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.

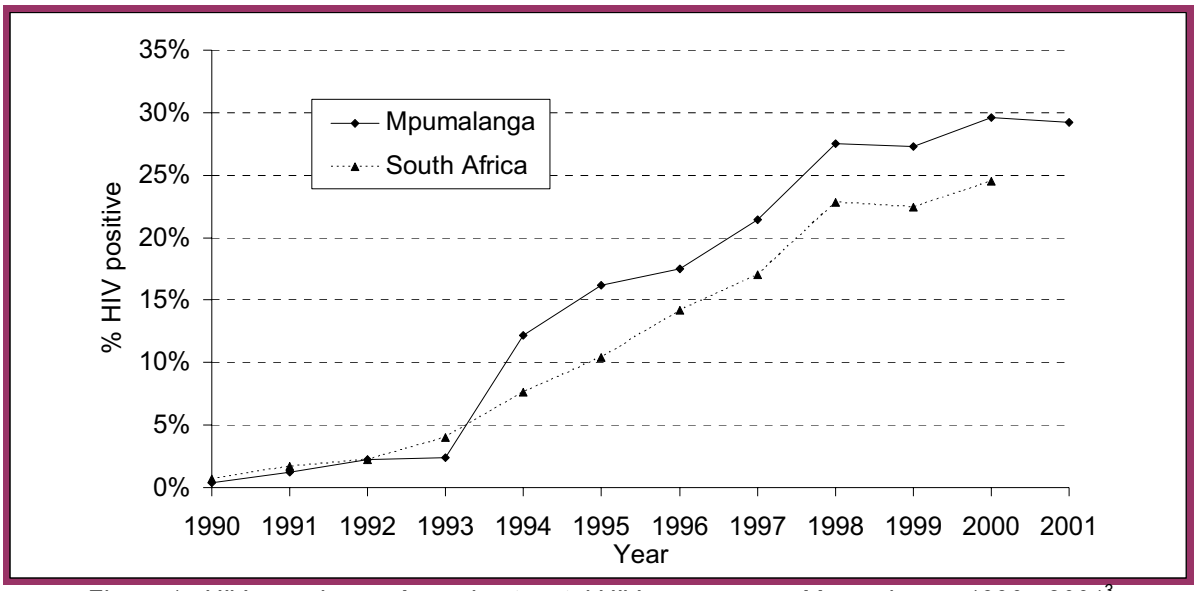

Figure 1 : HIV prevalence, Annual antenatal HIV serosurveys, Mpumalanga, 1990 - 2001[3]

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