PROVIDING CHOICE, ENSURING SERVICES

UNFPA’s HIV work in East and Southern Africa

2010-2011
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Introduction

The East and Southern African (ESA) Region of the United Nations Population Fund, UNFPA, is host to 18 countries in which the HIV epidemic has been classified by UNAIDS as high burden, severe/hyper-endemic and concentrated endemic with geopolitical relevance. UNFPA is one of 11 co-sponsors of UNAIDS and a contributor to the UNAIDS Joint Programme on HIV, which up until 2011 has been implemented jointly by the co-sponsors of the Joint Programme, based on an agreed Unified Budget and Work plan (UBW).

The purpose of this HIV publication of the East and Southern African Office of UNFPA is to highlight the good and promising practices that were identified during the 2010-2011 UBW reporting cycle. Innovation, focus, detail and measurable results contribute to programmes that were considered promising practices. These can become good practices when conducted over a full programming cycle with sustainable results and clear documentation about scale-up possibilities and the feasibility of replication in other countries. Good practices are an important tool for exchange and learning on effective programming.

While the first batch of identified good practices was included in this document, more are being developed and are to be published shortly in an electronic format on the regional UNFPA website (http://africa.unfpa.org).

The UBW’s 14 areas of programming have been consolidated into seven for the purpose of review and selection of good and promising practices, as depicted in the table that follows.

Overview of reported results

Each country report was analyzed critically from a results-based perspective and a determination was then made as to whether progress was being made in the area under review, whether concrete results had been reported and finally, whether the results that were being reported could then be disseminated as a good or promising practice.
An analysis of the country reports from all 23 countries within the ESA sub-region indicated that all countries were making progress in implementing their programmes in all key areas. Sexual and Reproductive Health and Rights (SRHR), HIV and gender in humanitarian emergencies showed less progress when compared to other areas. However, this may be because only a few countries within the sub-region have programmes in humanitarian settings.

The reports showed mixed results for national policy dialogue/AIDS strategies and strengthening SRHR/HIV linkages, including comprehensive Prevention of Mother-To-Child Transmission (PMTCT), and concrete results were stated. However, reports in these areas were not considered to be good or promising practices and this indicates that more needs to be done - i.e. innovation, consolidation and scale up. Good and promising practices are expected, however, to emerge in the context of HIV/SRHR linkages and comprehensive PMTCT programmes, due to the attention and focus that a significant number of countries are now giving to these areas.

Finally, differences in terms of progress, concrete results and being a good or promising practice were shown with regard to reproductive health commodity security (RHCS), comprehensive condom programming (CCP) & male circumcision (MC), as well as gender integration, HIV/SRHR in the context of sex work, comprehensive sexuality education, youth participation, and SRHR, HIV and Gender in humanitarian emergencies and programming. This would indicate that attention needs to be paid to ensuring that what is considered to be progress is actually translating into concrete results, in order to eventually become a best practice.

The East and Southern African Office of UNFPA hopes that the good and promising practices that have been showcased in this brochure (as well as those that will be published on the Africa regional website) will be an inspiration for improved programme implementation and results-based reporting in the areas that we, as UNFPA, are programming in. This will result in HIV prevention that contributes to the improved sexual and reproductive lives of women and young people, in particular.

Increasing access to cervical cancer prevention services in Botswana

Cervical cancer is the second most common cancer among women globally, with a prevalence of 1.4 million and incidence of 493,000 per year. In Botswana, the National Cancer Registry showed that cervical cancer accounted for 24 per cent of all cancers in women in the period 1998-2008.

In 2005, cervical cancer was among the top five causes of gynaecological admissions. Between 90 and 100 per cent of cervical cancer is associated with Human Papillomavirus (HPV) infection. A situation analysis conducted by the Botswana Government and the World Health Organization (WHO) in 2003 revealed a rising trend in invasive cervical cancer. A strong factor for this is the close association of cervical cancer with high HIV prevalence, due to higher susceptibility and the faster progression of cervical cancer among women living with HIV.

Botswana had an HIV infection rate of 17.6 per cent in 2009, with a higher prevalence among women (20 per cent) compared to men (14 per cent). It has been found that up to 61 per cent of women living with HIV develop cervical cancer. To address the severe and growing impact of cervical cancer, the Government of Botswana set up its National Cervical Cytology Programme in 2005. The programme included capacity building, community mobilization, screening and the management of clients at different levels. A central component of this prevention programme is the use of PAP smears to screen for lesions in the cervix at clinics and hospitals, referrals for verification with Colposcopy in the case of abnormal PAP smears, and bookings for treatment and further diagnosis with Cone biopsy for positive cases.

The process from the initial PAP smear to the biopsy can take from five to six months, which has led to a large backlog of cases. This has resulted in delays in getting preventive and treatment services and loss to follow-up, which has severely weakened efforts to reduce morbidity and mortality from cervical cancer, especially for women living with HIV. The regimen of tests and therapy is also very costly to the health system and is becoming more so due to the HIV epidemic.

Partnership for cervical cancer prevention services

With the aim of circumventing these shortcomings of the national programme and providing effective and timely cervical cancer prevention services to women living with HIV, a collaborative project between the Ministry of Health and the University of Pennsylvania, funded by BOTUSA (a U.S. Government supported programme) was initiated in March 2009. The Botswana-UPENN Cervical Cancer Prevention Project 2008-2013 was set up at one primary-level and one secondary-level Infectious Disease Care Clinic (IDCC) in Gaborone. These are among a system of clinics providing ART.

The service begins with the provision of information on cervical cancer to female clients of ART services at the primary-level clinic. Those who agree to be screened are offered additional information on Sexually Transmitted Infections (STIs) and family planning, and ‘see-and-treat’ services for cervical cancer prevention, involving a method known as Visual Inspection with Acetic Acid (VIA) and treatment with cryotherapy for minor lesions by a nurse.

