activities under RHAP are in four main areas: prevention and care interventions for highly vulnerable populations; coordination and management; capacity building for partner organizations and assessment and surveillance. The prevention and care interventions are implemented by the partners through peer educators and drop in centres. The main interventions are BCC messages through group and one-to-one meetings; distribution of free condoms; counseling and referral for STI treatment and VCT; and some care and support services.

## II. EXECUTIVE SUMMARY

### **Achievements and Constraints:**

This is a report on the activities that were carried out in FY04 from October 2003 to September 2004. The prevention and care interventions continued in the 5 countries with expansion to new sites in Zambia and Swaziland. This project relies on community volunteers (peer educators) for implementation of activities. In this year, the average number of active peer educators was 500, which is less than last year's average of 750. Of note is the observation that this fewer number of peer educators reached almost double the number of people reached this year: 1,160,546 compared to 689,950 reached last year. This is a demonstration of improved efficiency as the program matures. These people were reached with HIV/AIDS prevention and health seeking behavior messages through BCC group and individual meetings. The same trend was observed with condom distribution where 2 million free male condoms were distributed compared with 1.2 million last year. Condom distribution increases as knowledge of its benefits increase and stigma is reduced through appropriate BCC messages. Most of the condoms were distributed during outreach BCC activities and through the resource centres.

The peer educators continued counseling and referring clients for STI treatment. Out of the 23 implementation sites, only 11 provide STI treatment at RHAP funded clinics. This year 2,778 males and 11,481 females were treated for STI. Some sites commenced care and support services that include training and working with support groups and home based care givers. A few selected sites, particularly Zambia, started the provision of VCT services from the resource centres.

PSG, through a subagreement with FHI, continued to provide capacity building support to implementing partners through training, supportive visits and exchange visits to stronger projects.

A joint meeting to improve M&E systems was held for all Corridors of Hope partners (MEASURE, PSI, FHI, POLICY, JHUCCP) in the second quarter of this year. 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.

As a result of PEPFAR and the resultant changes in funding structure, the Zambia Corridors of Hope program will in future no longer receive its funding through RHAP. It is however hoped that the unified vision of Corridors of Hope will continue in the coming year.

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<sup>1</sup> See Annex for partners, countries and sites

During the first quarter of this year, RHAP began supporting the African Network of Religious Leaders Living with or personally affected by HIV/AIDS (ANERELA+). The network was set up through an initial funding period of 6 months.

To enhance program coordination and management, towards the end of the second quarter of this year, RHAP hired a full time program director based in Pretoria. This enabled consistent support to implementing partners and responsiveness to USAID/RHAP needs. To support the program director with financial management, a finance officer was hired at the beginning of the fourth quarter of FY04. To date financial technical assistance has been provided improving the quality of financial reporting.

Amongst the constraints that affected partners' projects implementation were lack of appropriate and target specific IEC materials and reference material for peer educators. Development of the BCC Strategy which would have addressed this constraint was behind schedule. Roll out of the BCC strategy in the coming year will improve the quality of peer education and alleviate the shortage of materials. CARE Lesotho experienced financial problems that necessitated staff reduction leading to a high drop out of peer educators. Commencement of the second round BSS in Lesotho was delayed due to prolonged discussions and lack of consensus or support for it. In the coming year decisions will be made based on data needs in-country. RHAP's short funding cycles have prevented long-term planning and cause anxiety which reduces the implementers' confidence in the project.

### III. SITE SPECIFIC INTERVENTIONS DURING THE YEAR

#### **Zambia: In partnership with World Vision International (WVI)**

The Zambia Corridors of Hope is a project jointly implemented by the Society for Family Health and World Vision Zambia. The project is funded by the US Agency for International Development and the Japanese International Cooperation Agency (JICA) and receives technical support from Family Health International. The overall aim of the CBI is to reduce the transmission of HIV amongst high-risk groups at multiple Zambian sites with particularly high rates of HIV transmission. This is a highly targeted intervention and the primary targets of the project are sex workers and their partners. The secondary target group members 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 which CSWs patronize. The three primary foci of the project are condom promotion, STI service provision, and behavior change communication. The number of sites at which the Cross Border Initiative operates is 10: Chirundu, Livingstone, Kazungula, Katete, Kapiri Mposhi, Kasumbalesa, Nakonde, Chawama, Chipata and Ndola.

