Project Support Association of Southern Africa

Initiating HIV AIDS Community Programmes

From 1996 to 2004

DR KG Billinghurst

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Foreword

Southern Africa is the sub region most affected by the HIV/AIDS epidemic, with South Africa having the highest number of HIV infected people. It is estimated that 5,3 million people were living with HIV in South Africa at the end of 2003. (UNAIDS, 2004). Approximately 30% of people living with HIV in the world are in Southern Africa although only 2% of the people in the world reside in this sub region. The devastating effect of this epidemic requires large-scale action and interventions that can be scaled up without compromising quality. The Project Support Association of Southern Africa (PSASA) has successfully implemented several interventions to deal with the epidemic at a large-scale using community volunteers as resources.

The Project Support Association of Southern Africa (PSASA) grew from a small local committee in the small mining town of Kriel in Mpumalanga in 1996 to a large organization supporting over 120 community peer education, home based care and orphan projects in several provinces in South Africa. PSASA is not only offering its services to South Africa but has become a major support and training resource for organizations in other countries including Swaziland, Mozambique, Zambia and Zimbabwe. The backbone of the work of PSASA is the thousands of dedicated community volunteers who freely offer their time to work in their communities. Their valuable contribution should not be underestimated but all credit for successful interventions is due to them.

The experience and contribution of PSASA in providing HIV/AIDS services to communities in Southern Africa is commendable. PSASA's interventions have been replicated with varying success in other countries of the sub region. This publication of the history of PSASA is lauded and will encourage similar organizations to capture and realize their contribution to HIV/AIDS in Southern Africa. This publication can also be useful for those intending to replicate the work of PSASA or such similar work. In addition, the publication will widely disseminate the successes and challenges faced by organizations while implementing HIV/AIDS interventions.

The challenge for PSASA is to further expand its activities and services without burning out or losing quality. I believe that PSASA are aware of this challenge and will work towards minimizing the possible impacts of burn out and loss of quality.

I wish PSASA every success in its future endeavors to mitigate the impacts of HIV/AIDS and congratulate it on the publication of its history.

Noeleen Dube
PSASA Director, May 2005

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List of Abbreviations

STI	Sexually Transmitted Infection
MPSA	Mpumalanga Project Support Association
MEC	Minister of Executive Council
PSASA	Project Support Association, Southern Africa
PSG	Project Support Group
HIV	Human Immune Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
CSW	Commercial sex workers
SSW's	Subsistence sex workers
NPO's	Non Profit Organizations
NGO	Non Government Organisation
CBO	Community Based Organisation
PVO	Private Voluntary Organization
PHC	Primary Health Care
DOTS	Directly Observed Treatment Short course
CDC	Communicable Disease Coordinator
MPU	Mpumalanga
KZN	KwaZulu-Natal
IGA	Income Generating Activities
VCT	Voluntary Counseling and Testing

Executive Summary

HIV AIDS has been steadily increasing in Southern Africa since the early 1990's. Mpumalanga Province in South Africa, with its heavy industry, tourism, common boarders and poorer communities has been particularly hit with HIV prevalence's in the total population recorded at 21.7%.

In partnership with the private sector, government health services and local communities a peer education prevention project targeting disadvantaged women in the Kriel community was established late 1996. Early monitoring data indicated a high exposure by the community to the project with increasing numbers of condoms being distributed. Later information demonstrated the positive outcomes and positive behavioural change.

The success of the peer education model used was then duplicated through out the province to other communities of Mpumalanga with 23 projects using 533 community volunteers at the beginning of 1998. A Non Profit Organization was established to manage the increasing number of projects and facilitate communities with new prevention initiatives. Later named the Project Support Association of Southern Africa (PSASA) it worked in close association with the Project Support Group (PSG) and went on to support Home Based Care activities.

Increasing numbers of community prevention and mitigation activities resulted in a number of challenges. Despite this, PSASA continued to expand the number and types of activities. By the end of 2004, PSASA was supporting 84 prevention activities (community, youth, student and workplace peer education activities) using 1730 volunteers and 108 mitigation activities targeting the sick dying and orphans and vulnerable children (using over 1200 volunteers). A key to the success of rapidly scaling up HIV programme activities is attributed to the energy and motivated staff using an effective model with support by numerous different partners. PSASA has gone on to develop its programmes in Mozambique, Swaziland and KZN.

This extensive community programmes resulted in the PSASA staff being awarded the African Heritage Foundation Trust award in December 2003.

Future expansion is planned especially in the context of the National ARV roll out and to continue expanding OVC programmes.

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Section A – History and Overview

Background

Mpumalanga Province is located to the east of Johannesburg and is one of the smaller South African Provinces, with approximately three million people. There are a large number of industries with mines, coal, gold, chrome and asbestos and power stations in the western highveld and intensive horticulture in the eastern lowveld. Game farms are scattered through out the province with Kruger Park attracting local and international tourists. Highways with Mozambique, Swaziland, the KwaZulu – Natal and Limpopo transect the province. Poverty is prominent with unemployment high and a large portion of the population lacking basic utilities and subject to multiple health problems (Box 1).

Mpumalanga Statistics

- ***Population (2001):*** *3 million (7% of SA)*
- ***Unemployment:*** *29.8 (2002)*
- *Water: Only 27.6% of households have piped water inside*
- ***Sanitation:*** *3.5% of households had no toilet*
- ***Infant Mortality Rate (2002):*** *59 per 1,000 live births*
- ***Stunting:*** *25.4% (Age 1-9 years)*
- ***Antenatal HIV prevalence:*** *29.2%*
- ***Reported cases of malaria:*** *293.1 per 100,000 (highest in the country)*
- ***Health expenditure per capita:*** *R554 (2001/02)*

Box 1.

HIV rates have steadily increased from the early 1990's (*Figure 1)* with high HIV prevalence figures documented (*Figure 2*) compared with the rest of South Africa. The 2002 population household survey[1] demonstrated a provincial rate of 21.7% (national average of 17.7%) and the annual antenatal survey results[2] at 32.6% for 2003 (compared with 27.9% nationally). An estimated 650 000 people currently are thought to be HIV infected within the province.

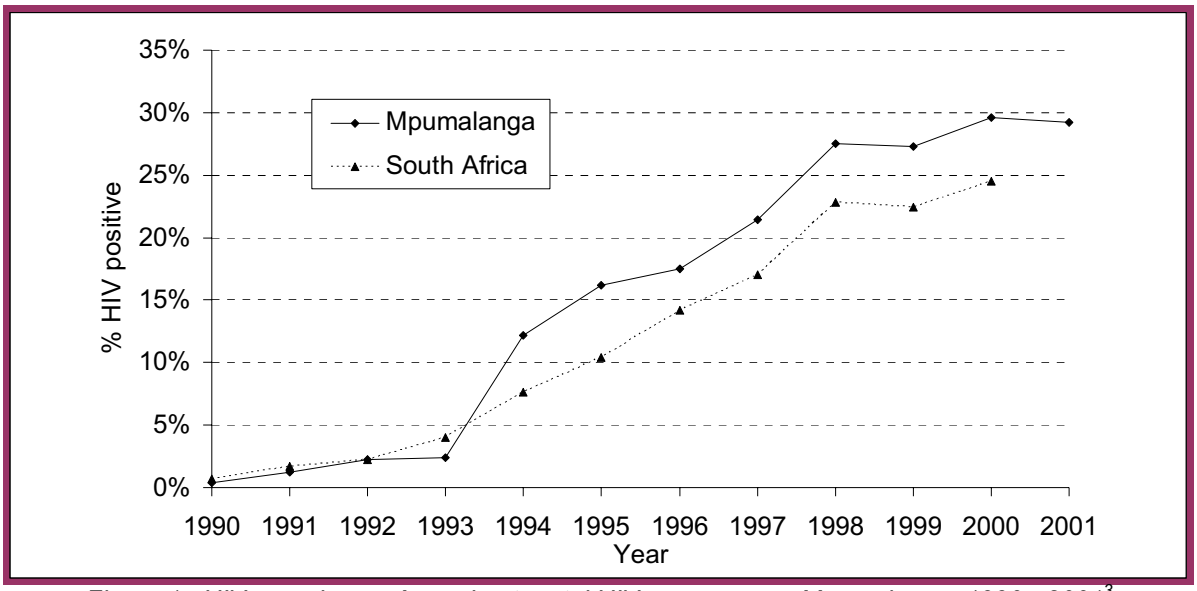

Figure 1 : HIV prevalence, Annual antenatal HIV serosurveys, Mpumalanga, 1990 - 2001[3]

In the early 1990's, while South Africa's focus was on political and social reform, the HIV epidemic was becoming entrenched in the general population. Responses at that time were limited; limited to

the number and type of role players and limited to the resources available. The country lacked a useable National Strategic HIV AIDS and a work plan focusing on effective community activities.

Figure 2. 2003 Provincial Antenatal Figures

Mpumalanga Province response was also inadequate for the increasing number of new infections. By the mid 1990's the Provincial Health Department was concentrating on health reform and developing a district based primary health structure. Most HIV AIDS funds at that time came from the National Department of Health to the province where the administrative capacity to disburse and utilize them effectively was limited. Other National funds available for NGO's largely bypassed the province in favor of larger metropolitan areas, advantaged provinces, and national NGO's who had little involvement in the Mpumalanga Province. Multiple smaller CBO's existed but undertook work sporadically, lacked capacity in project management, and had limited human and financial resources. Two ATICC's (AIDS Training Information and Care Centres) based in the urban areas of Witbank and Nelspruit provided training services but were also restricted in their provincial activities because of staff and capacity limitations.

It was in this context that PSASA developed.

Early Developments

While government ministries and agencies had little HIV AIDS involvement in the province, the private sector was recognizing its potential impact within the work force and local communities. In August 1996 Jenny Crisp, an employee from Anglo Coal involved with community services, facilitated a meeting between three private sector corporations in the Mpumalanga Highveld – AMCOAL, ESKOM and INGWE. AMCOAL (now call Anglo Coal) is the coaling division of Anglo American, ESKOM is Africa's major supplier of electricity and INGWE is one of the world's largest in the field of coal production and thermal coal exportation. These companies were becoming increasingly concerned with the impact of the HIV AIDS epidemic on their workers and surrounding communities. Representatives from the Project Support Group (PSG – in association with The University of Zimbabwe) presented Peer Education strategies successfully adopted in other areas of Southern

Africa. All three corporations' bought into the peer education model presented, going on to provide seed funding for a joint project based Kriel. This community was chosen because of its central location to each of the corporate donors.

A consultation meeting took place in November 1996, with over 65 community members attending. Key outcomes included a review of the project approach, goals and the formation of the Kriel AIDS Committee. Representatives from all partners including AMCOAL, ESKOM, INGWE, the Provincial & District Department of Health, Local Authority, PSG and representatives from the Kriel Community formed this committee. The initiative became known as the "Kriel Project", with the Kriel AIDS Committee a key driving force.

Peer education typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitude, beliefs, or behaviours. However peer education may also effect change at the group or societal level by modifying norms and stimulating collective e action that leads to changes in programmes and policies[4].

Box 2. Definition of Peer Education

The objective of the Kriel Project was to increase community awareness on HIV AIDS issues and promote preventative behavioural change. Knowledge among the local people about HIV AIDS and its prevention was lacking and condom usage especially in the context of high HIV transmission risk was limited. The Peer Education model (Box 2) used recruited community volunteers who undergo training on communicating HIV AIDS issues. This information is then presented through song, short drama, flash cards and dialogue at: large outreach meeting such as sheebeans and bottle stores; other public places; homes or other community settings. Ongoing technical support and management format including programme rganizing was provided by David Wilson and the team from PSG who initially developed the model being implemented.

Kriel Project Aims:
"The project seeks to change key sexual behaviours, including condom use and STD care seeking, among sex workers and their clients. It seeks to change behaviour through informal social networks of trusted friends and peers, who may be persuasive change models. To harness informal social networks, the project will recruit trusted, influential community members as peer educators. These peer educators will try to change sexual norms be rganizing thousands of community meetings and "one-to-one" motivational sessions and vigorously promoting and distributing millions of condoms. They will hold meetings and distribute condoms in shebeens, bars and bottlestores, sex worker residences, bus and truck-stops and workplaces. They will use genuinely participatory approaches to challenge people to reflect on, develop their own responses to, and shape a normative consensus concerning, STD/HIV. "

Kriel Project Goals:
"The project's overall goal is to reduce STD cases by 33%. Its immediate goal is to reach 75% of Kriel sex workers and clients and to increase condom use in commercial sex to 66%. Its intended activities are to: hold 2,000 community meetings; reach 100,000 people (including repeat attenders); and to promote and distribute one million condoms."

Box 3. Kriel Project Aims and Goals

The Kriel AIDS Committee appointed in March 1997 Fikile Mthumunyi, a Bethal-Kriel District Health Promoter as project coordinator. She underwent training and initiated the project by conducting a formative assessment and by September, recruited 17 peer educators who immediately commenced outreach activities in order to reach the projects aims and goals (Box 3).

Expansion of prevention projects

Early monitoring data indicated large numbers of people in the Kriel community had exposure to HIV AIDS messages and access to condoms because of the project. The project itself with its strong partnership (community, private and government sectors) exemplified key components of the then developing District Health System[5] and its multi-sectoral approach fulfilled recommendations of the National AIDS Review conducted late 1997[6].

Two developments followed which accelerated further new projects within the province. Firstly, Health Department staff; five district managers and one CDC Coordinator, visited projects in Zimbabwe and were trained on how to start up similar project. Secondly, district health personnel within the district health system were exposed to the Kriel Project through open or awareness days and were encouraged to develop similar projects in their own areas.

Corrie Oosthuizen participated on the Zimbabwe field trip and as the Health Manager for Bethel District (the location of Kriel) was represented on the Kriel AIDS Committee. Having been a key figure in setting up Kriel, she facilitated further peer education projects in the surrounding communities of Bethel, Ermelo, Breyton and Lothair. A further seven volunteer projects were established in the Lydenburg Health District by Anne-Marie Gouws (who had also traveled through to Zimbabwe).

This rapid growth in the number of projects and volunteers required a stronger management structure to provide technical support and channel resources. At the beginning of 1998, 12 effective Peer Education projects were functioning and by the end of the year 23 projects involving 533 volunteers had been established or on the verge of starting[7]. Senior management of the Department of Health [administrative, political and legal] agreed and supported this new management entity which was formally created in mid 1998. As a non-profit body and registered as a Private Voluntary Organization, it was able to function independently but in close cooperation with the Provincial Health Department. From mid 1998 to mid 2000 this relationship remained mutually supportive with senior members of both the Health and Welfare Departments attending meetings, Departmental staff assisting in programme activities and projects assisting with community outreach activities for the Department.

Figure 3 – Partnership of Women Against AIDS, MPSA coordinated and received a train of dignitaries and health promoters at Bethel Railway Station, March 1999.

The Mpumalanga Project Support Association (MPSA) as it was called aimed to –

- Assist communities, NGOs, private sector business and industrial partners to develop, manage and sustain optimally efficient, effective, evidence-based HIV prevention and mitigation activities
- Provide an efficient, economical, central funding and reporting system. It would vie for, receive funds, then provide a centralized on-grant or downstream funding mechanism - that is, appropriately distribute those funds and resources.
- Administer funds (including those coming from PSG) using explicit, already agreed upon protocols; seek to minimize administrative costs; perform banking, disbursement, accounting,

and external auditing; and carry out financial and activity reporting, for very low organizational costs.

Community projects would apply to MPSA for funds and receive technical support (such as training, supervisory personal, organizational structuring and practical resourcing) to start projects. Sound accountability procedures put in place at community level meant that MPSA acted as a bridge between donor and recipient communities.

MPSA's head office was located in the small Mpumalanga town of Bethal. Centrally located, it became a primary site for training, hosting visitors, management and developing further peer education concepts.