The VIA procedure is supplemented by the use of a digital camera to produce cervical images for more accurate diagnosis, continuing education of providers, distance consultation and better record keeping. Providers also use mobile phones to produce high resolution photos that can be used to transfer images in sites lacking internet connectivity. Those with higher
grade lesions are referred to the project’s secondary-level clinic for further evaluation by Colposcopy and the Loop Electrosurgical Excision Procedure (LEEP), also a relatively minor and timely procedure. Only cases with lesions too extensive for the LEEP procedure are referred for further management. An automated system to follow up clients for repeat tests or treatment is an important part of the service.

The project has been characterized as a truly comprehensive system of preventing cervical cancer, with obvious benefits in terms of providing one-stop screening and care, and thereby avoiding long waiting times and multiple visits for women and loss to follow-up. This will greatly strengthen the effectiveness of cervical cancer prevention and therefore reduce morbidity and mortality from cervical cancer among HIV-positive women. It is also a good example of task sharing and will significantly reduce the costs incurred by the health system.

In successfully integrating sexual and reproductive health (SRH) services in an HIV programme and strengthening the SRH rights of women living with HIV, the project strongly advances linkages in SRH and HIV. This is consistent with the findings of the Rapid Assessment of SRH and HIV linkages in Botswana, which found that integration was a well-established concept in policy documents and that the needs of people living with HIV were addressed in HIV policy.

However, the assessment also showed that integration was inhibited by the existence of separate Reproductive Health and HIV units in the Ministry of Health and a lack of joint planning, human resource shortages and unintegrated training programmes, on the one hand. On the other, it found that the integration of STI, family planning and maternity services in HIV services was quite common. Recommendations that emerged from the assessment addressed the need to strengthen collaboration between RH and HIV departments and the training of providers in integrated services, which are objectives that are reinforced by the experiences of the project.

Strategy for the intervention

The intervention aimed to increase access to effective cervical cancer prevention services for women living with HIV and to inform the development of a National Cervical Cancer Prevention Strategy. The project is located in one primary-level and one secondary-level Infectious Disease Care Clinic, which provide ART services in Gaborone. The new method involves the use of the relatively new VIA by nurses at the primary care level to provide one-stop screening (see and treat) for identified precursors of cervical cancer, and treatment for low grade lesions with cryography. It also entails referrals for further evaluation and treatment with LEEP by the gynaecologist at the project’s secondary-level clinic or with more advanced procedures at referral hospitals.

Delegation to nurses is made easy through the initial rigorous training provided to them. Most importantly, to monitor quality and ensure timely quality assurance and back-ups and checks by doctors, digital cameras and cell phones are used by nurses to produce enhanced images of cervical lesions. These are transferred to and shared with doctors to facilitate distance consultations as well as record keeping and follow-up of patients. It also allows for an automated system of data collection and management.

There are regular review meetings for nurses and doctors to ensure timely addressing of any challenging cases and maintenance of quality and effective interventions and support.

The objectives were as follows:

• To prevent cervical cancer among women living with HIV and AIDS; to provide see-and-treat services and referrals for cervical cancer prevention in women living with HIV and AIDS
• To increase awareness of cervical cancer among women living with HIV and AIDS
• To build capacity for preventive services through training and providing equipment; and to produce data on project performance to inform policy.
The project had a budget of US$400,000 per year, and the targets were to screen 1000 women per year over the period 2008-2013.

**Key challenges faced**

The main challenges experienced by the project were that of maintaining reliable access to supplies due to weaknesses in the supply chain management system, and achieving an adequate number of trained personnel, which is exacerbated by the practice of rotating trained staff. Also, continued funding for the project is proving to be a challenge in the face of donor cutbacks.

**Implementation**

The project was initiated by a Motswana gynaecologist working for a University of Pennsylvania cervical cancer prevention programme. The process of getting government approval began with a series of consultations with health officials in the Ministry of Health, Ministry of Local Government, hospital administrators and medical directors of a number of clinics in 2007 and 2008. A proposal for a PAP smear-based project submitted for funding to BOTUSA was rejected due to concerns about the lack of the necessary infrastructure.

In August 2008, a team consisting of representatives from the Department of Clinical Services, Ministry of Local Government and BOTUSA, and the gynaecologist met with CDC officials in Zambia, where a VIA project had been initiated and led to the development of a proposal for a similar project. Government approval and BOTUSA funding for the project was gained in September 2008.

Implementation of the project began soon after with the decision to set up linked VIA services at the Bontleng IDCC primary-level clinic and LEEP services at the IDCC secondary-level clinic at Princess Marina Hospital in Gaborone. A number of personnel were hired, including a project coordinator, two nurses, a data manager, a data clerk, and a gynaecologist. Equipment and supplies were purchased. The nurses were then taken to Zambia for two weeks of training in January 2009. VIA services started in March of 2009 under the guidance of a doctor, nurse and data manager from Zambia, and this was soon followed by the initiation of LEEP services. Ongoing training for nurses has continued ever since.

**Progress and results**

The project has provided cervical cancer prevention screening services for the targeted number of women living with HIV at the primary care clinic, where nurses have provided effective one-stop screening, treatment and referral services to the project’s LEEP service, or further management at specialized centres.

In the period between March 2009 and February 2011, 2175 patients were screened by nurses at the primary-level clinic. They treated 253 patients with cryotherapy, determined 1347 to have no abnormalities and referred 575 clients for further evaluation. The 506 patients who were determined by the referral clinic and hospital to have abnormal lesions received various treatments, including cryotherapy, LEEP and surgery or Cone Biopsy.