#### Interventions:

Of the 10 sites named above, three are new namely Chipata, Ndola and Lusaka as a result of project expansion this year. Although being considered new, Chipata is an old site which was closed in phase 1 because very few long distance truck drivers used it as a crossing point. This site was reopened due to increasing number of commercial sex workers and high risk behaviour. The other two new sites (Ndola and Lusaka) are cities along the main trucking route from the south to the north of the country, the trucking corridor along the main railway line. These towns not only make the term "Corridors of Hope" meaningful, but are a hive of high risk sexual activities.

This Corridors of Hope project continued to carry out BCC meetings reaching 545,742 people and distributing 186,950 male condoms. Only 196 female condoms were distributed throughout the year. Unique to this project is the provision of STI treatment at all its 10 sites and the use of full time outreach workers.

To strengthen the workplace initiative, FHI supported the Zambia Health Education Trust (ZHECT) to join COH and carry out a workplace initiative component targeting trucking companies.

At some sites, VCT services were introduced towards the end of this funding year and within the first month of initiation some sites reported high numbers of referrals (122 CSWs and 25 TDs referred from Livingstone) indicating the demand for VCT services among the COH target groups.

The project developed a BCC Strategy which guided the development of site-specific IEC materials using a participatory process including stakeholders, local communities and CSW. Data collection tools for outreach workers were revised. Three data collection tools for outreach activities, drop in centre activities and the BCC coordinators' summary report were developed to capture PEPFAR and RHAP needs.

The DHMT continued to provide free condoms for distribution through drop in centres and through outreach activities. COH has continued intensive condom promotion through both traditional (health facilities) and non-traditional (bars, small shops, guest houses) outlets and increased accessibility of regular correct and consistent use of condoms by the CSWs and their clients. All outlets had adequate stocks of socially marketed condoms. The access to condoms was increased through the establishment of new outlets increasing the total number of condom outlets to 269.

STI service provision remains a primary activity in this program. Recognising that high impact interventions reduce the risk of infection, the project continued providing presumptive treatment to new CSW and syndromic treatment to CSW revisiting the drop-in centres (Blue Houses). This 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. For syphilis screening to start in all sites, JICA procured rapid plasma reagin (RPR) test kits.

#### **South Africa: In partnership with Center for Positive Care (CPC)**

Centre for Positive Care is a community service provider organisation funded by FHI to implement a cross border STI/HIV/AIDS project targeting mobile communities, vulnerable women and where possible, uniformed services. The organisation has been funded since November 2000 to work in the Limpopo Province along the Zimbabwe/South Africa and Botswana/South Africa borders.

The project utilizes STI & HIV/AIDS intervention strategies in the community and workplaces in and around the borders. The projects are supported by community based volunteers recruited at each site and intensively trained and supported to deliver outreach activities to communities utilizing a variety of participatory methods of facilitating discussions on social issues that increase the impact of HIV/AIDS.

#### Interventions:

This project deals with a highly fluid population most of whom are refugees or illegal immigrants who cross the border fleeing political unrest in neighbouring Zimbabwe. Apart from an attraction to a more lucrative country, South Africa, the border areas are surrounded by farms which seek seasonal labor. Cohorts of community volunteer peer educators carry out BCC activities and distribute condoms to the target populations.

Public meetings were held at border posts and truck stops to reach as many truck drivers as possible and one-to-one meetings were held with border officials and uniformed services. Home-based meetings were also held at households of sex workers and other vulnerable women. Mass media activities were conducted with the assistance of SFH. Project staff visited a number of farming and uniformed services next to the border. In total the project reached 237,762 people and distributed 579,333 condoms.