Figure 4 – Behind the trees a hub of activity, PSG Offices in Bethal since 2002

The Association was to be headed by a multi-sectorial and culturally diverse Board, comprising of six members, with the Kriel Committee forming the initial core of this Board. The formation of MPSA increased the rate of project development for Peer Education and helped ensure equitable distribution of the projects through out the province. Visits, facilitated by PSG, to a number of the peer education projects were conducted by donors. Subsequent funding from PSG was forwarded through MPSA and distributed to communities for project activity.

Expanding Core Activities

Late 1998 the Department of Health released a document looking at the 'Impact Evaluation of HIV AIDS on the Health Department'[8] With anticipated increases in HIV AIDS among the general population and its own staff the health services would become over extended in their capacity to provide care. Alternate forms of care were needed. The Department had existing links with the Masoyi Home Based Care Project which was awarded in early 1998 funding from the National Health Department. A fast track training process was undertaken promoting the establishment of home based / orphan care projects for 1999 using Masoyi as a training site in the same way open days were used with the Kriel Peer Education project. District managers from the Department of Health identified a chief professional nurse to facilitate Home Based / Orphan Care projects in their districts. Many similarities existed between the peer education and the model of home care making MPSA an ideal partner with the Department of Health for expanding home care activities. These included –

- Experiences in rapidly rolling out community programmes with a management and support structure that was effective.
- Peer education and home care programmes both used recruited community volunteers. Peer educators concentrated on prevention and condom promotion while home care volunteers were trained in caring for the sick, dying, disabled, and destitute and orphans.
- Experience in maintaining community volunteers and project coordinators through regular training.
- MPSA was familiar with receiving and disbursing donor funds. Donors were assured funds reached community based recipients
- Existing relationship with the Department of Health
- Room existed for the integration of prevention and care programmes.

Coming Challenges

The numbers of projects were rapidly increasing by the end of 1999. At the end of 1999 there were 31 peer education and 14 home care projects. This had increased to 45 peer education and 22 home based care projects 6 month later by mid 2000.

Figure 5 – Home Based Care targets poorer communities, be they rural (as above), township or periurban

This rapid increase however was creating in itself a number of challenges. During this time the provincial Department of Health was undergoing both political and structural changes following the elections of 1999. With a new political head an increasingly confrontational attitude towards NGO's generally, the Department withdrew from the established close working relationship with MPSA.

MPSA responded in a number of ways –

1. The name was changed from MPSA to Project Support Association of Southern Africa (PSASA). This helped describe the increasing regional role and activities of the organization. PSASA was providing technical support to projects outside of the province. The staff complement was also increased during this time to ensure adequate support and supervision of projects.
2. A capacity building programme was initiated. PSASA helped develop the organizational capacity of many of the community projects. These became registered as Non Profit

Organizations and were trained on how to raise their own resources from both within their local communities and from other donors.

3. Two home care projects became partners to the Project Support Group. These had been funded from PSG via PSASA. They became anchor partners with PSG in their own right (Masoyi & Thembaletu) and assisted in supporting projects in their immediate vicinity. Home Care projects took on a greater holistic role of support addressing health, poverty and orphan needs.
4. Many volunteer personnel became incorporated into the fulltime PSASA staff structure. Corrie Oostuizen has already left the Department of Health to head PSASA on a full time basis. A number of then volunteer staff became incorporated into the staff establishment of the organization (See Appendix 1 – Staff Profile).
5. PSASA continued its operations in close partnership with Project Support Group which continued to provide funding. The Department of Social Welfare [Population Development] took over some of the functions previously conducted by the Department of Health. Other donors provided additional resources and with it came an expansion on the type of activities undertaken (see Appendix 2 – Partners). Prevention activities using peer methodologies became included specific work place, youth and student programmes. Home care expanded to include more specialized orphan care and income generation activities (IGA's).
6. Increased and strengthened links with The Centre for Positive Care in Northern Province and other PSG partners in adjacent Southern African countries.

While home care developed as a new project focus from 1999 onwards, PSASA was expanding its role as a regional partner, serving as a channel and source of administrative and technical support for other organizations in Southern Africa (Northern Province, KwaZulu Natal and Eastern Cape and in neighbouring countries such as Swaziland and Mozambique). It was also expanding its scope of activities to include more detailed orphan initiatives, adolescent and reproductive health programs. Work place prevention initiatives using peer education methods also were increasing with the corporate world funding and supporting workplace and community programmes. PSASA has also participated in research activities. An example of this is the international case controlled study looking at the effectiveness of peer education in the workplace and cultural aspects and effectiveness of female condoms (Appendix 3 - Publications / Conference Presentations / Posters). FHI has recently completed a review of the effectiveness and delivery of services within home care programmes. A number of qualitative research areas are currently being developed that include further measurements on the effectiveness of PSASA programmes and investigating new implementation strategies (Operational Research).

Accomplishments and successes as of the end of 2004

1. Prevention initiatives –
   1.1 Community and High Transmission Areas – 54 projects
   1.2 Youth clubs – 13 projects
2. Mitigation
   2.1 Home Based Care – 65 projects
   2.2 Orphan and child care – 48 initiatives
3. Satisfaction from donors concerning audit process and accountability.
4. Providing technical support to Swaziland for home based care, Eastern Cape, North Western for peer education and Northern Province for both peer education and home based care.
5. Piloted the distribution of female condoms through peer education projects
6. Close networking relationships with other anchor partners such as Masoyi and Thembalethu Home Based Care Programme for training, field trips and accountability.
7. Participating with the USAID Horisons Project which is a multi-centred trial based in Zimbabwe, Zambia and South Africa looking at the impact that work place interventions and or peer education and or periodic presumptive therapy has on workplace STD prevalence rates.

8. Partnerships with multiple organizations and HIV AIDS role players.
9. Long term stable and developing personnel.

Figure 5 – Training of Peer Educator Coordinators, Evander 1999.

Key reasons for success

The success of the Project Support Association can be seen in the expansion and effectiveness of its work over the years. There are several keys to the success of the organization. These include –

1. Motivated energetic personnel who believe in the project approach and are committed to reaching communities with effective HIV AIDS programmes. PSASA has created a family working environment and currently has had no turn over with managers and field staff. This has created a stable and trusting environment with the recipient communities.
2. Projects fitted in with the concept of primary health care / district system which was being developed by the Department of Health during the mid to late 1990's when PSASA was starting.
3. The type of model supported rapid expansion – this included a model of getting community involvement which was and is cost effective. Onsite training permitted 'model mentoring' where communities could experience the impact of the projects first hand. This provided the inspiration and energy to duplicate models of prevention and mitigation into their own area.
4. Technical and adequate financial support from PSG. PSG had created many working tools, frameworks and experiences that they were willing to share and contribute into the development of the organization and project. Process and output monitoring tools have been emphasized. As one project leader has said, 'if it is not recorded it never happened'.
5. Infra structure for support. This includes –
    - 5.1 Training support and on going motivation. This is primarily through site visits, phone call discussions and quarterly training sessions.
    - 5.2 Ability to rapidly disperse funds to new project areas according to felt needs. Also the ability to withhold funds following misappropriation by project or committee.
    - 5.3 Promotion of good communication between projects. This allowed for common challenges to be addressed collectively and the best practices or successful activities could be duplicated.
    - 5.4 Support from the key representatives of the Department of Health who understood the constraints of government and who facilitated in the partnership in the early days. The organization had the flexibility to respond quickly when this changed.

6. Communities motivated to respond to HIV AIDS issues. The HIV climate has also been an important factor for programme success. Communities needed a focused programme, one that was tangible and would give immediate and demonstrable results. This has been the case with both prevention and mitigation programmes run by PSASA.
7. Building of new and on going partnerships

Awards and Recognition

PSASA received African Heritage Foundation Trust award in December 2003 for the best HIV AIDS non profit NGO. The competition had more than 1003 entrants. This award proved to be a tremendous encouragement for the staff and project personnel and reflected the quality and strength PSASA has always aimed for (Appendix 4 – Awards).

Some of the individual projects have also won awards over the history of PSASA. Lydenburg area has won a number of primary health care awards based on the prevention and mitigation activities in the area.

Publications / Conference Presentations / Posters

PSASA has been involved in a number of presentations or posters at international conferences or meetings. The organization seeks to remain current on new developments in community based HIV AIDS prevention and mitigation activities as well as addressing broader social issues such as poverty alleviation and gender inequalities. Such conference presentations also increase the networking opportunity and increases exposure for ongoing donor support. More details of such presentations are given in Appendix 3 - Publications / Conference Presentations / Posters.

The organization has also participated in working with a number of organizations or groups who have used the community nature of the programmes for research, media presentations or enhancing their own programmes.

PSASA has participated as a key role player in developing the PSG Home Based Care Manual 2004-2008, which is now used as a resource tool across Southern Africa.

Challenges

A number of challenges face and continue to face PSASA. With so many projects based within communities of high HIV prevalence rates there is an attrition of volunteers from the programmes because of HIV AIDS itself. A clear challenge into the future will be to advocate funding of care workers to receive ART. As many of the care workers have taken in orphans into their own homes and are dependent on the minimum remuneration coming via PSASA increasing resources for volunteer staff remains a continual challenge. The use of ART will avoid second or even third time orphaning.

Partnering with government and accessing government resources remains a continual challenge. The Department of Health has commenced many home care programmes within areas covered through PSASA projects. This duplication creates tensions on the ground and leaves many communities uncovered with home care initiatives. Positive and ongoing working relationships with the Department of Health are currently being undertaken in the new dispensation.

Prompt, timely reception of funds from donors and ongoing recruitment of funding remains an ongoing challenge. Dispersement mechanisms are well developed to channel funds to project but these are

dependent on the support of the donors. With South Africa receiving such large quantities of funds (from the Global Fund for example), being a higher income country in Africa, having lower HIV prevalence than countries such as Botswana and Swaziland and having a government that has some welfare services and grants; many donors are placing support elsewhere.

Figure 6 – Office work

New developments within the HIV AIDS field require PSASA to remain current and to continually update their activities. The longer term impact of ARV for example will significantly alter prevention and mitigation activities. Mitigation activities towards orphans will need to continue with increasing emphasis on developing skills for employment and providing older adult orphan support. Home care programmes are likely to become focused on caring for non AIDS clients and providing supervision for clients taken ART.

Where to from here?

PSASA strives to remain relevant and current on HIV AIDS issues. With strong links into and with communities, PSASA has been approached to assist with numerous HIV related activities. Possible areas of future development include –

- The widespread expansion and implementation of OVC projects providing orphan education and income generating activities or skills building for potential longer term employment.
- Further developing and increasing HBC projects both the coverage and scope of activities that are currently being offered.
- Education and resources around Antiretroviral Treatment. Such areas include networking with medical providers to identify clients, supervise clients and readily refer clients back for medical support in cases of non adherence, side effects or toxic reactions. The provision of food and other material assistance are skills which the home care programmes can contribute with minimum change to the existing programme.
- Promoting VCT awareness as part of the home based / orphan care projects.
- Increase the counseling support for the care supporters.
- Access of Welfare grants to the destitute in the project areas.
- Develop skills training or income generation projects for older orphan children and volunteers.

- Training of care supporters in the area of palliative care.
- Expand the “reconstituted family” pilot project. This is where abandoned geriatric folk are brought into highly vulnerable families (such as a family where a single parent is dying of AIDS, or an orphan headed household), to act as carers within that family.
- Poverty Alleviation.
- Developing Youth Peer Education in Schools and making teachers more aware of HIV AIDS and sexual health and children’s rights issues.
- Developing Student Peer Education in Universities and Technicons and Colleges.
- HBC and PE volunteers will be trained on sexual reproductive health, family planning, better communication and adult teaching methods to enhance the training that is given to neighbours, family, clients.
- Incorporation of circumcision as a preventative strategy against HIV AIDS
- PSASA will continue to develop people and communities through effective and on going training.

Because of needing to expand PSASA has plans to ensure better coverage:

- Continued expansion of the projects into other areas around the country and Southern Africa at the request of other partners
- Registering of the current community committees as Non Profit Organisations
- Capacity building of the committee members in recruiting private sector funding and donor funds independently

SECTION B – Structure & Projects

PSAS Structure

Peer Education
- **Community**
- **Work Place**
- **Youth**

Mitigation
- **Home Based Care**
- **Orphan and Vulnerable Children**

PSASA Structure

Mission

The Project Support Association Southern Africa's mission to create community partnerships that enhance their ability to prevent, mitigate and alleviate the impact of HIV AIDS.

Vision

"To see Southern African communities equipped with skill enabling them to respond to the effects of the AIDS pandemic".

The vision will be achieved through supporting community-based HIV/AIDS prevention and mitigation approaches, which use carefully trained and supported community volunteers to deliver services. The major strategic thrust to achieve this vision will be innovation and operational excellence.

The organizations goal is to enhance the delivery of high quality, cost effective and evidence based HIV / AIDS interventions in the Southern Africa region.

Structure

Figure 7, illustrates the staff structure as at the end of 2004, staff profiles described in Appendix 1 – Staff Profiles. PSASA has striven for a lean but effective structure, allowing maximum resources to be directed to community level projects. For this reason appointed staff (especially programme directors and managers) are highly fluid in their job activities, are multi tasked, having the ability to fill programme gaps as they occur.

A board with representatives from the wider community of Mpumalanga meets at least twice a year and as necessary to provide overall support to PSASA. Ms Corrie Oosthuizen was nominated and appointed as the Coordinator (now Director) of the Project Support Association Southern Africa (now PSASA). She was previously the Deputy Director and the District Manager in the Ermelo/Bethal District for the Department of Health, a role from which she retired after 1999 to become full-time Coordinator of the PSASA. She has worked closely with provincial and district health staff in Mpumalanga for almost 40 years. She was also the Chair of the Kriel pilot project committee, upon which the provincial initiative is based.

Two Programme Directors are currently employed to oversee all programmes and projects. There are six Project Managers – one for each major programme area: Home Based Care, Orphans and Vulnerable Children (including Income Generating Activities), Peer Education, Youth Peer Education, Workplace Peer Education, and Student Peer Education. Project Managers work with Project Coordinators who are based in the respective community where the project is based who manage the zone leaders and volunteers. Each of the two Programme Directors are well versed in the management and running of the different programme area. Each of the programme areas benefit from a full time training manager who assists coordinates the many training sessions conducted reporting to the Director directly.

Within the Bethal office are a number of personnel responsible for managing and dispersing finances, documenting programme monitoring data coming from the projects, procuring items (food parcels, medicines and other forms of material support) managing and operating vehicles and the overall workings of the office itself.