A relatively small number of diagnoses (85) made by the nurses was later altered upon further evaluation. This shows the potential for the screening and minor treatments to be carried out by nurses in less well-equipped health centres, rather than involving doctors on a full-time basis.
The project is still to be rolled out but it has high potential for success in terms of decentralization because the interventions can easily be implemented by nurses with minimal supervision and a high level of accuracy of service provision.

The lessons learned

The importance of getting political buy-in has been demonstrated by the successful efforts to initiate the project. Continuing advocacy is important in order to retain the support of health service supervisors and providers, which is critical for sustained service provision. It is vital to get motivated service providers with the right competencies, who can be trained to provide this service. An adequate data collection system is critical for such a project for the purpose of follow-up of clients, advocacy, and monitoring and evaluation.

Conclusion and next steps

The project has provided effective and timely preventive services for cervical cancer among women living with HIV and demonstrated the reduced costs and improved efficiency of its alternative approach, as well as the requirements of this approach for strengthened supply chain management systems, human resources and specialized services. It can also serve as a blueprint for the integration of other SRH and HIV services, providing important lessons learned.

The next steps for the project include the phased roll-out of VIA/cryotherapy at the primary level and LEEP at the secondary level to assure programme quality and sustainability. Initially, services can target sexually active and highest risk populations (e.g. HIV-positive women and HIV-negative women aged 20–65). Also, consensus and agreement needs to be achieved on a protocol for testing, treatment, referrals and follow-up.

The supply chain management system needs to be strengthened to ensure steady supplies for preventive services. The availability of an adequate administrative structure, including support staff, needs to be ensured. A monitoring and evaluation plan needs to be developed, which includes computerized patient records similar to the pilot project, systematic reporting and a follow-up and recall system for clients. The final steps are to raise awareness and support for preventive services among health facility administrators and providers, and to promote see-and-treat preventive services at the community level.

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Scaling up male circumcision and comprehensive condom programming

Studies have shown that high coverage of male circumcision has a 60 per cent effectiveness rate in the reduction of heterosexual transmission of HIV. As one of its strategies to scale down the incidence of HIV in the general population, Rwanda has incorporated voluntary male medical circumcision into its strategic health policy documents.

The Government aims to reach 2 million men by June 2013. The strategy targets adult males specifically to increase the prevalence of circumcision, which could contribute to reduced heterosexual transmission of HIV, as well as newborn boys as a long-term strategy of reducing susceptibility to HIV infection in the general population.

The Government has also placed condom programming as an essential component for all HIV prevention and family planning programmes, yet condom use is often stigmatized by the general public as indicative of ‘immoral’ or promiscuous behaviour. The absence of clear guidelines for access to condoms and a lack of reporting mechanisms reduced potential users’ ability to get hold of condoms. Prior to the development of the Standard Operating Procedures (SOPs) manual, people seeking condoms from the public health sector did not know whether they had the right to acquire these condoms and from where. The SOPs manual has enabled an integrated supply chain system, taking into account the different population groups in need, especially those at higher risk of HIV infection.

The objective of the MC intervention was to reduce the incidence of HIV in the general population to 0.5 per cent, and to increase the prevalence of male circumcision to 50 per cent of men aged 10-19 years, 30 per cent of men 20+, and 50 per cent of newborn males born in the last 12 months circumcised at a health facility. It also aimed to increase the access of newborn boys, adolescents and adults to circumcision, by increasing to 80 per cent the percentage of health facilities with staff who can perform male circumcision.

The second inter-related intervention aimed to increase to 26 million the total number of condoms available for distribution nation-wide during the last 12 months, and to increase to 60 per cent and 80 per cent respectively the percentage of young women and men aged 15-24 who reported that they could get condoms on their own.

Implementation and communication

Achieving these results requires considerable capacity building and advocacy to enable health centres to offer the services, and appropriate targeted communication and follow-up activities for circumcision of both adult males and newborn boys.

It was widely acknowledged that low-risk sexual behaviour (reduction in concurrent sexual partnerships and consistent condom use) continue to be important for circumcised men, and that circumcision programmes should address the potential for behavioural inhibition among men who accept circumcision. Communication on circumcision was therefore integrated into broader HIV prevention communication efforts in the National Strategic Plan (NSP).

The National Strategic Plan on HIV/AIDS 2009-2012 has placed traders, truckers and other people on the move as most-at-risk populations (MARP), with specific strategies for interventions. Yet due to limited resources, efforts are still focused on the general population of which they are a part.
With respect to circumcision for newborn boys, it is important for service providers to clearly communicate to parents the purpose and advantages (not just in relation to HIV) of circumcision and additional HIV prevention measures. The routine offering of circumcision for newborn boys has been integrated into other basic health programmes at the health centre level. However, this population group is not at high risk of HIV infection when compared to 15-59 years old, especially those aged 15-24 years, who are more sexually active and a key population group for HIV infection.

Although circumcision is available to all adult males, voluntary circumcision has particularly been promoted for men with higher risk factors for sexual transmission of HIV, and men in settings such as the military, prisons and higher education establishments. Rwanda has also been a pilot country for innovative strategies for scaling up medical male circumcision, such as the piloting of the PrePex device and the scale up of surgical MC at the country level.

In 2008, UNFPA supported the Government in conducting a rapid situational analysis for condom programming in order to develop a comprehensive condom programming strategy. In 2009, the new CCP strategy was integrated into the overall NSP for HIV and AIDS, with the promotion of condom use as a fundamental component. With technical and financial support from UNFPA and other partners, the Government prioritized condom use.

To increase the demand for condom use, the Government launched campaigns involving key political and religious leaders, popular musicians and other artists, to help break the silence about condoms. The campaigns involved events such as football matches, music festivals, radio and television shows, competitions and debates in schools, sensitization sessions, marches, rallies and the use of promotional items like billboards and radio spots.