Some of the challenges that are faced by the project are that the number of peer educators fluctuates significantly due to the highly fluid population in farming communities. The other challenge was to provide adequate and appropriate promotional materials. Another challenge arose from the lack of female condoms which are in high demand. After creating awareness on the female condom, CSWs prefer the method which empowers them to protect themselves. Another constraint is related to the lack of access to STI services at the border sites. The only project's referral site for STI treatment at the border in Musina provides erratic services and the nearest clinic to the other busy border site, Grobblersbrug, is 15 km away.

### **Lesotho & South Africa: In partnership with CARE International**

The Sexual Health and Rights Promotion Program (SHARP!) is a cross border initiative implemented by CARE Lesotho. This initiative is being implemented in two border towns of South Africa, namely Ficksburg and Ladybrand with complementary activities conducted in the towns of Maputsoe and Maseru in Lesotho (bordering Ficksburg and Ladybrand respectively). The FHI subagreement with CARE supports a combination of activities in the four sites.

SHARP! has been working with priority groups in the selected border areas including sex workers, migrant laborers and their partners, youth, low-income women and long distance truck and taxi drivers. The program has a community development approach and works with local communities living in and around these border areas.

The overall goal of SHARP! is to protect and promote the livelihood security of individuals and households that are affected by HIV/AIDS. The program aims to reduce vulnerability of households to HIV/AIDS by increasing the safety of sex among priority groups and by facilitating skills empowerment for communities to positively contribute to the prevention and mitigation of HIV/AIDS and other related problems.

Following recommendations to re-focus on the core target groups, the project began phasing out non-core targets like school youths to concentrate on CSWs and transport workers.

#### Interventions:

Within the first quarter of the year, CARE Lesotho experienced major financial problems that necessitated the laying off of 50% of project staff resulting in drastic peer education attrition and ultimately low activity achievement. By the end of the second quarter, there were 89 active peer educators in Lesotho, down from 160 reported in the previous quarter. However, the financial problems were resolved and by the end of the third quarter, peer education morale had been restored and project achievements had taken an upward trend.

It was encouraging to note that despite program instabilities, peer educators continued with their work. At one site, Maputsoe, peer educators continued manning the resource centre and activities continued with minimum supervision from project staff. This was a demonstration of sustainability of project activities. The project reached an almost equal number of males and females totaling 320,545 and distributed 712,590 condoms.

In this year, SHARP introduced a home-based care component to activities in Lesotho sites. Some CBO members underwent two-week training in home based care by the Ministry of Health. By the end of the year, SHARP supported 70 active home based carers in Maseru and Maputsoe. Carers visit families at least 3 times per week and provide basic care such as bathing, changing bed linen, feeding the patient and cleaning of the house. Staff continued making visits and provided support and encouragement.

The program works closely with groups that are already rendering home based care such as Ladybrand Hospice and the Oranje Vroulik Vereeniging (OVV) in Ficksburg. As a result of this SHARP maintains good links with groups providing home based care and has established a referral system through the peer educators and resources centers. The system needs to be formalized.

The other challenge that the project faces is that of inability to provide care and support materials. The government has been providing very erratic supplies to the home based carers. For IEC materials, the program continued to benefit from the local Department of Health and other sources as it does not have its own.

### **Malawi: In partnership with Project HOPE**

Project HOPE has been implementing the HIV/AIDS Cross Border Behavioral Change program since June 2001 in collaboration with the Ministry of Health and Population (MOHP). The project is cited in Mulanje district in the Southern region of Malawi, at the Muloza border post on the Malawi – Mozambique border.

Peer education has been the main approach used to achieve positive behavioral change to reduce the transmission of HIV among various target groups: commercial sex workers, vulnerable women, youth (in-school and out-of school), and bicycle riders who transport people and goods to and from Mozambique. Strategies include treatment of STI at the resource center clinic and promotion of VCT.