PSASA Structure

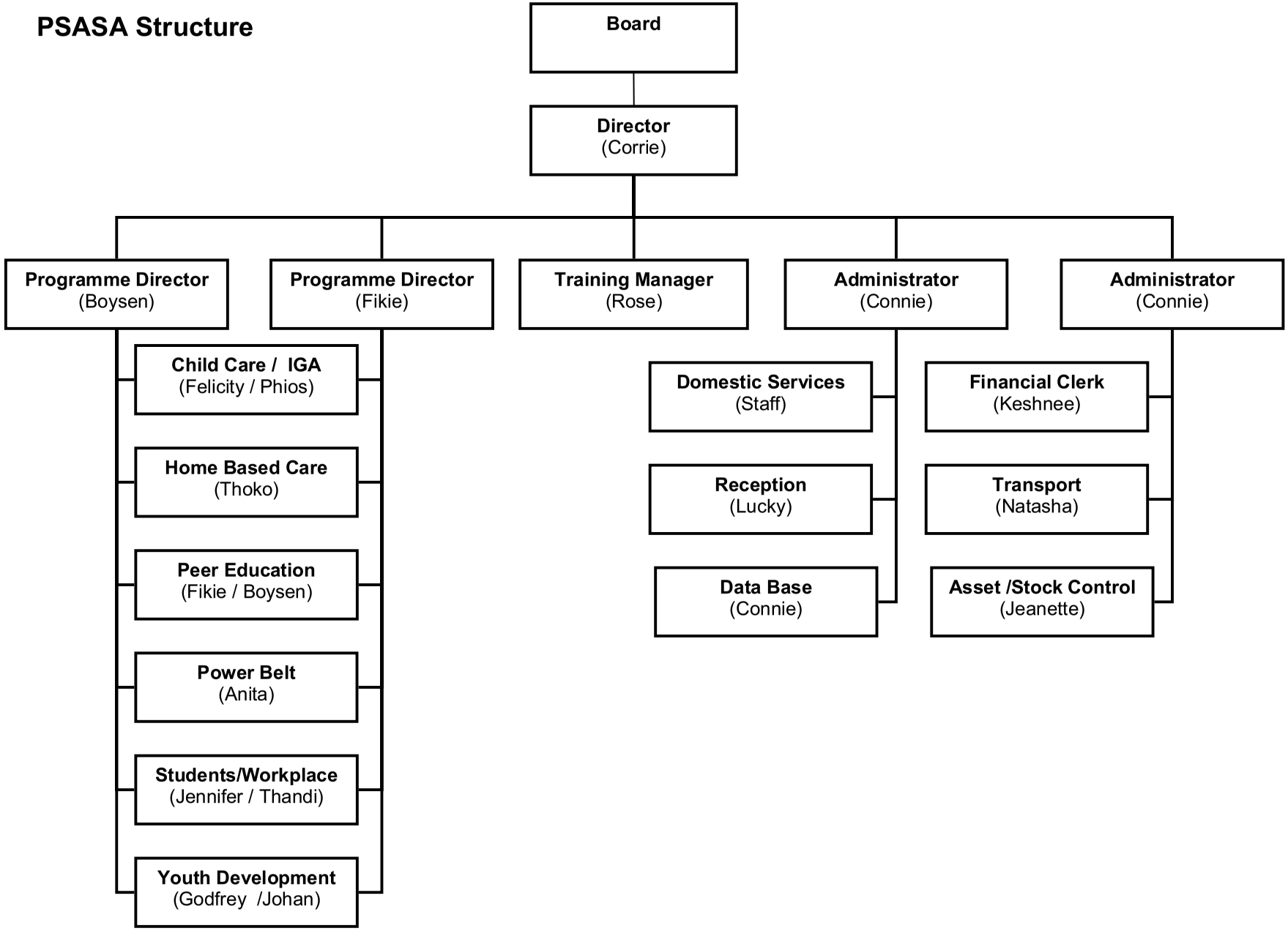

Figure 7 - PSASA Structure – 2004

Funding

1. The primary donor to PSASA has and is PSG. They in turn recruit funds from national and international donors. As a regional organization they fund partners conducting similar activities throughout Southern Africa (Malawi, Zimbabwe, Mozambique, Botswana, Namibia, Zambia and Lesotho).
2. Funds are channeled through to PSASA dependent on programme output.
3. PSASA partners with communities (either as NPO's or CBO's). It then reviews proposals and activity reports submitted by communities.
4. Funds are channeled to the respective projects once the proposal or new year business plan has been approved.
5. Projects submit 6 monthly financial reports, with each project being audited annually. Output monitoring data is collected monthly and added to the 6 monthly quarterly report.

PSASA is currently distributing over R11 million per annum into disadvantaged communities of the province.

The Project Support Group and has developed a set of application packages, contracts, monitoring and reporting forms to be used by the communities to access funds for projects. These are used as a standard for PSASA and its respective partners. Application packages are completed by communities wanting help with establishing or enhancing projects. The completed forms are then submitted to the Board who carefully reviews all budgets to assess project viability and to ensure funds are prudent and comparable across all the projects, to ensure equity. Upon full project approval, PSASA informs the community and begins the implementation of their support. The Association has developed guidelines for the composition and governing procedures for all the projects, and ensures ongoing training for its employees, to build their capacity to manage their projects.

Key Project Components

PSASA has two thematic areas for involvement. This is prevention using peer methods (community based (including high transmission areas), workplace, youth and student peer initiatives) and mitigation which includes home based care, orphan and child support and integrated with the later income generating activities. All however have similar components which includes –

1. Identification of a key area where the projects can be implemented. These are mostly areas traditionally impoverished, lacking adequate health services and where high rates of HIV AIDS are known to affect members. Workplace programmes differ in this regards.

2. Establishment of community based committees. These usually include -

    - Department of Health representative
    - Local Authority representative
    - Community members
    - Private sector representatives especially those with experience in financial management
    - Project representatives

    With each project that is established, a Community Project Committee is set up to advice the project and, mainly, to set up income generation initiatives, so as the projects are not entirely dependent on PSASA funding, but have additional sources for resourcing. These committees generally meet monthly and work alongside the projects to offer support and recruit resources.

3. Mapping of the community and identification of functional implementation zones. These maps identify areas where HIV transmission is most likely to occur (such as sheebens, bottle stores), and where facilities exist that may support care for those in the home (clinics etc.), facilitating areas of targeted interventions and links with key support partners in the community.

4. Volunteer Recruiting. From these zones key individuals are recruited as volunteers. For the many of the volunteers are recruited from formal or informal drinking centres for prevention activities, with mitigation activities from church groups. These volunteers undergo training in the project area and begin implementation of a basic package of services. This training is intentionally incomplete. Further training provides emotional support for the volunteers and re-emphasizes basic teachings to the community workers. And helps standards are maintained.

5. Individuals participate in community outreach activities. For their work, these volunteers are remunerated at about R300 per month for working between two to four hours per day. The Project Coordinator (who is supported at R550 per month for a 40 hour week) supports these volunteers. No remuneration is provided to government or other employees for any involvement with the projects.

6. Regular reporting and feedback concerning activities, along with ongoing training. Training and support meetings occur regularly (weekly or monthly), while quarterly one week trainings are held for all Project Coordinators.

7. Successful projects may become training sites for further expansion within the province or within local areas as illustrated by Kriel.

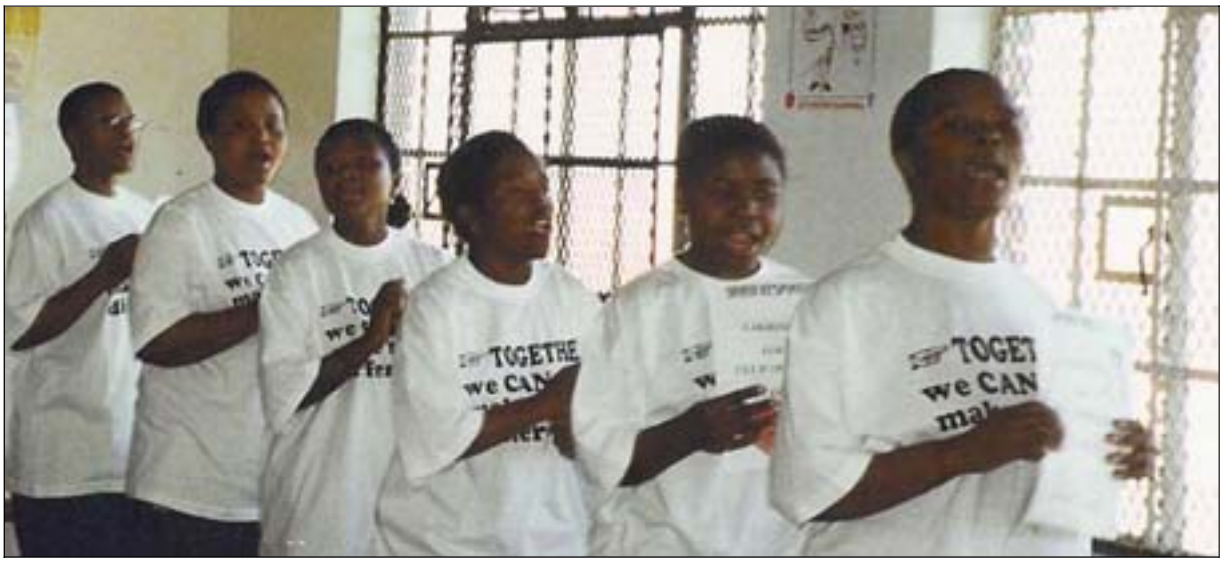

Figure 8 – Youth Prevention Programme Training

Prevention Programmes

Prevention programmes using peer education methods have the longest history of all the PSASA initiatives. Currently there are 55 community programmes with over 1100 volunteers. Project report summary is given in Appendix 5 – Peer Education .

Aims:

- To reduce STI/HIV transmission in HIV prevention partner project communities
- Foster safer sexual norms
- Large-scale condom promotion and distribution
- Improved STI treatment seeking behaviour

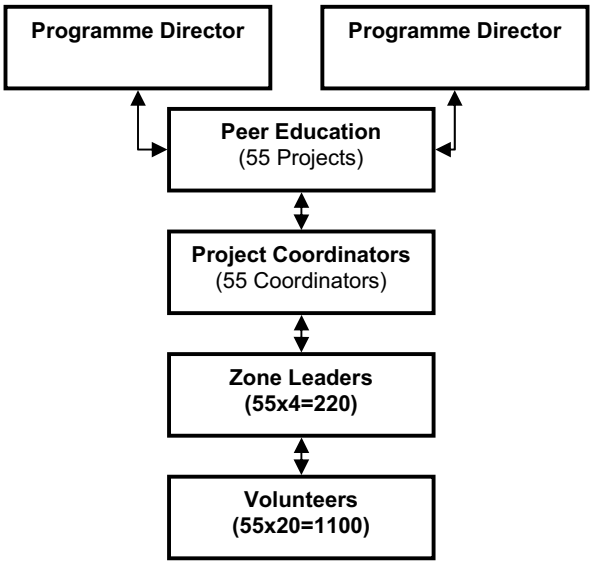

Figure9 – Prevention – Peer Education Structure

Target group and focus:

Prevention peer programmes focus on preventing current and future spread of HIV and on broader sexual health issues. There are many misconceptions about reproduction, sexual organs, sexually transmitted infection (STIs) and diseases (STDs) in the communities; safer sexual activity will immediately diminish the spread of HIV AIDS while simultaneously tackling other diseases and infections; sexual health impacts every aspect of a person, so to educate on ideals such as faithfulness to ones partner and abstinence impacts on relationships, families, household stability and so on.

The Peer Education programme aims to reach adult men and women. Although children are not directly targeted, they are often reached when they are at the location of the project outreaches. Also, volunteer recruitment is often directed at disadvantaged women, some of whom are involved with formal or informal sex work, so these volunteers also benefit and are supported in cultivating safer, healthier lifestyles.

Where:

Projects are established in a village or community. Because of Peer Education's target group, the outreaches become geographically diverse so as to extent to as great a range and quantity of people as possible. Outreaches may take place in the workplace, bars, nightclubs, homes, and in markets. Specific workplace programmes aim to reach the workers of that establishment.

How:

Request and Negotiation for Project Implementation. This process happens in a number of ways. Community members may form a group, do their best to provide for their community, and at some stage submit to PSASA for assistance. Or community members may request assistance before even getting to the stage of group formation. Alternatively, a PSASA worker (or health worker) may identify a community in need, and ask the Association to approach the community. The PSASA then enters into negotiations with a group of community people to organize the assistance and role that the Association will undertake.

Needs Identification and Survey. The next step taken in the implementation of a Peer Education Project is for the Peer Education Manager to identify the needs within the area (village, community etc) into which they are to establish a project. The manager then makes contact with the community (identifying leaders, key community players and stakeholders) in order to build relationship with them and get approval to undertake a Needs Assessment. The Needs Assessment involves surveying the community through interviews, data collection and statistical analysis in order to ascertain the extent of the need for a peer prevention initiative and community support.

Community Committee Formation. Early on in the Project establishment, a Community Project Committee is formed, consisting of community members, people directly involved with the project, and workers from the public health sector. The main role of these Committees is to devise and implement income generation strategies to support the project. This is done with the assistance of PSASA. The ideal is that the Committee becomes the driving sustainability of the project, in case funding dries out from PSASA and its funders. This also provides the projects with a sense of ownership, participation, responsibility, security and autonomy. Some Committees even become registered as CBOs, so they can themselves apply directly to funders for resources.

Mapping and Zoning. Having identified needs, gained approval from local leaders, and deduced that there is suitable community support for a Peer Education project; the next step involves mapping and zoning. This phase is for the Project Manager to map the area so as to divide it into workable zones. In order to map the area, the Project Manager walks, drives, examines and researches the community, mapping geographical, demographical, topographical and industrial conditions. This map serves to inform the Project Manager as to potential prime spots for outreaches, population spread, living conditions, commercial activity, extent of the sex industry and so on. The map is then segmented into workable zones allocated to specific volunteers. Such zones assists in the workability, accountability, reporting and progress analysis of the project.

Volunteer Recruitment. Once the area is mapped and segregated into zones, the Project Manager can ascertain the number of volunteers needed for complete area coverage, and begin to undertake the recruitment process. By this stage the Manager is well known and has established significant rapport and trust within the community. For this reason, s/he is able to successfully ask community members to volunteer as Peer Educators, with high rates of acceptance. The number of volunteers recruited will be based on the number and size of zones in the community.

Initial Volunteer Training. Recruited volunteers undergo an initial training over a five day period. This tuition educates them in a range of issues:

- Personal, home, food and environmental hygiene
- Nutrition

- Physical, social, mental and spiritual wellness
- Male and female reproductive systems
- Sexual Transmitted Infections and Diseases
- HIV AIDS issues
- Alcohol and drug issues
- Abuse
- Adolescent health

To complement this education is training in project outreach:

- Preventive counseling
- Role responsibilities
- Participatory approaches
- Organisation and implementation of community meetings
- Organisation and implementation of outreach meetings
- Organisation and implementation of home-based meetings
- Organisation and implementation of bar-based meetings
- Recording and monitoring system
- Quality assurance
- Condom use, storage and disposal
- Outreach activities
- Diagnosing and solving outreach problems
- Family planning
- Referral of health problems

Figure 10 – Youth Prevention Programme Training

Role and Zone Appointment. Throughout the training, the Peer Education Manager seeks to identify potential leaders within the group, so that at the conclusion of this initial training s/he is able to appoint a Project Coordinator to oversee the project, as well as a Zone Leader for each zone. Also, at the ending of the initial training volunteers are designated a specific zone in which they are to work.

Programme Implementation. Once all this preparatory work has been achieved, the Peer Education programme commences. Suitable venues or sites for outreach meetings need to be identified,

permission obtained for specific appointments. Groups of volunteers then gather at that agreed time and place where activities of singing and dancing, and a short drama are used to entice the audience into discussion and debate around HIV AIDS and other relevant issues. After this attention grabber, questions are asked to the audience inviting dialogue which is often relevant, applicable and re-enacted in their own lives. While the volunteers hold significant knowledge and aim to educate their audience, these discussions empower listeners to draw their own conclusions supporting positive behaviour change. After the volunteers bring the discussion to a close and summarise all that has been talked about, the audience is invited again to the next outreach, and the meeting is concluded with a song. Condoms are then distributed to those in the audience who wish to take them.

Weekly Volunteer Meetings. In order to sustain the workings of the Peer Education Projects, regular support and accountability for the volunteers is essential. Weekly meetings are held for all of the volunteers in a particular project. In these meetings, the workers cook and eat together, discuss issues that have come up, review new topics for presentations and evaluate activities. This also becomes and opportunity to forward reports from the zones to the Project Coordinator (see Appendix 5 for example of an Activities Summary and Appendix 6 for Prevention Tools). .