Following these demand-generation efforts, the public health sector condom supply chain system was reviewed to ensure condom access by all groups at risk. It was decided that if the condom distribution system was to be effective, parallel structures should not be created and rather, the current system should be used. UNFPA provided both technical and financial support to design a full supply chain system to ensure enough stock at the national level to absorb the anticipated increase in condom consumption. A standard operational procedures manual was developed to guide the storage, distribution and reporting of condoms at the central and decentralized levels. The Government, in partnership with the social marketing sector, initiated the creation of rapid sales outlets to increase the availability and accessibility of condoms.

**Challenges and opportunities**

About 38 per cent of all health facilities in Rwanda are religious based or supported and therefore cannot support the promotion and provision of modern methods and services related to FP, including condoms. However, the Government has strategies in place for creating secondary health posts to support these facilities in providing these services.

**Progress and results**

Rwanda developed an operational plan for male circumcision that incorporates all the necessary activities and resources for the achievement of the set strategies, ranging from coordination to communication. A technical working group (TWG) that brings together different stakeholders in male circumcision has been formed for regular technical monitoring of progress on implementation of the plans.

Campaigns were conducted in six district hospitals during the decentralized training for male circumcision and in their catchment health centres. Information was broadcast on local radio stations and national TV. Male circumcision communication tools were developed.

A total of 5400 community health workers were trained and charged with increasing in-depth knowledge on MC, as well as offering MC to eligible men, motivating women to support their partners’ and sons’ decisions on MC, and providing accurate
information to men and women to address misconceptions, including information about necessary additional HIV prevention measures. Community opinion leaders have also been trained on MC and HIV prevention to support social mobilization within their respective communities.

The Government conducted capacity-building activities for both high and lower cadre health personnel: 31 master trainers (surgeons) were trained to train lower cadre health personnel, with the aim of shifting the task of circumcision from the already burdened highly trained medical staff. The master trainers then conducted a national training of trainers from 41 district hospitals, making it 82 health-care providers who would in turn conduct cascade training at the health centre level, as well as at private health clinics. This has been scaled up to other district-affiliated health centres.

Rwanda is currently conducting an innovative pilot strategy for male circumcision using the PrePex device in Gasabo, Nyarugenge, Kicukiro, Nyamata and Gicumbi Districts. The Ministry aims to finalize the first phase of voluntary male circumcision scale up using the PrePex device. The first phase will involve 10,000 circumcisions in three hospitals in Kigali region. About 40,000 men have been surgically circumcised and 2300 men circumcised using the PrePex device.

Rwanda is the first country to adopt the device for wide-scale use, having received a WHO recommendation to begin scale up with this device following elaborate scientific validation of its safety, superiority over surgery and simplicity in the hands of nurses. Rwanda will be the centre of excellence for the PrePex device and will be training the region on its use.

Strategies such as the provision of circumcision services during weekends for adult men who may not be available during working days, and holidays for students in boarding schools, have contributed to making the services time friendly.

With regard to condom programming, the 2010 RDHS reported that about 86 per cent of young women and 91 per cent of young men aged 15-24 knew a source for condoms. Results from the recent 2010 BSS show that condom use at last sexual intercourse among the youth aged 15-24 and commercial sex workers (CSWs) has increased to 43 per cent and 83 per cent respectively, compared to 2000 and 2006 surveys. While 80 per cent of female sex workers used condoms at last sex with a client, the proportion for consistent condom use among all women with a paying sexual partner in the month preceding the survey rose from 28 per cent in 2006 to 33 per cent in 2010.

Rwanda is on course to achieve its target of distributing 26 million condoms annually by 2012, as an increase on 15 million in 2009. CCP strategic plan indicators are integrated in different HIV and AIDS strategic policy documents. Indicators for most-at-risk populations (MARPs) programme interventions at the decentralized level have integrated condom distribution indicators for each key population.

Condom use and promotion has been integrated in all HIV prevention minimum packages for populations at higher risk of HIV infection, except for prisoners. The standard operation procedures manual for the condom supply chain system has been disseminated to all at the central and decentralized levels. Evidence from the 2009, 2010 and 2011 national campaign reports shows that the need for condoms at the community level increased, yet the final distribution points for free condoms were not sufficient to satisfy the growing need.

At the community level, small organized community groups involved in HIV prevention are ready to distribute condoms to members, creating a window for accessing condoms.

Through the Delivering as One programme, UNFPA has supported the MoH to procure and install 700 condom vending machines countrywide to increase the number of condom sales outlets, especially in hotspots such as bars, hotels, motels,
lodges and restaurants. This is in addition to initiatives for rapid sales outlet creations.

**Lessons learned**

Task shifting (changing the roles and responsibilities of health-care workers) was an urgent option for management of the shortage of health-care workers in Rwanda, in line with the WHO global recommendations and guidelines on task shifting. These propose the adoption or expansion of a task-shifting approach as one method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health services.

The delegation of health care tasks from higher-trained professionals to lesser-trained professionals is one of the solutions to meet the growing demand for male circumcision services. Previous interventions have shown that an evidence-based male circumcision communication strategy has increased and sustained an informed demand for male circumcisions. But all male circumcision services should be accompanied with intensive, targeted communication efforts to address myths and misconceptions about the practice and its contribution to comprehensive HIV prevention. This could pose an obstacle to the effort to reach the set targets.

**CCP**

Identifying and engaging all those potentially involved in HIV prevention and family planning at all levels in the promotion of condom use is vital for the success of an integrated programme. Moreover, involving key opinion leaders in the promotion of safer sex behaviours can contribute substantially to increasing individuals’ risk perception.