#### Interventions:

This project has had a fluctuating but relatively stable number of peer educators. By the end of the year, the project had an average of 70 active peer educators who reached out to 143,959 people and distributed 178,960 condoms. Following technical assistance to strengthen peer education by PSG, recommendations were implemented. The zone peer educators training continued throughout the year (six trainings per zone per quarter). This project implements effective peer education strategies including a minimum of five outreach meetings per zone per month in addition to one to one approach. Outreach activities were significantly affected by political campaign meetings for presidential elections this year.

As peer education continued in the community, STI clients were also being identified and referred for treatment. Apart from Zambia, this is the only other project that runs a RHAP funded clinic for STI services and continued to see an increasing number of mostly female clients. The district health office continued to supply the clinic with STI drugs. Minimum stock outs were experienced.

During the year, clinic staff routinely administered an informal questionnaire to female clients and the general conclusions are that condom knowledge is very high but use is low. In addition, a high number of housewives around the border area engage in transactional sex and have multiple sex partners.

There was a general lack of IEC materials. The resource centre continued to provide health education sessions through drama performances, songs and dances, video shows and discussions. Indoor games like bawo, chess, drafts and cards continued to provide some entertainment at the resource centre.

Out-of-school youth club meetings have decreased because the sporting equipment supplied by the project is now worn out. With the project's refocus on the CSWs and transport workers, phase out of this target group was commenced towards the end of the year.

This project, being in the heart of a rural area, is concerned with maintaining relationships with the communities and their leaders. Health education campaigns and open days were conducted for community mobilisation and advocacy. This helped to inform the communities of the project objectives and harness the support of community leaders who acknowledged the presence of high risk behaviour leading to HIV/AIDS. Follow up meetings with local leaders and traditional healers were conducted. These meetings helped to provide proper direction on how to more appropriately address the needs of the people.

The project started limited care and support activities including the training of support group members in Home Based Care services. This laid the groundwork for expansion should funds permit.

Project staff continued to supervise and monitor peer education work through observation of message dissemination, quality of performance and peer education communication skills. Due to its growth in scope the project has gained recognition from the National AIDS Commission.

The usual problems experienced by the project persisted in the year: Blackouts due to erratic power supplies and malfunction of the only computer in the project.

#### **Swaziland: In partnership with Family Life Association of Swaziland (FLAS)**

The Targeted Prevention for Mobile Populations project had an amendment under the Cooperative Agreement signed between Family Health International (FHI) and The Family Life Association of Swaziland (FLAS). Project expansion was staggered to start with one project site after the other. The first site of intervention was Ngwenya in July 2003, then Lavumisa a month

later. In this year, the project expanded to two more sites, Lomahasha and Manzini. The project particularly targets vulnerable women in the border areas of Lavumisa, Ngwenya and Lomahasha and the hotspots in Manzini where truckers stop. This is a comprehensive community based peer education and condom distribution project whose goal is to promote behavior change amongst high-risk groups. The intended activities to be implemented in each of the sites include conducting community meetings, reaching people with BCC messages and distributing condoms.

#### Interventions:

FLAS continued to grow with the opening of two more sites, Lavumisa and Manzini. Following this expansion, the project ended the year with 59 peer educators. In order to reinforce what the PEs learnt during their initial training, weekly training meetings were held at each site. The duration of weekly training meetings was increased to just over four hours per meeting per site to allow for extensive discussion of project related issues. The weekly meetings provided PEs with a forum to share their day-to-day experiences and learn from each other. The Project Coordinators used these meetings to clear misunderstandings, myths as well as misconceptions. This increased the PEs' confidence and ability to handle issues professionally.

As part of their responsibilities, the PEs were involved in participatory activities such as one-minute role plays, short dramas and picture codes. Educational talks and distribution of condoms were done in hotspots such as; bars, truck stops, shebeens, market places, schools, border sites, army barracks, playing grounds, bus/kombi ranks and shopping places. The peer educators met with 59,569 people and distributed 362,728 condoms. The PEs also distributed IEC materials provided by Population Services International. These pamphlets however fall short in terms of language appropriateness and being target group specific.