Ongoing Training. The project workers need to be well informed on issues relevant to their communities. Three week-long training sessions per annum are held for Coordinators in addition to weekly training. Here they liaise, support each other, and receive thorough training on issues which they will then feedback to the volunteers.

Peer education among low-income women: South Africa, Zambia, Zimbabwe[9]

The prevalence of HIV/AIDS in many African countries is particularly high among low-income women, migrants, and people who work away from home. From January 2000, IFH and the Project Support Group, the Human Resource Trust and the Mpumalanga Project Support Association trained community representatives in South Africa, Zambia, and Zimbabwe to reach their peers using role-play, games, and group discussions. The emphasis was on sharing knowledge about safe sex behaviour, distributing condoms, and referring peers to health services for STI treatment. Peer educators also provide home-based assistance to people living with HIV and address the prejudice these groups experience by raising awareness about HIV/AIDS in the wider community.

Box 3 – IFH partnership with PSASA

Roles

Volunteers: Work in team with other volunteers to conduct outreach activities. They record activities and report outputs to zone leaders during the weekly training session.
Zone Leader: Have oversight for volunteers in a defined geographical area (zone). The zone leader coordinates activities aiming to reach coverage and activities goals in their zone through supporting volunteers, assists in outreaches, and meeting weekly. They compile zonal reports to the coordinator.

Coordinator: Oversees the activities of all the volunteers (including the Zone Leaders), organize the weekly training (content, discussions and training) and fellowship meetings. They attend the coordinator week-long training with other project coordinators and feed this information back to their respective projects. They represent the volunteers and zone leaders to the project management committee and to the Programme Manager who they compile and submit the monthly report.
Project Committee: Assists the running of the project, and works with PSASA to generate income and resources for the project.

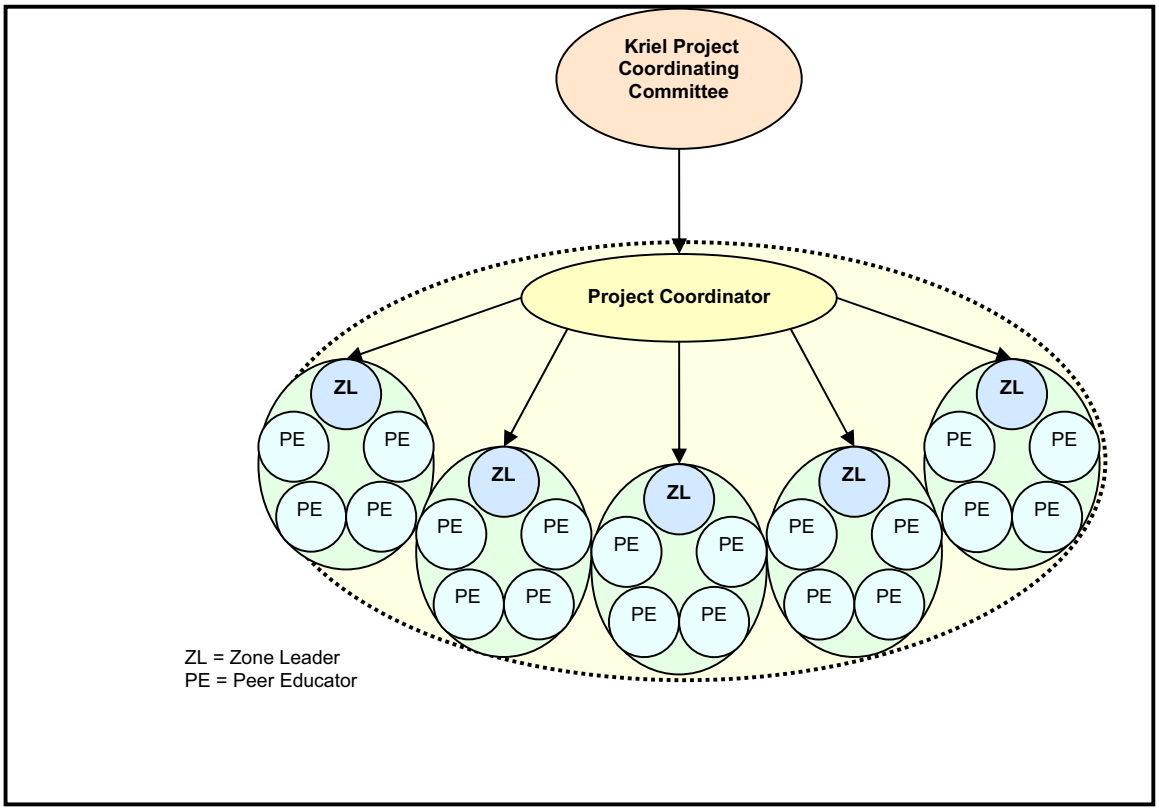

Figure 11 – General Programme Management Structure

Work Place Prevention

The impact of HIV AIDS on the business sector is significant, and because of this many companies see prevention programmes to their own workforce as cost effective interventions. Several businesses in the Mpumalanga area have elected to use PSASA supply Peer Education training within the workplaces, and in neighboring communities. Similar methods are used with the recipients receiving HIV AIDS messages in the work context. Currently there are 15 projects with 350 workplace volunteers and 60 zone leaders.

Youth Prevention

Youth prevention programmes following the peer model and process described above. Initiated in 2000, the aims and process are similar using youth to educate the youth. Because of this, the settings and content of outreaches are tailored accordingly to address youth issues and meet youth needs. Often, Youth Peer Education Project volunteers organize fun activities and sporting events, which they turn into educative opportunities. There are 14 projects each with a coordinator and approximately 280 volunteers (20 per project). An example of a monthly Youth Report is given in Appendix 6.

Student Prevention

It has been observed that early education and prevention is essential in stopping the spreading of the HIV AIDS virus. Because of this, PSASA has in 2003 year established a fresh branch in its activities – Student Peer Education projects. Here, universities and other tertiary education sites are targeted in

the same way as the other Peer Education approaches. The Protec Student programme is funded through SAPPI.

Category (Kriel Men)	Project (6 weeks)	2 Year	4 Year
(1) Knowledge of HIV	**-**	**-**	**94.76%**
(2) Attended peer education meeting in Kriel	**54.93%**	**91.43%**	**94.12%**
(3) Attended more than one peer education meeting in Kriel	**1.30%**	**9.78%**	**83.30%**
(4) Received condoms at peer education meeting in Kriel	**46.48%**	**93.13%**	**94.70%**
(5) Discussed AIDS with other people in Kriel	**68.06%**	**93.46%**	**91.00%**
(6) Perceive personal risk of getting HIV	**25.40%**	**97.25%**	**81.98%**
(7) Used condom last time with spouse	**11.76%**	**40.57%**	**73.50%**
(8) Have boyfriend/girlfriend	**85.71%**	**80.37%**	**61.62%**
(9) Used condom last time in casual/commercial sex	**44.12%**	**92.54%**	**86.63%**
(10) Had STD symptoms in last six months	**42.86%**	**26.41%**	**17.80%**

Figure 12 – Kriel 2 & 4 Year Assessment Summary

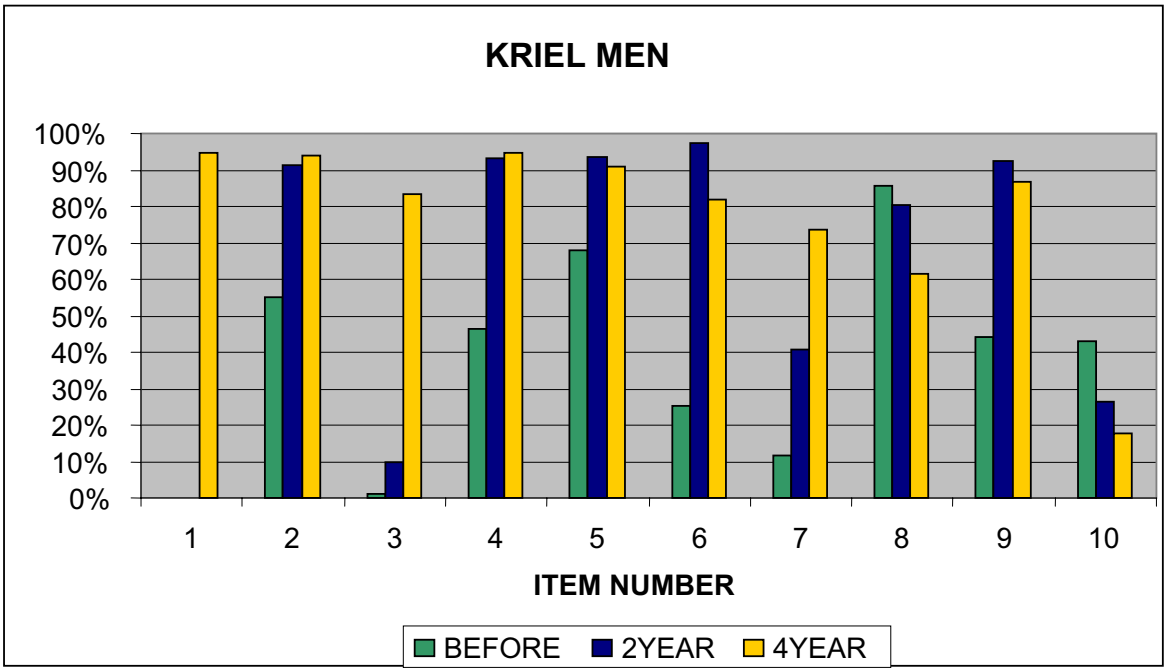

Figure 13 – Kriel 2 & 4 Year Assessment Graph

Prevention Summary

Are such prevention projects effective? Do they make a difference in preventing the spread of HIV AIDS? The lead project in Kriel was evaluated at two and four years from commencement and clearly demonstrated a marked improvement in HIV AIDS awareness and positive behavioral change among males and females in the target community (see Figures 12 & 13). Considering this and the number of projects through out the province (where an estimated 20% of the total adult population of the province have regular contact with peer education projects) an estimated 30 000 to 50 000 STI's are thought to be averted per annum because of these programmes.

Home Based Care

PSASA began to implement and support Home Based Care projects in 1999. Since then the number of projects has increased to over 60 with 1500 volunteers (including zone leaders) participating in the programme. Over the last year, some of community based peer education activities that were not specifically addressing high transmission areas have reoriented their activities into home care. Efforts have also been undertaken to add care issues to the content of some of the peer projects. The provision of home care provides an entry point to address many needs within communities.

Aims:

- To increase HIV AIDS coping capacities in mitigation project communities
- To increase the quality of HIV AIDS care and support to those infected and affected in partner project communites
- To improve knowledge and attitudes toward the needs of the infected and affected at household and community levels
- Sustainable community mobilization
- Increased access to medical and material support services to the infected and affected (includes OVC's)

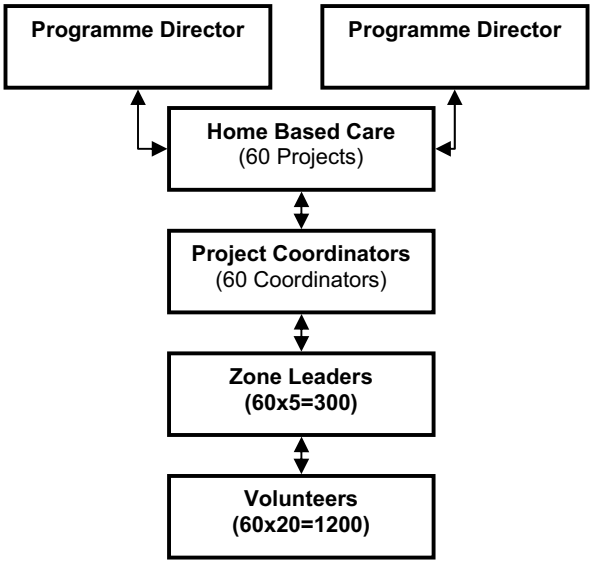

Figure 14 – Home Based Care Structure

Target group and focus:

The focus of the Home Based Care programme is to provide care for those who are chronically sick and terminally ill, care for the destitute and disabled in communities. These patients are often suffering from HIV AIDS but not exclusively. The care and dignity of the patient is foremost. Nursing is an essential part of the care given to the patients, and HBC workers are trained and resourced to provide basic health care and nursing, including DOT's. Patients are regularly monitored and evaluated in regards to their health and health needs. In situations where the medical needs of the patient exceed the nursing capacity of the workers, these workers are prepared to refer to other health care services, and are encouraged to maintain a sound relationship with these services. In addition to the nursing care, the workers also provide support to the families and household, home help and counseling.

Goals of Home Based Care[10]

Home-based or home care refers to "any form of care provided to the sick in their homes". Such care includes physical, psychosocial, palliative and spiritual activities[11]. This holistic approach can mean the 'things' a person does to manage their own care or the care given by the family or the community within the home of the needy person. The term "community home based care" [CHBC] is often used. This is where home care occurs in a community, to the community and by the community. It may occur with or without external support.

"The goal of Home Based Care is to provide hope through high-quality and appropriate care that helps family caregivers and sick family members to maintain their independence and achieve the best possible quality of life"[12]

Target of Home Based Care

In the context of this manual, comprehensive home based care refers to care of the most needy of the following –

1. **Care for the <u>afflicted</u>** [remembered by the 4 "D's"]. These are the -
   a) Dying – those who are dying for whatever reason such as HIV / AIDS, cancers, chronic diseases or just old age.
   b) Disabled – this is includes both physical and mental disabilities and includes a young child with a hearing problem to an older person who has had a stroke.
   c) Diseased – especially those who have any form of chronic disease such as diabetes, heart problems, cancers etc and is also inclusive of HIV related conditions
   d) Destitute – care for the impoverished and destitute. This includes adults and children who live in extreme poverty and specifically the neglected elderly.

1998 **Care for the <u>affected</u>**. This includes all those who are directly or indirectly affected by HIV / AIDS and may need some form of additional support.

   a) Orphans and vulnerable children in need of care
   b) Widows in need of care
   c) Elderly in need of care
   d) Other family members in need of care

Box 5 – Goals & Target of Home Based Care

The project workers are not only trained in caring for their patients, but are also trained in training others to provide high quality palliative care. They can then assist family members and neighbours to gain all that is necessary to effectively and appropriately nurse the patient, thus empowering the community with skills, knowledge and responsibility.

Many home care clients die while under HBC care. Lose of income can enhance or exacerbate poverty. Provision for economic down turn of families is an essential component of the HBC programme. Project workers are trained in establishing income generation schemes within communities, and so are able to assist the families of their patients in implementing their skills to create a new source of income to sustain them. These income generation schemes include community gardens, and arts and craft work. Such projects are also extended through to orphans and vulnerable children.

Where:

As with the Peer Education projects, Home Based Care projects are established in villages and communities, particularly in poor and poverty stricken areas in order to reach the target group. Liaising with other community services may occur wherever those services are based.

How:
The processes and procedures undertaken to establish a Home Based Care project are similar to, and based on the same model as, the launching of a Peer Education project, as described above. Key summary points includes:

Request and Negotiation for Project Implementation. The request for a Home Based Care projects usually come from within the communities. In some circumstances an outside member of a community may identify a site suitably in need of a health mitigation project. PSASA is frequently asked by community members or groups to assist with the establishment of a project. These people have identified the need to care for the ailing within their own areas, they may have already formed a group, and need the resources, education, modalities and training to meet those needs. A proposal for a Home Based Care project must be submitted to PSASA, where the funding and finance personnel examine their budget and the proposal, in order to ascertain the likelihood of project implementation. PSASA receives many applications that it is unable to approve because of limited finances. Projects cost between R45, 000 and R150, 000 per annum depending on their size, and save the health services R400, 000 to R1, 000,000 per year in averted hospital costs[13]. Social and averted clinic costs have not been included in these calculations. If and application for project establishment is successful, a Project Manager then engages in negotiations with the respective community.