The condom supply chain system was facilitated by the Government of Rwanda to improve the supply chain system in the public health sector through a decentralized health system, and this can easily be replicated in countries with decentralized reproductive health commodities distribution systems. The exercise also gives room for the mapping of organizations involved in HIV prevention and condom programming, and strengthens partnerships for the supply of condoms up to the end users at the community level.

**Conclusions and recommendations**

Considerable effort and resources are needed for Rwanda to achieve its target of circumcizing 2 million males by 2013. The combination of male circumcision procedures, training of all health care providers with an emphasis on shifting some tasks to lower cadre health practitioners to be able to handle mass-scale circumcision programmes, as well as mass campaigns on the benefits of male circumcision and other elements of combination HIV prevention to create demand, will be vital. The availability of sufficient facilities, including surgical kits or the PrePex device, is necessary for services where and whenever clients are ready to be circumcised. Finally, making services free will encourage people to use them.

With regard to condom programming, to ensure improved responsibility towards safer sex and increased sustainability of these programmes, partners need to focus more on raising HIV risk perception and condom promotion. This will weigh down the Government and its partners’ (especially UNFPA and USAID) burden of purchasing and distributing free condoms.

All stakeholders in the supply chain system for condoms for the public health sector need to be provided with clear guidelines for access to and reporting of condoms. Finally, consistent follow up is needed to ensure that the established supply chain system is functional, open to new stakeholders, that the new stakeholders are given appropriate orientation to the system, and that the system is owned by all stakeholders from the central, decentralized and community levels. There has been a significant increase in distribution since the inception and dissemination of the SOPs manual at the country level.

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• Another initiative could be to assess the possibility of establishing and strengthening private condom sellers.
South Africa has the highest number of people living with HIV (PLWHIV) in the world, with 5.2 million in 2008 (Shisana et al., 2008). In response to the epidemic, the South African Government has intensified the implementation of policies and strategies for preventing STIs, new HIV infections and unplanned pregnancies through a multi-sectoral approach. Condoms, therefore, remain at the centre of South Africa’s HIV prevention Programme; the country has one of the largest and most established male condom programmes globally (Department of Health, 2005).

The three main providers of condoms to South Africa are the Government, Society for Family Health (SFH) and the private sector, the Government being the largest provider. The National Department of Health (NDoH) works in partnership with the private sector, non-governmental organizations (NGOs) and community-based organizations (CBO) to distribute condoms in traditional and non-traditional outlets. Annually, it is estimated that 350 million male condoms are distributed on a demand basis to sexually active people in South Africa.

The Female Condom Programme was introduced by the NDoH as early as 1998. The distribution of female condoms started in 33 pilot sites in eight provinces and these sites included 19 DoH facilities, 12 NGO sites and 2 sex worker sites. The backbone of South Africa’s HIV/AIDS prevention programme is the distribution of condoms through the public sector. However, the provision of female condoms has been one of the major gaps due to a shortage of this commodity, leading to an inadequate supply. Although South Africa is the second largest distributor of female condoms in the world, with a highly successful condom promotion and distribution system, the number of female condoms distributed annually in 2005 was 2.4 million, with an increase to 3.5 million in 2008 (Marumo, 2009).

Evidence shows that new HIV infections in South Africa are driven largely by sexual transmission, followed by mother-to-child transmission and other modes. However, recent epidemiological evidence has shown the region’s epidemic to be more diverse than previously thought, with other focal areas, including sex work, intravenous drug use and sex between men playing a role in new infections (UNAIDS, 2008).

In June and July 2010, South Africa hosted the Federation of International Football Association (FIFA) Soccer World Cup. More than 1.4 million tourists visited the country during this period, with some arriving prior to the event and staying on afterwards. Ten stadia hosted 64 matches over 43 days in nine cities in eight provinces; namely, the Eastern Cape, KwaZulu-Natal, Free State, Gauteng, Limpopo, Mpumalanga and North West. Each stadium hosted at least six matches and all had a fan park, public viewing areas (PVAs) and training venues for the 32 teams. This was a period of festivities and therefore an increase in unprotected and casual sex, with the risk of HIV infection, was anticipated. With a current HIV prevalence rate of 10.6 per cent in South Africa, the need to strengthen, sustain and support HIV prevention strategies was identified.
The aim of the intervention

The NDoH, with support from UNFPA, requested the services of a consultant to support the Government’s efforts in the context of STI-HIV prevention during the 2010 Soccer World Cup. The aim of the project was to provide technical support to the NDoH in the planning and coordination of supplies of male and female condoms and the distribution process during the Soccer World Cup. Additionally, the project aimed to update condom distribution points, to train providers on reporting and monitoring tools, and to document the process in order to inform preparations for future events of this nature.

The project was implemented between June and September 2010. MatCH (Maternal, Adolescent and Child Health) supported and monitored condom distribution in the provinces where the FIFA World Cup soccer matches were played. The number of condoms distributed was collated on a weekly basis in all provinces, using a reporting form. Overall, 5,047,675 male condoms and 56,009 female condoms were distributed during the FIFA World Cup period. Staff working at the soccer venues were trained in the use of the reporting form, which was developed by MatCH for monitoring condom distribution. All project activities were closely monitored against the set objectives.

Key challenges experienced

The intervention had a number of challenges, such as the late approval of the work plan, which delayed the planning process and led to inadequate time to prepare for the start up, the implementation of activities beyond the World Cup and preparation of the final project report. Difficulties were experienced regarding the long distance management of the project by the consultants. Support and monitoring had to be done simultaneously in all eight provinces where matches were being played, as well as other provinces where the fan parks and public viewing sites had distribution points. It was not possible to suggest changes to the provincial plans as staff from the NDoH were already in the field when the consultant’s support began.