Challenges still faced include: difficulty accessing client friendly service provision centres in the project sites and providing good and accommodative venues for the weekly meetings.

#### **In partnership with Project Support Group (PSG)**

The Project Support Group provides services for research and assessment and provides technical assistance to IMPACT partner organizations in Southern Africa. Under a number of sub-agreements, PSG has undertaken assessments of HIV/AIDS risk environments in South Africa, Zambia, Zimbabwe, Swaziland, Lesotho, Namibia and Botswana. PSG also trains IMPACT partners in skills for peer education, such as interactive drama, and one-on-one interaction. PSG provides technical support and capacity building to RHAP partners through field visits and trainings.

This relationship along with resultant efforts and activities continued throughout the year. Support has continued to be focused on the following partners:

- Centre for Positive Care
- Family Life Association of Swaziland
- Project HOPE

#### Interventions:

PSG worked closely with CPC, Project HOPE and FLAS through technical Support visits. The purpose of these visits was to observe activities, offer training and facilitation support. During Quarter 1 of 2004, PSG conducted a needs analysis of coordinators across the three partners. The assessment reviewed recruiting and retaining volunteers, skills training in outreach activities and integrating projects into country specific interventions. The main needs include: To develop or update educational material with practical activities translated from English into local languages; To drive exchange programmes to and from model projects; To plan and prepare more effectively for meetings and visits, allowing partners the same benefit; To provide teams with problem solving skills; Training of managers in marketing and public relations skills as well as offering basic life skills allowing volunteers to supplement their income and quality of life; Training peer educators in order to ensure project sustainability and decrease volunteer turnover.

As part of the ongoing capacity building plans, PSG conducted two workshops, one on M&E in South Africa and the other on Care and Support in Zambia. In addition they conducted exchange visits that enabled partners to learn from stronger projects resulting in improvement of peer education and retention of peer educators.

### **African Network of Religious Leaders Living with or Personally affected by HIV & AIDS (ANERELA+)**

ANERELA+ (the African Network of Religious Leaders Living with or Personally affected by HIV & AIDS) was founded in November 2002 with a vision of an African Region where religious leaders living positively with and affected by HIV & 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+ or personally affected religious leaders for fellowship, mutual support and empowerment. ANERELA+ is an international body with various national chapters affiliated to it and an elected Steering Committee to see it through the first three years. These three years are divided basically into: a six-month setup period; thirty months to build the basic network involving initially 12 Countries within the African region; and a mature phase.

#### Interventions:

FHI supported the initial six-month set up period from November 2003 to May 2004. During this period, most of the project activities were accomplished. These include:

- Recruitment of a coordinator
- Registration of the organization
- Purchase of office equipment
- Production of a newsletter
- Formation of a national network

The major constraints during this period were related to staffing shortages. The project coordinator's responsibilities required a lot of travel leaving little time for project management issues. This led to delayed reporting and a long time lapse after the end of the first subagreement. During this year FHI commenced the process of writing a new subagreement which will focus on strengthening project management and the formation of a South African network.

#### **IV. ASSESSMENTS AND EVALUATION**

During the year, Sara Bowsky, FHI conducted a rapid assessment of Community Home Based Care in Lesotho. The recommendations from the report provided insight on how to implement limited care and support in resource poor settings.

USAID requested FHI to support a rapid appraisal for HIV/AIDS program expansion in Swaziland and Lesotho. Results from this assessment will be communicated in the coming year to allow for implementation of recommendations.

A second round BSS in Lesotho was scheduled to start this year. This did not take place due to prolonged discussions to establish support for this exercise. Decisions and the way forward will be determined in early FY05.

#### **V. PROPOSAL DEVELOPMENT**

FHI worked on amendments for CPC, FLAS, CARE Lesotho and Project HOPE to renew subagreements and enable the continuation of project activities. Projects primarily continued with their previous activities with a stronger focus on the core target groups.