Figure 14 – Home Based Care Team in Standerton 2002

Needs Identification and Survey. The next step taken in the implementation of a Home Based Care project is for the Home Based Care Project Managers to make contact with the wider community (identifying leaders and key community players and stakeholders) in order to build relationship with them and get approval to undertake a Needs Assessment. The Needs Assessment involves surveying the community through interviews, data collection and statistical analysis in order to ascertain the scope of need for a Home Based Care project, community resource availability, community acceptance of the project and so on. If there is already a PSASA scheme operating in that

location (such as a Peer Education Project), this initial step is automatically accelerated, as rapport for the Association has already been built, and the workers are very aware of the needs in the community.

Mapping and Zoning. Having identified the level of need, gained approval from local leaders, and deduced that there is suitable community support for a Home Based Care project; mapping and zoning is undertaken. The Project Manager walks, drives, examines and researches the community, mapping geographical, demographical, topographical and industrial conditions. The mapping serves to inform the Project Manager as to where the chronically and terminally ill live in the community, how the housing is dispersed, and the nature of the landscape in the area. Zones are drawn based on the mapping, taking into consideration potential recipients of care, the geographical layout of the housing, and the accessibility of the volunteers to those zones.

Volunteer Recruitment. The Project Manager can ascertain the number of volunteers needed for complete area coverage, and begin the recruitment process. By this stage the Manager is well known and has established significant rapport and trust within the community. For this reason, s/he is able to successfully ask community members to volunteer as Home Based Care workers, with high rates of acceptance. The number of volunteers recruited will be based on the number and size of zones in the community with most being recruited through the local churches.

Initial Volunteer Training. Subsequent to volunteers being recruited, the initial training of these workers begins and extends over a five-day period. This tuition educates them in a range of issues:

- HIV/AIDS transmission and prevention and basic facts
- Food safety and nutrition
- Feeding an infant
- Healthy eating for people with HIV AIDS
- Physical, emotional, and social health
- Self care
- Counseling
- Preparing for death (e.g. wills, providing for children, deeds and entitlements)
- Child care
- Referring and collaborating
- Basic nursing skills
- Distributing, administering and monitoring medical supplies
- Managing own and community resources
- Managing clinical problems and symptoms associated with AIDS
- Recording and documentation

Role and Zone Appointment. Throughout the training, the Home Based Care Manager seeks to identify potential leaders within the group, so that at the conclusion of this initial training, s/he is able to appoint a Project Coordinator to oversee the project, as well as a Zone Leader for each zone. Also, at the ending of the initial training volunteers are designated a specific zone in which to work.

Programme Implementation. Implementation involves nursing of the chronically and terminally sick by dressing wounds, administer and prescribe basic medications, monitor and ensure the administration of professionally prescribed medication, wash and clean the patient, ensure his/her personal hygiene, and assist in accessing the best possible nutrition for that person. A key activity involves the training of family members or neighbours to undertake this care.

Figure 15 – Income Generation Activities, Making Cards for Sale

Because the volunteers' nursing training is limited, it is often necessary to refer to other medical services and professionals (such as doctors, nurses and public health services) to obtain diagnosis and appropriate medication. For this reason Home Based Care workers aim to keep close and healthy relationship with other health providers. The volunteers are often required to act as advocate for their patients with medical services, and also to ensure that the prescribed treatment is being administered according to directions. Also, new patients are often referred to Home Based Care workers directly from the community, clinic or hospitals.

Care activities are also include other family members. Volunteers are trained in counseling, asset management (ensure that deeds, entitlements, wills and so on are in order before the patient passes away), and general orphan care and support.

Weekly Volunteer Meetings. Weekly meetings are held for all of the volunteers in a particular project. Key issues are discussed and new topics are presented. It provides and opportunity for submission of reports and documentation (see Appendix 7 – Home Based Care and Appendix 8 – Mitigation Tools).

Ongoing Training. Three week-long trainings per year are held for Coordinators where they liaise, support each other, and receive thorough training in relevant issues. The Coordinators then take that information back to the volunteers in their projects.

To date, PSASA supports over 60 Home Based Care projects. These projects have proved essential in the community for the support, care, and resources they provide. Care workers activities are broad and volunteers often work very hard for their communities.

Orphans and Vulnerable Children

PSASA's Orphans and Vulnerable Children programme is a childcare-focused facet that flows out from Home Based Care. **C**hildren are expected to care for their ailing parents, provide food and income, miss out on schooling and education, and are left orphaned if their parents die, meaning that in many cases young children have to take responsibility to head their own households. Home Based Care workers meet a core package of OVC care, at times however there are needs for more specialized services.

Figure 16 – OVC Concert

Core Activities for OVC's[xiv]

Care to orphans and vulnerable children, like all components of the home care programme should not separate HIV infected / affected orphans from those orphaned for all other reasons. Care for the terminally ill adult naturally progresses into the care of children both while the parent is alive and after death. Some maternal orphans [loss of mother], paternal orphans [loss of father] or dual orphans [loss of both parents] remain highly vulnerable and can suffer severe developmental consequences. Others may be taken into supportive environments where they are loved and cherished as valuable members of the new household. There are many reasons why children are described as vulnerable even in the presence of parent/s. For both orphans and vulnerable children the essential activities by the care personnel involves –

- *Identifying OVC's*
- *Registration of OVC's within the project with relevant documentation (i.e. copy of death certificate, clinic cards etc.)*
- *Assignment of care supporter to every orphan for □ounseling and support of the child through:*
  a. *Mentoring towards adulthood*
  b. *Intervention especially when there are no extended family or when they are not able to assist*
  c. *Support includes protection and advocacy for the best interest of that child, moral and spiritual support, and legal support. This may mean assisting with accessing of grants or benefits [where these are available], inheritance protection etc.*

d. *Assisting in keeping children in schools*
e. *Prevention awareness to orphans on HIV / AIDS and other relevant infections*

These are the basic areas that need to be addressed in regards to orphans. However the objective of any HBC programme should be to expand orphan activities into more practical orphan care such as food provision, school support, shelter etc.

Box 6 – Core Activities for OVC's

While children have always been a focus of Home Based Care projects in which the PSASA is involved, the development of their care as a separate function is relatively new, and is still in need of wide spread expansion throughout existing projects. Project establishment operates in much the same way as Home Based Care project establishment, the focus on the needs of the child.

An OVC volunteer's role includes:

- Ensuring that the children have shelter
- Ensuring that the children have food
- Ensuring that the children have water
- Organizing the care or placement of children with family members
- Helping the children access schooling
- Helping to access grants
- Helping get children's birth certificate
- Helping to get death certificates of parents
- Accessing appropriate medical and health care
- Helping authenticate children's housing deeds and obtain secure rights to these
- Negotiating with and advocating to other services and agencies
- Income generating activities

Aims:

- To strengthen households
- To sustain community support for orphans and vulnerable children
- To provide improved care for orphans and vulnerable children.

Christmas Parties for Orphans – 23rd of November, 2004 to 7th of December, 2004

Three Christmas parties were held through out the region. The party was attended by orphans, grandparents, foster partners and volunteers. Activities included: singing, praying, telling of the Christmas story, eating and giving of presents. The highlight of the activities was opening the presents by the children, their faces brightened up as they picked out each item one by one from the bag. They were all excited to have their photographs taken. Food was served which added to the party spirit, as the children tasted variety of eats. The orphans presented music, traditional dances and drama's which added to the life of the party. Traditional and community leaders, home care volunteers, Department of Social Welfare and local businessmen attended in supporting these activities.

Overall 3000 children benefited (20 from each of the 60 home care projects) from the Christmas parties with each receiving a small gift to the value of R20-.

Box7 – Christmas Parties -2004

Figure 17 – Delighted children with their toys at one of the many Community Christmas Parties held for Orphan Children

Contact Details

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Section C - Appendices

Appendix 1 – Staff Profiles

PSASA has steadily been increasing employed staff to support and maintain the quality of the community projects. The organization seeks to develop its own people and as a result many staff have come up through the ranks into higher management and training positions. As a result it is a stable workforce with currently no turn over of salaried staff. Current staff as of the end of 2004 (in alphabetical order) are:

Chiliza, Ntombi Jennifer
Clark, Natasha
Daniel, Keshnee
Fakude, Staff Bellinam
Gomo, Rosemary
Kubheka, Christopher, Vusi, Lucky
Le Roux, Janet
Madikazi, Anitta
Maseko, Johan M
Mashiane, Klaas Phios
Masilela, Zanele
Masina, Constance Lindeni
Mthethwa, Boysen France
Mthimmunye, Fikile, Elizabeth
Mtshiue, Thoko Gladys
Mujaho, Thandi
Oosthuisen, Corrie
Shongwe, Bongikile Busisiwe
Sibiya, Felicitus Tholakele
Sibiya, Godfrey
Van Zyl, Doreen
Xulu, Nini Aurelia

Name	
Chiliza, Ntombi Jennifer	
Current Position with PSASA	
Project manager and trainer for the FIETA programme	
Brief Description of current activities	
Training of Protec Students and workplace peer education in KZN with Mondi and SAPPI	
Year Starting with PSASA	
1998	
History of activities with PSASA	
1998 as a peer education coordinator , then trainer.. 2002 as project manager for Powerbelt. Currently working in KZN to start the FIETA programme	
Interests	
Music, soccer and reading	
Other (Married, Children, Family, etc)	
Not married with one baby girl	

Name	
Clark, Natasha	
Current Position with PSASA	
Transport Office Assistant	
Brief Description of current activities	
Fleet management and office assistance	
Year Starting with PSASA	
2002	
History of activities with PSASA	
Store room and stock control, travel with the director to projects	
Interests	
Gardening, Interior and exterior decorator, makeup artist, animals	
Other (Married, Children, Family, etc)	
Many pets: monkey, 1 dog, 2 birds, one child, one mother and two brothers (single)	

Name	
Daniel, Keshnee	
Current Position with PSASA	
Finance clerk	
Brief Description of current activities	
Do all financial filing, banking, typing as needed and assisting projects with their finances	
Year Starting with PSASA	
2000	
History of activities with PSASA	
Started at the switchboard, doing copies, faxes and making appointments for the director	
Interests	
Cooking, watching movies, sports and reading	
Other (Married, Children, Family, etc)	
I am married with one child aged 8 years, he is in grade 2.	

Name	
Fakude, Staff Bellinam	
Current Position with PSASA	
Office Assistant	
Brief Description of current activities	
Help with switchboard, photocopying, faxes and providing the staff with coffee and tea	
Year Starting with PSASA	
August, 2000	
History of activities with PSASA	
Assisting with the stock room, packing uniforms and stationary for projects	
Interests	
Church, cooking and washing	
Other (Married, Children, Family, etc)	
I am single with no children	

Name	
Gomo, Rosemary	
Current Position with PSASA	
Training Facilitator	
Brief Description of current activities	
Training of coordinators and volunteers in collaboration with FHI	
Year Starting with PSASA	
July 2004	
History of activities with PSASA	
Involved with PSA since 1997 doing formative assessments	
Interests	
Providing ARV & VCT with all volunteers being able to communicate effectively	
Other (Married, Children, Family, etc)	
Married with three children and one daughter in law (26, 21 and 10 are the ages of my children)	

Name	
Kubheka, Christopher, Vusi, Lucky	
Current Position with PSASA	
Reception, driver	
Brief Description of current activities	
Assists with the reception, payouts, driving and store room.	
Year Starting with PSASA	
November, 2002	
History of activities with PSASA	
Started on probation and then worked as a driver and now at reception	
Interests	
Listening to music, being on the road traveling	
Other (Married, Children, Family, etc)	
Single with one child who I love spending time with.	

Name	
Le Roux, Janet	
Current Position with PSASA	
Assistant	
Brief Description of current activities	
Emails, typing for the director, filing, follow up with project reports, stock control (medical supplies and stationery)	
Year Starting with PSASA	
June 2004	
History of activities with PSASA	
As above	
Interests	
Needle work, music, cooking	
Other (Married, Children, Family, etc)	
19 years married with 2 children (girl – 19 years, boy – 15 years), both sides of family stay in Bethal or Secunda	

Name	
Madikazi, Anitta	
Current Position with PSASA	
Power Belt Project Manager	
Brief Description of current activities	
Promoting abstinence, condoms and behavioural change, more recently income generating activities	
Year Starting with PSASA	
March 2002	
History of activities with PSASA	
As above	
Interests	
To see people changed through our projects and to see youth abstaining	
Other (Married, Children, Family, etc)	
One child, not married	

Name	
Maseko, Johan M	
Current Position with PSASA	
Project manager	
Brief Description of current activities	
Managing youth school programmes, peer education and the activities in Mozambique	
Year Starting with PSASA	
1998	
History of activities with PSASA	
Started in 1998 as a peer educator coordinator, with the project being funded in 2000, then formally started with PSASA as a driver	
Interests	
Young people and seeing them living constructive lives	
Other (Married, Children, Family, etc)	
Single one child, staying with my beloved mother and my sister and her son and my sisters grandchild.	

Name	
Mashiane, Klaas Phios	
Current Position with PSASA	
Facilitator	
Brief Description of current activities	
Goelama Child Care in Thaba Chweu working with orphans	
Year Starting with PSASA	
1998	
History of activities with PSASA	
Started 1996 with peer education, worked with Horisons as an outreach activities and doing mapping and zoning for a number of the projects Started with peer education in Strydom Tunnel and mamokgale Maphiri	
Interests	
Traveling, soccer, TV and collecting donations for orphans	
Other (Married, Children, Family, etc)	
Married with three children 8, 5 & 2 years	

Name	
Masilela, Zanele	
Current Position with PSASA	
Trainer	
Brief Description of current activities	
Visiting the projects, support volunteers, counseling	
Year Starting with PSASA	
January 2004	
History of activities with PSASA	
As above	
Interests	
Meeting with people everyday and sharing ideas	
Other (Married, Children, Family, etc)	
Married with no chidlren	

Name	
Masina, Constance Lindeni	
Current Position with PSASA	
Administrator	
Brief Description of current activities	
Data capture for projects, cheques, copies, fax, emails and telephoning Office oversight and assist with project payout	
Year Starting with PSASA	
2000 August	
History of activities with PSASA	
Started with doing the financial administration for Horizons Data base from 2001 to present 2003 capturing the registers	
Interests	
Meeting new people, love computers and doing further financial studies	
Other (Married, Children, Family, etc)	
Married with one child	

Name	
Mthethwa, Boysen France	
Current Position with PSASA	
Programme Director	
Brief Description of current activities	
Directs the programmes and assists in PSASA's management including payouts to projects, training workshops for project coordinators.	
Year Starting with PSASA	
1997	
History of activities with PSASA	
Started with PSASA in 1997 with a trip to Zimbabwe after that started as a volunteer for Ermelo, Lothair, Warburton and Breyten peer education projects as a coordinator. Full time employed with PSASA in 2001 as the Peer Educator Manager and trainer.	
Interests	
Meeting with people and attending church To sustain all our projects as long as we can and to see all HIV positive patients when needed receiving ARV's.	
Other (Married, Children, Family, etc)	
Married with three children (17, 16 & 13 years)	

Name	
Mthimmunye, Fikile, Elizabeth	
Current Position with PSASA	
Programme Director	
Brief Description of current activities	
Directs the programmes and assists in PSASA's management including payouts to projects, training workshops for project coordinators.	
Year Starting with PSASA	
1997	
History of activities with PSASA	
Began in 1997 as the project coordinator for Kriel and later 1998 as the peer educator trainer. On the 1st of December, 2000 began working with PSASA full time as the peer manager and trainer.	
Interests	
Church, gardening Aim to see the projects strong and sustainable and to get ART for people who need it.	
Other (Married, Children, Family, etc)	
Married with three children – 19 year old twins and the last born who is 12 years.	