Planning and implementing the activities

The activities in the planning phase included the mapping of all FIFA World Cup Soccer stadia, in order to have a clear picture of the geographic distribution of these venues, to facilitate effective condom distribution strategy planning. In preparation for condom distribution, the NDoH, through consultative meetings, developed a condom distribution plan for the period of 9 June to 11 July. Central to the plan was ensuring that all local and international soccer fans and the community in general could easily access male and female condoms and that these commodities were freely available. Planning meetings were held by the NDoH together with the provinces to ensure the harmonized preparation of condom distribution plans that were customized to provincial conditions and the demand and supply. The condom distribution plan included establishing health desks in each of the 10 accredited country-wide soccer stadia and 12 fan parks, including 59 PVAs.

The implementation of the condom distribution plan during the FIFA World Cup included the availability of a health desk with NDoH (HIV and Health Promotion) staff to distribute male and female condoms and health information to soccer fans at each of the ten stadia, PVAs and fan parks on a daily basis or on selected days, as decided by the provinces and local municipalities. The health desks were used to distribute information and educational material on different health issues and to promote, demonstrate and distribute male and female condoms. This activity also entailed the collation of statistics to determine the number of condoms distributed during this period.
**Progress and results**

A MatCH reporting form was developed and shared with provincial and district managers. Staff members responsible for distributing condoms were trained on how to use the tool. Overall, over 80 staff members received training on the reporting form designed by MatCH. Consensus was reached, with provinces allowing staff to use either the MatCH reporting form or the existing bin card. Stock control was based on the existing condom logistics management and information system (LMIS).

Distribution reports were collected on a regular basis (weekly, in most cases) and distribution numbers were confirmed with Health Promotion and the HIV Coordinators in the provinces. In addition to the distribution of condoms, successes, gaps, challenges and recommendations were also documented. MatCH played an important role in coordinating and monitoring the condom distribution process, which was complicated and difficult at times as activities were undertaken in multiple venues.

**Lessons learnt**

The following lessons were learnt from this initiative:

- Planning for a national project requires adequate buy-in time to ensure that all key players are on board and to effectively coordinate a multi-sectoral approach to HIV prevention.
- Condom distribution during short-term, high-profile events can increase awareness and may have a ripple effect on changing sexual behaviour among people.
- Sharing programme plans with other sectors may increase support and demystify personal stigma (e.g. police, municipal officers, etc.) for large and complex events.
- South Africa was able to plan and successfully implement a nationwide HIV prevention programme based on condom distribution at relatively short notice.
- Assigning a neutral organization to coordinate, support and monitor a programme such as this was effective as there was no opportunity to engage in local issues (territorialism, personal issues, etc.).
- A dialogue on HIV prevention and the use of condoms (especially the female condom, with which some people were not familiar) was established through the project with people of different ages, ethnic groups and races.

**Conclusions and recommendations**

The FIFA RHCS project was accepted and received positively by national and provincial DoH staff. Full cooperation, commitment and participation in the project from senior personnel across partners at all levels and provinces is critical for the success of an intervention of this scale. Projects of this nature need to be planned even further in advance to ensure the support and ownership of all key partners.

The project provided an opportunity to increase coordination among government and civil society members at various levels, which strengthened the South African Government’s ability to scale up the provision of accessible condom distribution for similar future events. It is hoped that other countries that host large-scale, international sporting events in future would be able to benefit from the lessons learnt in South Africa and advocate for their governments as well as international sporting bodies to include condom distribution. This would be an opportunity for all communities to build broader community awareness and strengthen access to reproductive health services.

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Training of Health Providers in PMTCT in Zimbabwe

The HIV and AIDS epidemic has had a devastating impact on Zimbabwean society, especially on women and girls of reproductive age, and children. The estimated adult HIV prevalence was 15 per cent in 2008 and this was projected to decline to 13 per cent in 2009.

The prevalence in young females aged 15 to 24 years was projected to rise to 7.5 per cent in 2009, compared to 3.5 per cent in young males. The prevalence among pregnant women aged 15 to 49 years was as high as 17.7 per cent in 2008, but was projected to decline to 16.9 per cent in 2009.

As a result, HIV has been associated with up to 25.5 per cent of maternal deaths, which rose from a low of 283 deaths per 100,000 live births in 1994 to 725 in 2007. This meant that as many as 105,740 children were living with HIV in 2009.

Constraints to health-care services

The capacity of primary health-care services in Zimbabwe to respond to the devastating impact of HIV and AIDS has been constrained by the lack of integrated provision of maternal and child care services and comprehensive Prevention of Mother-to-Child Transmission (PMTCT) services. A major factor behind this has been the absence of integrated training for health workers. In addition to a severe shortage of human and financial resources, this has led to missed opportunities in providing comprehensive services to mothers and children and the reduced effectiveness of both maternal and child health (MCH) and HIV interventions.

A related problem has to do with the sub-optimal implementation of training programmes. The high loss of staff from their posts has brought about the need for continuous training. The presence of MCH and PMTCT programmes that target the same provider has meant that health workers have been overwhelmed by parallel training programmes and reporting systems.

Rapid assessment of SRH and HIV linkages

A rapid assessment of sexual and reproductive health (SRH) and HIV integration and linkages, which was conducted in 2010, found that the reproductive health (RH) and HIV policies of the country were generally weak on integration, although calls for integration did exist in some policy documents. The assessment also observed that separate RH and HIV Units in the Ministry of Health and Child Welfare (MoHCW) meant their interaction and coordinated programme management and supervision were inhibited.

Other gaps in achieving integration were poor referral and follow-up of clients and the absence of monitoring and evaluation (M&E) tools and registers to record integration.