#### **VI. MANAGEMENT AND ON-SITE TECHNICAL ASSISTANCE**

PSG provided technical assistance to partners focusing on strengthening peer education. Sara Bowsky's provided TA to CARE/Lesotho on CHBC.

To improve the management of FHI/RHAP, a director and a finance officer based in Pretoria were hired to provide more intensive support to implementing partners.

Two meetings were conducted for the development of the BCC Strategy. A planning meeting comprising a team of COH partners was held March 22 –24, in Pretoria, South Africa, to discuss the communication initiatives ongoing in the COH and plan for a subsequent stakeholders meeting involving implementing partners in the field. JHU/CCP, PSI, AED and FHI worked together to plan the stakeholders meeting which followed on March 31 – April 2 at the Sheraton Hotel in Pretoria,

South Africa to develop the strategy. Revision of the strategy carried on and responsibilities were allocated to partners. Finalisation and implementation of strategy activities will be achieved in the coming year.

A Monitoring and Evaluation meeting was held March 16-18, 2004 and attended by RHAP COH partners. The meeting reviewed the monitoring and evaluation activities to-date before working on an overarching M&E plan with responsibilities allocated to different cooperating agencies and their implementing partners. The indicators and systems for collecting and managing process/output data were also reviewed. This was followed up by revision of the data collection tool for quantitative process data.

**Activities Planned for FY05<sup>2</sup>**  
**Technical Assistance Plan and Trips Taken<sup>3</sup>**  
**RHAP/FHI – Countries, Partners and Sites**

<b>COUNTRY</b>	<b>PARTNER</b>	<b>SITES</b>	<b>ACTIVITIES</b>
1. South Africa	Centre for Positive Care (CPC)	1. Musina – border and workplace 2. Doreen 3. Grobblersbrug 4. Noordgrens	<b>Peer education – 99 volunteers<sup>4</sup></b> -BCC – group and one to one meetings -Distribution of IEC materials -Condom distribution – free condoms -Education/counseling and referral for STI treatment
2. Lesotho and South Africa	CARE Lesotho	5. Maseru 6. Maputsoe 7. Ladybrand 8. Ficksburg	<b>Peer education – 142 volunteers</b> -BCC – group and one to one meetings -Distribution of IEC materials -Condom distribution – free condoms -Education/counseling and referral for STI treatment -Counseling and referral for VCT -Care and support activities with community support groups
3. Swaziland	Family Life Association of Swaziland (FLAS)	9. Ngwenya 10. Manzini 11. Lomahasha 12. Lavumisa	<b>Peer Education – 59 volunteers</b> -BCC – group and one to one meetings -Distribution of IEC materials -Condom distribution – free condoms -Education/counseling and referral for STI treatment
4. Malawi	Project HOPE	13. Mulanje, Muloza/Mozambique Border	<b>Peer Education – 70 volunteers</b> -BCC – group and one to one meetings -Distribution of IEC materials -Condom distribution – free condoms -Education/counseling and referral for STI treatment -Treatment of STI at RHAP funded clinic -Counseling and referral for VCT -Care and support activities with HBC volunteers
5. Zambia	World Vision and Society for Family	14. Chipata 15. Chirundu	<b>Peer Education – 61 outreach workers, full time employees</b>

<sup>2</sup> See table 2 below.

<sup>3</sup> See table 3 below.

<sup>4</sup> # of peer educators fluctuates.