Name
Mtshiue, Thoko Gladys
Current Position with PSASA
HBC Project Manager
Brief Description of current activities
Training, monitoring and visits to projects and homes with the volunteers, assist with grant applications and birth certificates
Year Starting with PSASA
2000
History of activities with PSASA
I started as a volunteer visiting houses to identify the sick and orphan children, then becoming a coordinator of the group and now project manager

Interests
I like to sing in my church and teaching Sunday school
Other (Married, Children, Family, etc)
Widow with three married daughters and seven grand children

Name
Mujaho, Thandi
Current Position with PSASA
Facilitator – Work Place Peer Education
Brief Description of current activities
Facilitating and supporting SAPPI and Global Forest work place programme and community projects in Bamjee, Kanyamazani and Barberton. Activities also involve the Protec Youth Programme and Swaziland support (activities of SAPPI)
Year Starting with PSASA
February 2005
History of activities with PSASA
Assisted with PSASA activities part time from 1998 while working with PSG. These activities involved assisting and implementing prevention projects at community level and in the work place.

Interests
These include going to church and watching soccer. I enjoy working and mixing with different people and venturing into new fields of my job.
Other (Married, Children, Family, etc)
Married with five children.

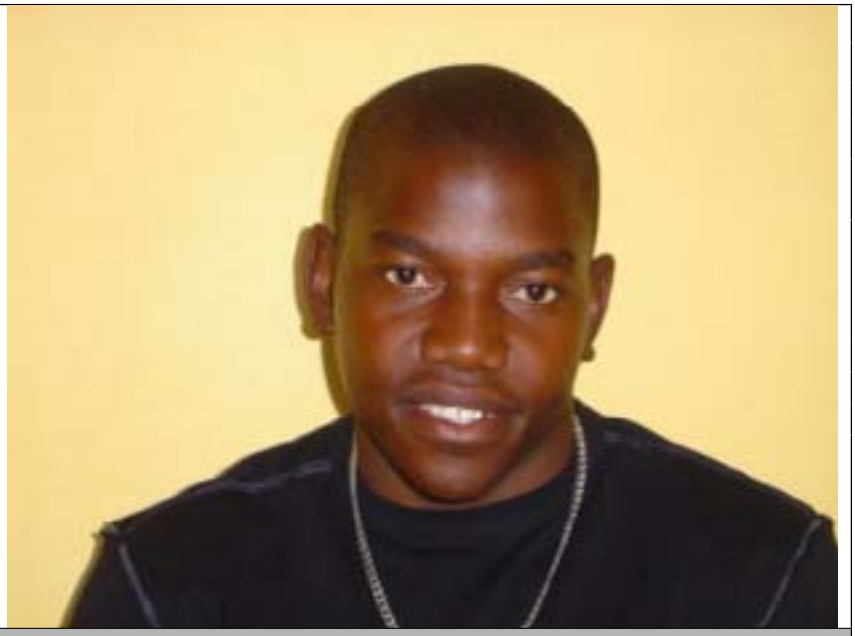
Name
Oosthuisen, Corrie
Current Position with PSASA
Director
Brief Description of current activities
Run the organization, fund raising, meeting with donors, reports and project visits
Year Starting with PSASA
1996
History of activities with PSASA
Founder of PSASA starting with the first peer education project based at Kriel

Interests
Birds, two dogs and my work
Other (Married, Children, Family, etc)
3 children and 2 dogs

Name
Shongwe, Bongikile Busisiwe
Current Position with PSASA
Assist with Home Base Care training
Brief Description of current activities
Training on HBC, assist with reception, faxes and phones and monitoring HBC
Year Starting with PSASA
June 1999
History of activities with PSASA
Started as a receptionist, worked with youth programme and now working with home based care

Interests
Computer, music sports
Other (Married, Children, Family, etc)
Single

Name	
Sibiya, Felicitus Tholakele	
Current Position with PSASA	
Child care project manager and home care training	
Brief Description of current activities	
Training of project coordinators and volunteers, liaise with project facilitators	
Year Starting with PSASA	
2002	
History of activities with PSASA	
As above	
Interests	
Cooking watching TV and going to church	
Other (Married, Children, Family, etc)	
Married with four children and grandchildren	

Name	
Sibiya, Godfrey	
Current Position with PSASA	
Trainer – Youth Programme	
Brief Description of current activities	
Training and support on communication skills, counseling, stress reduction and income generation	
Year Starting with PSASA	
2004	
History of activities with PSASA	
As above	
Interests	
Working with different people and also with	
Other (Married, Children, Family, etc)	
Single	

Name
Van Zyl, Doreen
Current Position with PSASA
Financial Manager
Brief Description of current activities
Handling all financial issues for PSASA
Year Starting with PSASA
2000
History of activities with PSASA
Assist with proposals, auditing and report writing
Interests
Children and music

Other (Married, Children, Family, etc)
Married with two daughters

Name
Xulu, Nini Aurelia
Current Position with PSASA
Project Manager (KZN)
Brief Description of current activities
Training, monitoring, mentoring, evaluation, organizational management and fund raising
Year Starting with PSASA
2000
History of activities with PSASA
Training in Mpumalanga from 2000 to 2002 before becoming project manager for KZN

Interests
Computer literacy and computer management
Other (Married, Children, Family, etc)
Single, two children and three grandchildren

Appendix 2 – Partners

Partners

Over the years PSASA has partnered with a number of different organizations in the development of its programmes. These are described in the following table (Table XX)

Name	Time	Description
Primary Donor/s are the Dutch, NORAD and SIDA through Project Support Group (PSG)	1996 – current	Prevention, mitigation, funding, technical support, workshops, weekly training, outreach activities, administration to the organization
ACTS	1998 - current	Counseling and updated training to Home Based Care coordinators on ARV's and counseling
Centre for Positive Care (Limpopo)	1998 - current	PSG partner – networking partner for South and Southern Africa
Family Health International (US)	2004-current	Workshops on communications, sexual reproductive health, family planning and STI's. Training took place by training master trainers down up to care giver level in the homes of people. Is presently still doing training and a lot of technical assistance. Also did two workshops on stress management for coordinators. IFH works in partnership with organizations with which it shares common objectives. In particular, IFH works with organizations which have the potential to implement, and increase access to, integrated and comprehensive sexual and reproductive health programmes and services which meet the needs of IFH's priority beneficiaries in its focal regions. IFH also works in partnership with organizations that support the development and replication of innovative approaches as well as influencing sexual and reproductive health policy and practice[1].
FIETA Mpumalanga and KZN	2004 - current	Training of Protec students as well as workplace peer education by Jennifer Chilisa in KZN and Thandi Mujaho in MPU. This include Technical Colleges, Technicon, University of KZN and Zululand.
Horizons	2000-2002	Technical assistance and conducting evaluation studies on the effectiveness of the peer education initiatives in high transmission communities.
International Family Health (UK)	2001 – 2002	Funding received for the Barberton area on prevention programmes for mobile communities in high transmission areas surrounded the border of Swaziland and mining communities. Technical support.
Little Seeds	2003-current	Training of OVC programme coordinators on managing, relating to children, child development and psychosocial support.
Masoyi Home Based Care	1998 - current	PSG partner – networking partner for South and Southern Africa

Mondi	2003-2004	Training of workplace peer education and supporting and training surrounding communities to plantations.
Nelson Mandela Children's Fund	2002-current	Support to orphan and vulnerable children along with youth development programmes. Technical support and M&E.
Power Belt	1996 - current	Prevention in both community and workplace. Power Belt is a combination of mining companies, Eskom, Sasol and local municipalities and department of health. Prevention.
Provincial Department of Health – (KZN)	2003-2004	Technical support from Provincial department of Health to mitigation projects in the area between Melmoth and Eshowe
Provincial Department of Health – (Mpu)	1996 - 2000	Prevention & mitigation projects. Provided seed funding for Bethal, Ermelo and Middelburg peer education projects, facilities for training, field staff to initiate prevention projects and supplied seed funding for Masoyi Home Based Care.
Provincial Department of Population Development (Welfare)	2003-2004	Funding went directly to Mitigation projects in Mpumalanga. Funding was specifically allocated for food parcels to orphans and vulnerable homes. They also render technical support to volunteers.
SAPPI	1996-current	Workplace peer education (prevention) doing training throughout South Africa. Fikile Mthimunye was responsible for this training.
Thembalethu Home Based Care	1998 - current	PSG partner – networking partner for South and Southern Africa

Appendix 3 - Publications / Conference Presentations / Posters

A number of publications, conference presentations (oral or poster) and other research has been undertaken using the community activities of PSASA.

Meeting Name	XIII International AIDS Conference
Date	July 10th to 14th, 2000
Location	Durban, South Africa
Conference Description	An estimated 15 000 delegates were present comprising researchers, academics, People living with HIV AIDS, community representatives, politicians, developmental agencies and activities. The programme was divided into a number of tracks: Basic Science, Clinical Science, Epidemiology & Public Health and Social Science, Rights Politics, Commitment and Action. Within these tracks, 4969 abstracts were accepted for oral or poster presentations.
Type of Presentation	Dr Elliot Marsielle presented this paper as first author with DR Billinghurst as third author.
Overview of Presentation	The female condom had been introduced to a number of the peer education projects of PSASA through out the province from 1998 onwards. It was well received by both the peer volunteers and individuals who were recipients of the programme. Targeting female condoms to this high-risk group would not only have a greater epidemiological impact but also be economically beneficial, given the higher cost and limited availability of these products. A modeling exercise was conducted in partnership with Dr Marsiele based on these projects and health care services within the public sector. The outcome of this modeling, which demonstrated the effectiveness of the female condom to sex workers in terms of HIV and other STI's averted, was presented during the conference.

Conference Abstract number: WePeE6677

[MoOrC131] Cost-effectiveness of the female condom in preventing HIV and STDs in commercial sex workers in Rural South Africa

E. Marseille1, J.G. Kahn2, K. Billinghurst3, J. Saba4
1Health Strategies International, 2 Madrone Place, Orinda, CA 94563, United States, 2University of California, San Francisco, San Francisco, CA, United States, 3Mpumalanga Department of Health,, Nelspruit, South Africa, 4Axios, Dublin, Ireland

Background: Though apparently as effective as male condoms (MCs) , female condoms (FCs) are more expensive. Under what circumstances, if any, can this additional cost be justified? We assessed the cost-effectiveness of the FC in preventing HIV infection and other STDs among commercial sex workers (CSWs), and their clients in the Mpumulanga Province of South Africa.

Methods: Current MC use was compared with expected condom use (MC + FC) in a one-year program of FC provision to 1,000 CSWs with an average of 25 clients per year. A simulation model calculated health and public sector cost outcomes assuming five years of HIV infectivity, one month of syphilis and gonorrhea infectivity, and FC use in 12% of episodes of vaginal intercourse. Recurring infections and interactions between STDs and HIV were modeled. The simulation was extended to non-CSWs with as few as ten casual partners per year. We conducted multiple sensitivity analyses.

Results: The intervention is estimated to avert 5.9 HIV, 38 syphilis, and 33 gonorrhea cases while saving the public sector health payer $9,116. Univariate sensitivity analyses indicate that the finding of cost savings or cost-effectiveness is robust across a wide range of values for key inputs. The program generates net savings of $2,216 if per-episode FC efficacy is only 80% rather than the 95% base case estimate; savings of $5,365 if HIV prevalence in CSWs is 25% rather than 50%; and savings of $8,930 if each CSW has an average of 10 clients per year rather than 25. If only 25% of episodes of FC use result in supplemental protection rather than 75% as assumed in the base case, the program would save $645 while averting 2.0 cases of HIV. A program focusing on non-CSWs with only ten casual partners would save $6,484.

Conclusion: A well-designed female condom program oriented to CSWs and other women with casual partners is likely to be highly cost-effective and can save public sector health funds in rural South Africa.

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Meeting Name	2001 A Science Odyssey Capricornia Medical Science Association and Australasian College of Tropical Medicine
Date	8th to 11th of June 2001
Location	Rydges Capricorn International Resort, Yeppoon, Central Queensland, Australia
Conference Description	Approximately 200 delegates attended this conference with most participants working in Australia, Pacific and South Asia as researchers, public health personnel and health providers interested in laboratory and tropical medicine. Most were members of the Medical Science Association and Australasian College of Tropical Medicine with a number of participants other similar organizations in the Pacific and South East Asia. The conference was held over three and a half days which included oral presentations, posters presentations and workshops.
Type of Presentation	Verbal presentation of 15 minutes with 5 minutes for questions.
Overview of Presentation	The oral presentation consisted of the following – - Context of HIV AIDS in South Africa and the need for alternate care - Types of care models and the need for home care - Description of the context of the Masoyi & (PSASA) Home Based Care Projects - Key components in the development of the project - Output and costing data - Implications in the local and wider context of southern Africa

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Meeting Name	13th International Conference on AIDS & STD's in Africa (ICASA)
Date	21 to 25th of September, 2003
Location	Nairobi, Kenya
Conference Description	The ICASA conference theme was "Accelerating Action Against AIDS in Africa".
Type of	Skills building workshop

Presentation Overview of Presentation	A number of Skills Building Workshops had been arranged for each day of the conference. We proposed a workshop using and sharing the experiences gained in home care. The title was "Expanding Home Care" using work from the Project Support Group (PSG) where I work as the Home Based Care Training Officer. Mr. George Snayman programme manager from the Masoyi Home Based Care Project and recipient of PSG project funding, attended and assisted with facilitation. The conference organizers had planned for 20 participants and we intended to use interactive discussions, work exercises and short presentations for the 60 minutes allocated to us. Key topics in the workshop were to include – - Programme administration - Forming partnerships – finding anchor partners - Accessing resources and recruiting funds - Technical support at community level - Programmatic monitoring and evaluation

Title: "Starting Slow – Building Big" Keys in scaling up community HIV AIDS projects.

Issues:
Scaling up effective HIV AIDS programmes is both a priority and challenge within South Africa.

Description:
The Project Support Group [PSG] is a Southern African Regional Organization focusing on community based HIV / AIDS prevention and mitigation projects. Involvement in South Africa commenced in mid 1996 with one peer education project targeting disadvantaged women. Since then, a total of 38 prevention projects have been established. In 2002 a total of 1158 peer educators were involved who conducted 167 376 outreach meetings, reaching 2518826 individuals and disbursing 6686454 condoms.

With the progression of the HIV epidemic in South Africa home care or mitigation projects were prioritized in 1999. These now comprise 60% of community projects. PSG in 2002 supported 6926 community care volunteers who provided care for 37658 clients with a total of 596485 visits.

Lessons Learnt:
PSG has developed from zero involvement to supporting over 8000 community participants in prevention and home care projects over the last seven years. Keys in scaling up include having an effective flexible model, strategic anchor partnerships, access of resources, technical support at community level and an effective ongoing programmatic monitoring and evaluation. Effective management of human resources through appointment of motivated staff, hands on training within effective projects and regular supportive training to maintain motivation have been essential.

Recommendations:
Effective programmes can be scaled up rapidly and successfully as demonstrated through PSG's involvement in South Africa. Strategic partnerships and flexibility have been essential with the building of capacity at community level. As significant HIV resources flow into Africa for HIV, the role of organizations supporting community initiatives with technical expertise and motivation should increase and assist in scaling up effective HIV programmes.

Meeting Name	XV International AIDS Conference

Date	11th to 16th of July 2004
Location	Bangkok, Thailand
Conference Description	The XV International AIDS Conference comprised of 20 000 delegates and followed a similar format as previously described presented. The theme was "Impact for All" and included tracks of Basic Science, Clinical Science / Treatment & Care, Epidemiology & Prevention, Policy and Program Implementation.
Type of Presentation	Poster Presentation – three abstracts were submitted and accepted. I was first author on two of these.
Overview of Presentation	The first abstract (Scaling up within the tempest of political change) describes how an NGO could expand in the context government constraints. The second abstract describes the transition of Project Support Group in support prevention programmes exclusively to supporting both prevention and mitigation projects and then to the integration of such projects.