The recommendations that emerged from the training included the development of a national plan on integration, and adapting health worker training, and the setting up of health facilities and M&E systems to accommodate integration.
It was in this context that the PMTCT Department in the AIDS and Tuberculosis (TB) Unit and the RH Unit of the MoHCW initiated a collaboration to strengthen the integrated provision of maternal and newborn health (MNH) and comprehensive PMTCT services by providing integrated training to health providers in both areas. This involved a process of merging and adapting a number of documents on PMTCT, HIV care, antenatal care and emergency obstetric care to develop a training manual on integrated maternal and neonatal care and comprehensive PMTCT, and the provision of training to health workers on the use of the manual.

Strategy and key challenges

The intervention aimed to strengthen the integration of HIV prevention and care in maternal services through the integrated training of health providers in maternal and neonatal care and comprehensive PMTCT.

Achieving collaboration between the RH Unit and the PMTCT Department of the AIDS and TB Unit to develop and implement the training programme on integrated MNH and HIV prevention and care services initially proved a challenge. This was achieved, however, through the readiness of the heads of the RH and PMTCT Units to collaborate on this effort and the support provided by the Director of Preventive Services. Operational norms, the setting up of health facilities that have been oriented towards a vertical provision of services, and weak supervision systems remain challenges to be overcome.

Implementation of the intervention

The PMTCT Department of the AIDS and TB Unit and the RH Unit of the MoHCW implemented the following steps:

A training manual on the Integrated Management of Adolescent and Adult Illnesses (IMAI) and Integrated Management of Pregnancy and Child Birth (IMPAC) was developed in a participatory manner in 2010-2011. Initially this involved a meeting of health experts and professionals, including paediatricians, doctors, provincial medical directors and provincial nursing officers, who identified the relevant WHO recommendations and MoHCW training manuals and guidelines for integration into the training manual.

With the support of a consultant, professionals from various departments, including the PMTCT and Opportunistic Infections (OI) Departments in the AIDS and TB Unit, the RH Unit, the Zimbabwe National Family Planning Council and other partners, subsequently developed the manual through individual and group work. The manual covered issues such as antenatal care, management of labour and delivery, provider-initiated counselling and testing (PCT), counselling for HIV prevention including disclosure and dual protection, family planning for HIV-negative and HIV-positive women, ART for HIV prevention and treatment, as well as the recording of services in maternal and HIV registers.

Finally, a five-day workshop was held, at which provincial RH officers and sisters in charge of labour and delivery pre-tested
the training manual. In the second quarter of 2011, the MoHCW proceeded with integrated training for health-care providers at the national, provincial and district levels.

Progress and results

Collaboration was achieved between the RH and AIDS/TB Units in the Division of Preventive Services to develop the integrated training manual and to plan and implement roll out of the training. Since training activities started, 30 national-level health service providers and 300 provincial-level health service providers have received training, and the roll out of training to the district level has taken place.

The programme has optimized the use of human and financial resources and reduced the diversion of health workers from service provision for training. The training has also enhanced the capacity of the health system for integrated MNH and PMTCT services, supervision, planning and monitoring and evaluation.

The impact at the level of service and end beneficiaries will be measured alongside further programme measures at the district and community levels for the promotion of integrated services.

The lessons learnt

A number of lessons can be learned from this intervention. The placement of the RH and AIDS/TB Units in the Division of Preventive Services, reporting to its director, and the willingness of the heads of the RH and PMTCT Units to work together has been crucial in achieving the coordination necessary to develop and implement the integrated training.

Advocacy and support from partners has also been an important factor in the initiation and implementation of the training programme in integrated services. And finally, integrated training has allowed the optimal use of limited resources and reduced the diversion of health workers from their normal activities. This is an outcome that has been appreciated by Provincial Medical Directors, whose support is important for the success of the training programme.

Conclusion and way forward

In conclusion, the IMAI/IMPAC training has optimized the use of financial and human resources to build the capacity of the health system to provide integrated maternal and neonatal care and comprehensive PMTCT services. The intervention also provided an important link to translate political commitment for linkages into integrated services, through more streamlined health personnel training at the system level.

The next step is to strengthen the capacity of districts to supervise the provision of integrated MCH and HIV services, including the development of adequate supervision tools. Institutional support should be provided to health providers and the physical setting up of health facilities should be adapted to fully implement integrated services.

Also, a revision of antenatal and maternity registers should be implemented to measure integrated services and develop registers for postnatal care. The National Integrated Health Facility Assessment to assess the impact of the IMAI/IMPAC training on the provision and utilization of integrated maternal and PMTCT services needs to be implemented. Finally, the training of different cadres of community health workers needs to be harmonized and integrated to enhance their capacity to strengthen awareness, utilization and impact of integrated services.

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Empowering young sex workers for safer sex in Malawi

For Malawian girls, the selling of sex has become an increasingly popular means of acquiring money and material goods, especially in urban areas (FPAM, 2004). Scores of young people can be seen loitering in the streets in front of hotels, casinos, bars, discos and other entertainment venues.

In a needs assessment study in Lilongwe and Dowa districts of central Malawi, it was found that 61 per cent of young sex workers depended solely on their earnings from sex work for their living (FPAM, 2004). While the study and intervention in Dowa captured sex workers whose ages ranged from 18-49 years old, it became clear that minors as young as 12 years old were involved in sex work. Moreover, these young girls are subjected to unprotected sex for various reasons, including failure to access condoms and pressure from their clients, who bargain to pay more if they do not use a condom.

The consequences that arise from this situation are infection with STIs, including HIV, and teenage pregnancy leading to young motherhood or unsafe abortions. The majority of these young women were knowledgeable on the transmission, signs and symptoms, and prevention of HIV and other STIs. The young women indicated that they were aware of the relationship between ‘sex work’ and HIV and AIDS, yet 72 per cent have had unprotected sex and 21 per cent indicated that they have had an STI. Although prostitution is illegal in Malawi, many young girls regard it as an easy way to obtain money and material goods.