	Health	16. Kapiri Mposhi 17. Kasumbalesa 18. Katete 19. Kazungula 20. Livingstone 21. Lusaka 22. Nakonde 23. Ndola	-BCC – group and one to one meetings -Distribution of IEC materials Condom distribution – free condoms -Education/counseling and treatment for STI at 10 RHAP funded clinics -VCT on site
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#### ACTIVITIES PLANNED FOR FY05

Activity	Q1	Q2	Q3	Q4
<b>Prevention and Care Interventions</b>				
▪ Implement Prevention & Care Interventions at FHI/RHAP sites in Southern Africa	X	X	X	X
▪ Implement recommendations from Swaziland/Lesotho rapid appraisal (based on USAID decision)		X	X	X
<b>Participation of Networks</b>				
▪ Develop new subagreement with ANERELA	X			
▪ ANERELA implementation period	X	X	X	X
▪ Review meetings with ANERELA	X	X	X	X
<b>BCC Strategy Assessments</b>				
▪ Mapping and Assessment of Services	X			
▪ Assessment of Peer Education	X			
▪ Disseminate Results of Assessments	X	X		
<b>BCC Strategy: Implement Activities to Strengthen IPC Interventions</b>				
▪ Develop BCC toolkit, with support from FHI/HQ BCC team	X			
▪ Workshop: present draft toolkit to partners for input and refinement & train in use of BCC materials and IPC	X			
▪ Finalize BCC toolkit and produce materials	X	X		
▪ Workshop: Review final toolkit and develop strategy and timeline for rollout by all partners		X		
▪ Roll-out BCC toolkit across sites		X	X	X
<b>Lesotho BSS or M&amp;E Capacity Building</b>				
▪ Finalize decision on BSS or Capacity building	X			
▪ Implement	X	X	X	
<b>Capacity Building of IAs</b>				
▪ PSG Training, Site Visits, Mentorship & Internship	X	X	X	X
▪ Technical assistance on STI interventions	X	X	X	X
▪ TA on M&E	X	X	X	X
▪ TA to implementing partners on BCC	X	X	X	X
▪ TA to CARE-Lesotho on HBC	X		X	
▪ Program and financial site visits to IAs	X	X	X	X
<b>Quarterly Reporting to USAID</b>	X	X	X	X

**Technical Assistance Plan FY04**

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Type of Expertise	Scope of Work	Likely Source	Time	Trips Taken
SOTA update, management issues	IMPACT Management Meeting (cost shared 40%)	Program Manager	Q1	1 trip taken by Lee Pyne-Mercier
STI	Provide TA to Project HOPE (Malawi): Participate in training of service providers in STI management, share regional lessons, assist Project HOPE in strengthening referral system and review current STI services and make recommendations for improvement.	Zambia STI Technical Officer	Q1	1 trip taken by Joseph Kamanga
STI	Implement recommendations from RPM+ assessment of STI services	FHI regional staff or consultants	Q2, Q3, Q4 – four trips programmed	None taken. Joseph not available and partners not ready
Home-based care	Provide TA to CARE Lesotho activities in Maseru and Maputsoe, meeting with CARE staff, HBC providers, MOH staff and clinic staff. Conduct rapid assessment and make recommendations for improvement, if necessary. (cost shared)	FHI/Washington C&S officer	Q2 – one trip programmed	1 trip taken by Sarah Bowsky Dates: March 20-27, 2004
BCC	Provide TA to IAs to implement BCC strategy at site level.	Africa-based consultant or staff	Q2, Q3, Q4 – four trips programmed	1 trip taken by consultant to map services at CoH sites. Other implementation of activities delayed.
C&S	Provide support to implementing partners to strengthen and develop additional care, support, and mitigation services in sites.	Africa-based consultant or staff	Q3, Q4 – four trips programmed	None taken. Awaiting rapid appraisal recommendations
M&E	Provide TA to IAs to provide on-going M&E support	Program Director/Africa-based consultant	Q2, Q3, Q4 – four trips programmed	3 trips taken: -FLAS in June by Roger Schimberg -Project HOPE on August 22-28, 2004 by John Kadzandira - FLAS on 6-12 September by John Kadzandira
Facilitation, coordination, &	Participation in PSG Training (3 trainings)	Program Director	Q2, Q3, Q4 – three trips	2 trips taken: -Boksburg M&E training on

capacity building		programmed	June 23-25, 2004 -Zambia C&S training on September 29 to 1 October
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