Integrating HIV prevention and care: a challenge for the third millenium

M C Robotin[1], C J Oosthuizen[2], K E Billinghurst[1], N Dube[1], R Muyambo[1], D Wilson[1]
[1]Project Support Group, Bethal, South Africa; [2]Mpumalanga Program Support Association, Bethal, South Africa

Issues: The Project Support Group (PSG) is a non-government organization, supporting community-based AIDS prevention and mitigation programs in peri-urban and rural settlements in nine Southern African countries. While originally focusing exclusively on HIV prevention activities, the magnitude of the epidemic, coupled with the lack of available services at community level, led to an increased involvement of PSG in providing community care and support for people with HIV-AIDS.

Description: During the last decade, the balance between prevention and care programs has radically altered and currently 60% of the 338 programs supported by PSG focus on HIV impact mitigation activities. This increasingly encompasses the care and mentoring of orphans or vulnerable children (OVCs) and assistance with income-generating activities. Recently in South Africa, (the site of 170 of PSG-supported programs), PSG and its partners have been focusing on integrating prevention and care programs in underserved or remote rural areas. We describe herein some of the salient operational aspects of this care and prevention model.

Lessons learned: Integrating prevention and care programs is an effective method of enhancing service delivery in rural and remote communities. Its benefits include raising community awareness of HIV-related issues and mobilizing communities to support OVCs, leading to a reduction in stigma and discrimination against people with HIV-AIDS and facilitating the implementation of new interventions such as community-based voluntary counseling and testing (VCT).

Recommendations: Developing tools for measuring the program's impact, determining its cost-effectiveness and exploring its potential role in developing community-based HIV treatment programs would better define its potential relevance for identifying new strategies for the improved management of HIV-AIDS at community level.

MedGenMed. 2004 Jul 11;6(3):WePeE6677 [eJIAS. 2004 Jul 11;1(1):WePeE6677]

Conference Abstract number: WePeE6875

Scaling up within the tempest of political change

K G Billinghurst, C Oosthuizen

Project Support Group, Nelspruit, South Africa

Issues: Elections and the resulting political change can produce many new challenges for HIV AIDS organizations. As personalities, priorities and interest adjust, effective functioning and delivery of HIV AIDS services may be compromised.

Description: The Mpumalanga Project Support Association was established in 1997 through the Provincial Health Department to assist in the rapid delivery of HIV AIDS initiatives at community. Becoming an NGO in its own right, it established 30 peer education projects targeting sex workers or disadvantaged women and eight home based care projects over its first two years. South Africa's second democratic elections resulted in changes to the Provincial Minister of Health and senior management of the Health Department. NGO's were alienated as partners and a confrontational environment pursued. Within this context the organization was able to expand to 42 peer education projects, 8 work place & 8 youth / school peer projects and 51 home based care projects using 1675 community members.

Lessons Learned: Effective monitoring systems and proven documentation of outcomes favored new civil society community partnerships. These strategic alliances established additional resources without compromise to core services. An acceleration of training and capacity building resulted in two projects becoming autonomous in their own right and expanding the quality, coverage and technical services through out the province. Committed motivated and supportive staff was an important factor promoting the scaling up process. Advocacy efforts within community resulted in both material and moral support to the projects, creating a demand for expansion locally and further a field.

Conclusion: NGO's need to plan and prepare for local, provincial and national political change, so as to ensure their on going functioning. An antagonistic political environment can create opportunity for expansion of HIV initiatives.
MedGenMed. 2004 Jul 11;6(3):WePeE6875 [eJIAS. 2004 Jul 11;1(1):WePeE6875]

Meeting Name	South African 2nd HIV AIDS Conference
Date	7th to 11th of June, 2005
Location	Durban
Conference Description	South African national HIV AIDS conference with approximately 5000 delegates mainly from South and Southern Africa.
Type of Presentation	Verbal presentation of 15 minutes with 5 minutes for questions.
Overview of Presentation	PSASA was one of the six home based care programmes used by FHI for evaluating the effectiveness of the home based care programmes.

Exploring the role of family caregivers and home based care programs in meeting the needs of people living with HIV/AIDS: An assessment of 6 home based care programs in South Africa.

Authors: Catherine Searle,[1] Eka Williams,[1] Rick Homan,[2] Marc Aguirre,[3] Sibongile Mafata,[4] Farshied Meidany,[5] Corrie Oosthuizen,[6] Liz Towell,[7] and Noeleen Trollip.[8]

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Background

The HIV/AIDS epidemic has meant that an increasing number of chronically ill people need assistance with care and support. Currently these services are available from both formal and informal caregivers. This study examines different formal home based care (HBC) organizations providing care and the role they play in meeting the needs of PLHA. The research also investigates the unmet needs of PLHA despite the receipt of formal home based care services.

Methods

Six home based care programs were selected for the study, two in KwaZulu Natal, two in Gauteng and one each in Mpumalanga and the Eastern Cape, representing programs in both rural areas and urban informal settlements. Household heads from 374 households currently receiving care and support services from the six programs were interviewed in June 2004. In addition, focus group discussions were conducted with beneficiaries and with caregivers from each of the 6 programs.

Results

Households receiving care were remarkably similar, with 5-6 people making up a household, one of whom was sick. Around two thirds of program clients were female. Over 50% of clients were 26 – 45 years old, while 15% of clients were under 26 years of age.

In terms of the needs of clients, the most common need identified was someone to provide emotional/spiritual support (counseling). This was followed by someone to assist with physical care (bathing eating, dressing, using the toilet) and nursing care (pain management, treating wounds, taking medication). Assistance with household chores such as cleaning, cooking, shopping, running errands or gardening and someone to provide information and education or skills training were cited by more than half the households.

Household caregivers were mainly family members (82%) and female (78%). 38% of caregivers were 46 years or older, 43% of caregivers are in the 26 – 45 year age while 18% were less than 26 years old. While household caregivers provided the majority of physical care and assistance with household chores, formal caregivers provided the bulk of counseling, nursing care, information, transportation, and legal aid. While the majority of households felt someone in the household could substitute for the outside caregiver, more than 10% of the clients would not receive the service if not for the formal caregivers. Unmet needs of PLHA included food, financial support and more frequent visits by caregivers.

Conclusions

This research documents the differences in types of care provided by informal and formal caregivers. Findings suggest that the formal caregivers serve more as a complement to the household caregivers than a substitute. Even where formal caregivers are providing HBC services, we still find on average that the household caregivers spend more time per week assisting the sick person than the formal caregivers. This information is useful for determining gaps that exist in the provision of services and for assisting organizations to offer services that are complementary to those provided by informal caregivers, in order to better meet the needs of PLHA and their families.

Programmatic implications of the findings from a cost study of 6 home based care programs in South Africa.

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Background
The HIV/AIDS epidemic has meant that an increasing number of chronically ill people need assistance with care and support. Programs providing home based care services are a key component of the response to HIV/AIDS. However, few programs are using evidenced based programming and cost studies to decide what services to provide and how to structure their services. This study collected cost data in an effort to provide key programmatic information to NGOs, governments and donors on the cost of HBC services, the best use of resources and on how well programs are able to meet the needs of their beneficiaries and their families.

Methodology
Six home based care programs proving formal services to clients were selected for the study, two in KwaZulu Natal, two in Gauteng and one each in Mpumalanga and the Eastern Cape, representing programs in both rural areas and urban informal settlements. A cost analysis approach involving a review of each program's financial records and service statistics was used to determine the scope of services offered and their cost.

Results
All of the formal home based care programs provided services at no cost to the client. In all cases, the programs were providing supplies to the households including nutritional supplements, basic hygiene supplies, simple medical supplies, to assistance with doctor fees and medicines. The annual value of these supplies, on a per client basis ranges from R9 to over R2300. The other costs within the formal HBC programs cover the support staff, supplies for the caregivers and the program, supervision, training, equipment, and infrastructure. Information on the total annual cost of the programs as well as indicators of the size of the program (number of clients, number of visits and number of caregivers) showed that there were large differences in the programs in terms of the scope as well as the intensity of the services being provided. Researchers also determined the fraction of total costs that were of direct benefit to clients and the cost per visit made for each program.

Conclusions
Data collection indicated that there was a need to strengthen and standardize record keeping within programs. There was also a need for determining the optimum client load for volunteers and program staff. In some cases there were opportunities to restructure how resources were allocated to better reflect the program's goals. This analysis of the cost of services has provided important data for program planning and has widespread policy implications that will be discussed in the presentation.
361 words

Successful HIV AIDS Programme - Mpumalanga, South Africa

- *Date*: Wed, 5 Apr 2000 23:18:41 -0400 (EDT)

Successful HIV AIDS Programme - Mpumalanga, South Africa

PRESS RELEASE
3rd April, 2000

Successful HIV AIDS Programme

The Mpumalanga Project Support Association [MPSA] is a government partner Non Profit Organisation [NPO] established for supporting community-based projects in the area of HIV AIDS. Established in early 1998 with government and non-government participants, it has taken strategies from effectively working HIV projects of Zimbabwe and applied them successfully within the province. Currently MPSA is supervising 50 community projects through out Mpumalanga Province in the area of prevention and mitigation.

Prevention projects target disadvantaged communities in historically neglected areas focusing on vulnerable groups for effective HIV prevention and behaviour change. Peer Education Projects are successfully running at 40 sites using over 600 community volunteers. An estimated 20% of the population within the Province have been reached on a regular basis during 1999. A total of 1.1 million people directly attended a peer education activity in over 47 000 outreach meetings during the year. A hallmark of the projects has been the clear messages on HIV prevention, STD awareness, empowering of women and distribution of male condoms. Over 6 million condoms [or one third of the provincial total of male condoms] were distributed through the peer education projects. The lead project in the Kriel area has clearly demonstrated that people do make appropriate behavioural changes when they are aware of
their HIV risk. These include -

* a 38% reduction in STD's over a two year period in which the project has been running
* 32 000 STD's have been estimated to have been averted across the whole province
* 97% condom usage during paid sexual acts had been achieved among males
* increasing demand for condoms
* condom usage during non commercial sexual acts had also increased

Further expansion of peer education projects is envisaged for 2000 targeting other high risk groups of people such as the youth, school aged children and workers in industry.

Twelve home based care projects have already been established within Mpumalanga, with an additional eight projects about to be launched and support being provided to eight projects outside the Province, including Northern Province and Swaziland. A total of 20 000 home visits
were conducted serving over 3000 clients within the province during 1999. These projects are in the early phase of integrating orphan is sues as part of their routine work.

Both the prevention and mitigation projects recruit volunteers from the community for the respective projects. Integrated community committees manage the day to day running of the projects. MPSA provides the financial and technical expertise for both the projects and management committees.

MPSA is truly an example of the call by president Mbeki in 1998 for effective partnerships in the fight against HIV and AIDS. Mpumalanga clearly has a strategy that is working.

From this Departmental Press release the following comment was in the Sunday Times ((9th of April, 2000).

Project is the right medicine[15]

A STRICT "no glove, no love" policy has cut the spread of sexually transmitted diseases in one Mpumalanga health district by 38% in just two years, reports SIZWE SAMAYENDE.

The peer education project in Kriel, where volunteers were trained by the health department to teach people about STDs and HIV-AIDS, has proved so effective that the department plans projects for all Mpumalanga's health districts.

The Mpumalanga Project Support Association is helping and more than 600 volunteers are working in high-risk areas.

A departmental spokesman said: "We have realised that giving information alone does not make people change their behaviour but when people in the same environment talk repeatedly about the same subject there's a change."

The department estimates 32 000 STD infections have been averted as a result of the project. - African Eye News Service

Appendix 4 - Awards

The following is an extract taken from

African Heritage Foundation HIV/AIDS Awards 2003[16]

03 December 2003

The AIDS Awards Programme was instituted by the African Heritage Foundation to recognise contributions made by individuals and organisations in the fight against HIV and AIDS.

The African Heritage Foundation Trust (AHF) presented the 2nd annual HIV/AIDS awards 2003 on 03 December 2003 at a gala dinner at the Sandton Convention Centre.

1300 NGO's throughout South Africa was nominated for the awards and 45 candidates short-listed. The AHF Chairman, Mr Langa Dhlomo presented the awards and Prof Ruben Sher made a touching speech about our social responsibility towards fighting the HIV/AIDS epidemic.

LearnScapes was honoured with the Chairman's award. This award recognizes the significant contribution **LearnScapes** have made in countering the effects of HIV/AIDS in the community and workplace.

WINNERS FOR THE 2003 HIV/AIDS AWARDS

a) Overall Winners

1. Project Support Association Southern Africa (PSA)
2. Centre for the Study of Aids, University of South Africa (CSA)
3. Lonmin Platinum

b) Recognition Awards

1. SANLAM
2. National Ports Authority (NPA)
3. UNILEVER
4. Margaret Sanger Centre
5. Department of Correctional Services
6. Morning Star Children's Home
7. SAFCOL
8. LIFELINE East London
9. ACFS Community Education
10. Hospice East Rand
11. Department of Environmental Affairs & Tourism
12. Helen Joseph Hospital HIV & AIDS Unit
13. Department of Agriculture, North West Province

c) Chairperson's Awards

1. National Ports Authority (NPA)
2. Treatment Action Campaign (TAC)
3. LearnScapes

d) Acknowledgement of Efforts

1. Boitelo Youth Network
2. Mokwallo Home-Based Care (Relebohile Clinic)
3. Department of Trade & Industry
4. Entokozweni HIV & AIDS
5. Makomba-Ndlela Youth Project
6. National Department of Agriculture
7. Far East Rand Hospital
8. Leratong Hospital
9. Department of Housing & Land Administration, Mpumalanga
10. Nomotsha HIV & AIDS Project
11. SANCA Central Rand
12. Tshepong AIDS Project
13. Vukani Youth Club
14. Aplitec (NET1 Applied Technology Holdings)
15. CINDI (Children in Distress) Network

Appendix 5 – Prevention – Peer Education

Peer Education – July – December, 2004

Project Name:	Site	Number Enrolled	Number Trained	Number Active	Number PE Trained	Outreach Meetings	Men Reached	Females Reached	Male Condom Points	Male Condoms Free
Asiphileni	Kanyamazane	122	122	122	408	1231	8148	5703	22722	11437
Bank	Bank Mine	71	69	71	110	208	2395	1381	120	54200
Bhamjee	Ngodwana	100	98	89	213	451	5003	3325	0	75950
Blackhill	Blackhill	153	153	153	396	435	2560	2337	78	25956
Consmurch	Murchison	24	24	24	64	23	305	54	0	2450
Cwayisizwe	Nhlazatshe	117	117	111	184	849	7276	6978	29455	10160
Dilokong	Gamaroga	52	52	52	193	398	701	507	17500	10950
Dunusa	Dunusa	144	144	141	384	630	3198	4467	55	10232
Emgwenya	Waterval boven	53	35	47	147	318	10000	8400	500	4700
Emthonjeni	Machadodorp	46	45	46	128	331	1658	1981	20	10170
Emzinoni	Bethal	66	63	63	158	878	17090	14000	44558	87204
Ermelo	Wesselton	123	120	123	192	1067	7738	11222	136548	132989
Evander	Evander	75	75	63	200	328	2841	1413	21380	85692
Goedehoop	Goedehoop	86	86	70	251	200	10895	8082	60	43876
Hlanganani	Standerton	93	93	87	234	1236	10816	12373	25000	62812
Hlanganani	White river	118	118	117	216	2574	10681	7730	372	28983
Inhogoia	Mozambique	80	80	80	239	2395	3210	2660	20000	27000
Kleinkoppie	Kleinkoppie	230	91	87	265	933	7994	8647	436	43288
Kriel	Kriel	103	103	103	234	1395	13475	9239	15146	49735
Kwazanele	Breyten	48	66	72	235	1464	22548	27363	32103	34003
Lesedi	Balfour	79	79	79	250	1231	5422	7922	243	18251
Light of the nation	Barberton	186	186	176	574	2033	25174	24206	11060	135001
Lothair	Lothair	60	60	59	200	733	7306	7409	10474	36355
Lusito lwethu	Shongwe	153	180	146	139	63	1243	1770	12405	14512
Mamokgale maphiri	Ohrigstad	64	64	64	192	679	3593	3070	0	7294
Mapochs	Rossenekaal	27	27	27	69	182	3773	2558	38	26270
Mashishing	Lydenburg	90	90	88	271	883	4959	4945	46367	26113
Masiyephamb ilingempilo	Rustplaas	114	114	103	311	692	5860	6199	0	16432
Masizakhe	New denmark	84	84	83	284	647	10120	6444	51	95883
Mhluzi	Mhluzi	62	62	58	239	151	1125	1550	147	51140
Mzinoni	Bethal	29	29	27	50	163	2959	2869	72	3996
Navigation	Landou navigation	97	97	95	225	301	1768	1728	95	16865
Phakamani	Leandra	84	84	84	239	1548	8129	12105	168	53517
Phola	Ogies	120	120	114	296	344	3449	2093	194	37151
Qaphelani	Embalenhle	232	232	228	509	3099	16644	27835	11756	45476
Qondisa	Witbank	90	82	82	268	1240	4471	2145	280	18922
Resano Garcia	Mozambique	126	126	124	208	3038	11260	8010	47000	56950

Rietspruit	Rietspruit	72	72	72	234	1416	8482	9525	17585	65250
Silestimpilo	Matsulu	25	23	23		160	1341	1436	2760	3085
Siletsimpilo	Matsulu	75	73	69	242	843	8829	8819	17585	14385
Silwanayo	Pietretief	74	120	93	314	1075	22131	27499	34060	13676
Simunye Against Aids	Mpuluzi	168	168	164		768	6534	15468	41359	20213
Sinethemba	Ext 14 Embalenhle	89	83	94	292	1310	5894	11113	2440	17198
Siyathuthuka	Belfast	53	53	53	128	502	2419	3115	40	6800
Siyavikela	Witbank	50	45	46	107	190	577	633	32	6194
Sizanani	Hendrina	108	114	108	312	322	1538	1238	11000	10388
Sizonqoba	Fernie	70	70	28	83	79	518	1294	10092	2584
Sonqoba	Tonga	136	136	133	434	2344	5150	5950	29000	40000
Strydom Tunnel	Ohrigstad	72	64	61	178	580	1705	2250	8558	13732
Thibela	Burgersfort	76	14	72	216	350	14376	16393	10600	5037
Vuselela	Kwambo	54	36	37	40	67	1753	1893	6	2721
Warberton	Nganga	9	9	9		86	522	752	500	6239
Warburton	Nganga	48	48	48	188	581	2882	3240	600	17371
TOTAL		**4780**	**4598**	**4468**	**11543**	**45044**	**350438**	**371338**	**692620**	**171678**

Appendix 6 – Prevention Tools

PROCESS INDICATOR FORM FOR PREVENTION

Project Name	Site Name	Month & Year	Coordinator's Name	Signature

VOLUNTEERS		
Number of PE Enrolled	Number of PE Trained	Number of PE Active

Date of PE Training (Weekly Meetings)	Topics	Number of PE Trained	Hours Training

Adult One-on One discussion

Date	Topics	Males	Female	Totals

Youth One-on –One discussion

Date	Topics	Boys	Girls	Totals

Outreach Meetings	Men Reached	Woman reached

CONDOMS		
Male condom points (outlets)	Male condoms sold	Male condoms distributed free
Female condom points (outlets)	Female condoms sold	Female condoms distributed free

SCHOOLS VISITED				
Name of schools	Boys attended	Girls attended	Topic discussed	Response

YOUTH REFERRED TO					
Health centers		Local government centers		Social worker	
Attended Positive	Attended Negative	Attended positive	Attended negative	Attended positive	Attended negative

STI's		
1.Public STI care facilities	Male STI cases treated	Female STI cases Treated
2.Workplace STI care facilities	Male STI cases treated	Female STI cases Treated
3.Private STI care facilities	Male STI cases treated	Female STI cases Treated
1. Public facility RPR test	2. Workplace facility RPR test	3. Private facility RPR test
Negative -	Negative -	Negative -
Positive +	Positive +	Positive +

Example of Youth Programme Reporting

Type of project: Adolescent prevention support and delivery services

Name of project: Isibane Sezwe Youth Peers

Name of coordinator: Ephraime Nhlanhla

Project area/location: eMzinoni

Brief description of project area/location:
The area of eMzinoni is full of young people who are unemployed. Because of that situation they are involving themselves in drugs especially the boys from ages 19-25years. The youth (girls) is also engaging themselves in sexual activities, which leads to abortion, teenage pregnancy, drugs and alcohol. We are now facing the problem of lots of abortion, which is killing them as they are doing it illegally. The death toll is increasing daily but with the help of the existing youth club, there is a difference, which they make.

ACTIVITY	2001	2002
Number of adolescent prevention delivery services volunteers	16	16
Number of adolescent prevention community meetings	132	171
Number of boys reached by prevention services	1396	6675
Number of girls reached by prevention services	1782	7332
Number of condoms distributed to the community to avert STDs/HIV/AIDS	1281	5027
Number of adolescent referrals to clinics for treatment of diseases	18	89

Appendix 7 – Mitigation - Home Based Care

Home Based Care Statistics: July to December 2004 – Example of some of the routinely collected programme monitoring data

Project Name:	Site Name:	Number HBC Trained	Number Male Trained	Number Female Trained	Number Boys Trained	Number Girls Trained	Men Receiving Home Care	Woman Receiving Home Care	Existing Clients	New Clients	Clients Lost	Total Clients
Bambanani	Zaaiplaas	612	130	222	155	261	29	38	78	24	35	67
Bophelong	Ekangala	89					58	103	105	61	5	161
Bophelong	Kwamhlanga						208	298	475	37	5	507
Care with love	Embalenhle	589	81	182	108	199	589	1400	1994	59	72	1981
Coromandel	Lydenburg	130					386	1033	1506	2	89	1419
Dunusa	Dunusa	96		70	47	137	463	664	1044	148	3	1189
Ekukhanyeni	Delmas	284					1142	506	862	4	28	838
Elukwatini	Elukwatini	268	141	237	169	245	316	618	755	128	44	839
Empilweni	Breyten		90	212	105	179	14	24	39	7	8	38
Empilweni	Pietretief	149					101	624	334	23	25	332
Emthonjeni	Witbank	118					38	76	115	17	18	114
Entokozweni	Leandra	581	94	151	50	136	577	593	1172	26	22	1176
Gamanoke	Burgersfort	108	1164	601	78	224	193	433	623	5	15	613
Helping hands	Ermelo	144					103	66	176	4	11	169
Helpmekaar	Graskop	292					141	125	260	7	0	266
Hope	Kinross	335	53	32	321	104	236	257	467	39	13	493
Itereleng	Steelpoort	198					591	1319	1871	78	43	1906
Kathleho	Balfour	108	19	83	16	12	94	83	171	11	5	177
Kgautswane	Ohrigstad	267					276	564	834	11	8	837
Kromdraai	Kromdraai	192	88	113	563	580	307	475	777	17	12	782
Kungwini	Ekangala	345	1219	1781	729	1629	656	929	1575	44	34	1585
Kutlwano	Greylingstad						42	36	44	34	6	72
Kwachibikhulu	Kwachibikhulu						45	97	141	25	25	141
Kwadela	Davel	158	38	42	63	52	52	216	278	3	8	273
Leboeng	Ohrigstad	408	66	258	150	200	848	2027	2897	16	38	2875
Leroro	Leroro	280					83	216	299	4	4	299
Lethimpilo	Melmoth	257	33	59	34	50	232	569	844	23	70	797
Lethuthando	Mthonjaneni	156					349	439	766	29	10	785
Maope	Gariba	44					31	37	945	3	0	948
Masakhane	Monstorlus	400					118	402	541	10	31	520
Mashishing	Lydenburg	552	169	227	192	225	1026	1677	2689	16	41	2623
Masibonisane	Diepdale	320	49	139	62	99	626	1377	1986	40	26	2000
Masiyephambile	Rustplaas	68					82	66	145	16	13	148
Masiyephambili	Rustplaas	109					236	258	481	39	26	494
Matibidi A	Matibidi	396					394	537	927	10	6	771
Matibidi B	Matibidi	560	140	380	370	738	465	578	1019	34	10	1043
Mfule	Melmoth				29	24	221	246	469	7	6	470
Mhluzi	Nkangala	121	12	39	28	53	387	562	1291	35	226	1100

Mlalazi	Eshowe	184	30	25	44	33	368	276	628	26	10	644
Mmamethlake	Mmamethlake	340			457	816	480	932	1358	88	44	1402
Moremela	Moremela	231					137	164	292	9	0	301
Ndabazensangu	Melmoth	277	30	86	75	100	1220	2864	4075	88	79	4084
Ndundulu	Melmoth	92					155	240	481	2	88	395
Nomakhaya	Phola	124					410	595	825	197	17	1005
Nyahato	Ekangala	256	1365	2511	728	1628	523	800	1309	55	31	1333
Peloleditatla	Driekop	264	115	141	108	206	1026	2456	3567	2	87	3482
Philisa	Bethal	667	43	78	54	67	1156	4807	5972	44	56	5960
Phiring	Ohrigstad	330	103	207	174	228	901	911	1766	47	7	1806
Pilgrimrest	Pilgrimrest	44					65	147	92	2	5	89
Pilgrimsrest	Pilgrimrest	44					18	28	30	16	0	46
Sabie	Sabie	381					1146	1612	2526	148	96	2578
Sakhisizwe	Hendrina	225	46	118	93	163	183	393	529	65	33	553
Silindile	Lothair	304	43	127	27	83	48	87	133	30	28	135
Silusizo	Dullstroom	297	161	247	126	161	37	70	91	54	48	97
Sinobuhle	Melmoth	246					588	978	1685	7	66	1626
Sithembinkosi	Morgenzone	44					167	355	523	5	4	524
Siyanakekela	Witbank	197	146	250	143	252	370	675	1116	45	49	1112
Siyanqoba	Greytown	91					93	109	171	54	13	212
Siyaqhubeka	Caroline	236					155	181	336	49	32	353
Sonqoba	Breyten	228	325	434	445	510	175	332	504	15	19	467
Tholimpilo	Standerton	57	8	32	4	8	58	87	128	33	16	145
Tjakastad	Tjakastad	185	89	151	95	40	308	324	622	48	38	632
Vezokuhle	Melmoth	299	25	56			807	1878	2664	172	191	2645
Vuma impilo	Witbank	196	22	25			245	544	774	46	31	789
Zigcine uphilile	Philadelphia	58	130	151	235	332	143	291	489	169	114	544
		14631	**6267**	**9467**	**6077**	**9774**	**22737**	**41704**	**63681**	**2612**	**2243**	**63807**

Appendix 8 - Mitigation Tools

MITIGATION CARE AND SUPPORT MONTHLY REPORT

GENERAL

PROJECT NAME: _____ **MONTH AND YEAR:** _____

SITE NAME: _____ **NUMBER OF VOLUNTEERS:** _____

COORDINATOR: _____ **NUMBER OF ZONE LEADERS:** _____

VOLUNTEERS – TRAINING

WEEKLY DATES:	TOPICS:	NUMBER TRAINED:	HOURS TRAINED:

VOLUNTEERS – VISITS

NUMBER OF VISITS: _____ **MEN REACHED:** _____ **WOMAN REACHED:** _____

CLIENTS

NEW CLIENTS THIS MONTH: _____ **CLIENTS TERMINALLY ILL:** _____

CLIENTS LOST THIS MONTH: _____ **CLIENTS CHRONICALLY ILL:** _____

NUMBER OF CLIENTS REFERRED TO – VCT: _____

ARV: _____

F.P: _____

STI: _____

AMOUNT OF CLIENTS RECEIVING ARV: _____ **CONDOMS DISTRIBUTED:** _____

CARE GIVERS / FAMILY MEMBERS / NEIGHBOURS

WEEKLY DATES:	TOPICS:	MEN RECEIVING TRAINING:	WOMAN RECEIVING TRAINING:

NUMBER OF CARE GIVERS / FAMILY MEMBERS / NEIGHBOURS REFERRED TO – VCT: _____

ARV: _____

F.P: _____

STI: _____

CONDOMS DISTRIBUTED: _____

OTHER INFO

FOLLOW-UPS

VCT TESTED ON – MEN: _____

WOMAN: _____

PLWA SUPPORT GROUPS – MEN: _____

WOMAN: _____

STI'S TREATED: _____

_____

FP METHODS: _____

_____

Child Care Monthly Report

HBC Coordinator _____ CCS Name _____
HBC PROJECT NAME _____YEAR/MONTH _____
MUNICIPALITY _____

ACTIVITIES DONE DURING THIS MONTH	
• Tot no. new orphans benefiting at site this month?	
• Tot no. orphans moved away/deceased?	
• Tot no. orphans at the end of the month?	
• Tot no. families counseled?	
ADULT HEADED HOUSEHOLDS WITH ORPHANS	
• Tot no. adult headed households?	
CHILD HEADED HOUSEHOLDS WITH ORPHANS	
• Tot no. child headed households?	
VULNERABLE CHILDREN	
• Number of vulnerable children reported during this month?	
OTHER INFORMATION ON CHILD CARE	
• No. of children referral made?	
• No. of children referrals followed up?	
• No. of children referrals received?	
• No. of children registered in school?	
• No. of children not enrolled in school?	
• No. of children missed more than 3 times in last 3 weeks of schooling?	
• No. of children regularly leaves early/arrives late at school?	
• No. of children denied access to school due to associates with HIV/AIDS?	
• Tot no. children issued with school uniform?	
• Tot no. children issued with stationery?	
• Tot no. children- do not have to pay school fees?	
GRANTS AND REGISTRATION	
• Tot no. birth registration – applied?	
• Tot no. children waiting birth registrations?	
• Tot no. children -child support approved?	
• Tot no. foster grants approved?	
• Tot no of parents assisted with will preparation?	
HOME VISITS	
• Tot no. of visits?	
• Hours spend during visits?	
• Tot no. of community meetings held?	
• Tot no. of people reached?	
• Tot no. of male condom distributed?	
• Tot no. of female condom distributed?	
• Tot no. children – accessed VCT service?	

Home Based Care Work Programme Form

DATE OF VISIT	TIME SPENT	NEEDS ASSESSMENT/ MEDICAL PROBLEM	OTHER PROBLEMS	ACTIVITIES PERFORMED	SIGNATURE

Home Based Care Health Record File

Date of visit:_____Time spent:_____Transport to patient: Foot/Car

Patient Name:_____Age:_____Sex:_____

Marital Status:_____Primary Caregiver for patient:_____

Physical Address where patient is staying:_____

NEEDS ASSESSMENT:

Medical problems (eg High blood, diabetes, rashes, etc):

Spiritual/Social/Mental problems (eg Unable to wash clothes/fetch water, etc):

ACTIVITIES PERFORMED: (please write only what you did for the patient)

Nursing (e.g. wound dressing ect.)_____

Health Education (e.g. Nutrition, hygiene, etc)_____

Practical Support (e.g. Fetched water, cooked food etc.)_____

Spiritual Support/Counselling:_____

Who accompanied you on visit?_____

Name of person completing form:_____

Signature:_____Date:_____

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