Intervening on behalf of sex workers

In 2004, the Family Planning Association of Malawi (FPAM), with financial assistance from UNFPA, the United Nations Population Fund, implemented an intervention targeting sex workers in places of entertainment by cooperating with the owners of discos, pubs and other venues, and working with disc jockeys and some willing sex workers. The project employed various IEC media to provide short but moving talks using stories and other messages that would empower and encourage the sex workers to insist on correct and consistent use of condoms, regardless of how much a client is willing to pay. The messages were also designed to encourage the young sex workers to rethink their reasons for engaging in sex work, and to opt for other sources of income generation to earn a living.

This study investigated the involvement of sex workers as peer educators. It also looked at the role of disc jockeys and the owners of discos, pubs and other entertainment venues, as partners in an IEC campaign to empower young sex workers to reduce STI infections, including HIV.

The intervention was implemented in Dowa and Lilongwe districts. Sensitization seminars were held with 200 sex workers, at which information on HIV was shared through presentations, group discussions and testimonies. Sex worker action groups were formed so that they could be used as a contact point for the intervention.
Out of the sex workers that participated in the seminars, volunteer peer educators were identified. These peer educators were given six days of training in a workshop setting, where they learnt about HIV transmission and prevention, negotiation skills for safer sex, the use of male and female condoms, rights and how to fight sexual abuse, violence and exploitation, and other options for income generation. A workshop was held for DJs, proprietors of entertainment venues and sex worker representatives to orient them on the initiative and seek their support.

**Distributing condoms and messages**

During the intervention, the entertainment venues were used to promote and distribute condoms and to put peer educators in touch with sex workers. The DJs issued safer sex messages between songs and used other activities related to sexual and reproductive health. Condom and safer sex promotional events were held weekly, during which condoms were distributed free. On average, each venue was issued about 1000 males condoms a week. The national average consumption of condoms was about 4.5 condoms per person per year. As over 1000 condoms were issued per site serving about 100-200 clients a week, this was regarded as sufficient.

Special quiz sessions on HIV were held, with prizes awarded to those taking part, including calendars, t-shirts, ball point pens and packs of condoms.

The intervention established 16 condom dispensing sites in toilets in entertainment venues, for easy access by sex workers. Condoms were also distributed through peer educators in residential areas and in the entertainment venues. A Safer Sex Kit was produced and printed for the sex workers. This contained guidance on safer sex, negotiation skills and what to do if abused. It also contained instructions on how to correctly use male and female condoms. Voluntary counselling and testing and STI services were offered through Youth Life Centres or at the entertainment venues. Follow up was a component of the project.

**Results of the intervention**

Sensitization workshops were carried out and 85 sex workers were reached. An orientation workshop was held for nine DJs and ten proprietors of entertainment venues. Six sex worker representatives were also oriented. Twenty-five peer educators were recruited and trained. A total of 3000 flyers and 200 posters containing safer sex negotiation points were produced and distributed. Nineteen safer sex and condom promotion sessions were conducted in 19 entertainment venues, reaching an estimated 47,000 people. Of these, 1800 were sex workers (about 20 per cent of them minors). This was determined from the baseline survey and the rudimentary size estimation exercise conducted.

Through Youth Life Centres and outreach clinics, 241 sex workers were offered VCT services. A total of 416,038 male condoms and 60,644 female condoms were distributed. Of the 1028 VCT clients, 452 were sex workers. More than 87 per cent of the sex workers tested HIV positive. A similar number (452 sex workers) received treatment for STIs. In the intervention area, 604 beneficiaries received family planning services.

**The lessons learnt**

A number of lessons have been learned from this exercise, as follows:

- Innovative methods can be used to reach out to sex workers and their clients, including using disc jockeys, to increase access to services in a less stigmatized environment and manner.
- Lack of access to condoms is a major impediment to their use. With this innovation, access to condoms was made easy and hence there was an increase in uptake.
- The project has good potential for replication as it is affordable and can be applied in nearly all settings.

**Recommendations**

The following are recommended:

- Collaboration with the owners of entertainment venues is key to project implementation.
- The involvement of DJs increases the participation of sex workers and their clients in project activities.

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Sex work and HIV – checking the reality on the ground in Namibia

Sex workers are a key high-risk population group for Namibia’s plans to tackle HIV and AIDS. However, up until 2011 little was known about their needs and challenges and nor were there national guidelines for effective, rights-based programming with sex workers. A series of rapid assessments on sex work and HIV was conducted by sex workers to identify common issues.

Sex work is widespread in Namibia. Sex workers are disproportionately affected by HIV and they are more vulnerable to infection due to their having a higher-than-average number of sexual partners, as well as the attitudes and behaviours of service providers, the authorities and the wider community. They have been identified as a priority population in the country’s National Strategic Framework for HIV and AIDS.

**Funding to scale up HIV prevention**

Funding from the Global Fund to fight AIDS, Tuberculosis and Malaria and from USAID is enabling a significant scale up of HIV prevention and treatment efforts with sex workers in Namibia. In this context, a series of rapid assessments on sex work and HIV was conducted by sex workers with the support of UNFPA and UNAIDS Namibia and the Society for Family Health (SFH). This was implemented as part of UNAIDS’ programme acceleration funding (PAF) award to UNFPA Namibia.

The assessments were designed to provide a better understanding of the situation of sex workers, their vulnerability to HIV and their access to services, as an invaluable guide to programming to reduce HIV and AIDS. A participatory approach was chosen because there is considerable evidence that the active participation of and increased solidarity among sex workers – as well as addressing HIV through a framework of human rights – are essential to making programmes targeting them more effective.

**What the rapid assessments entailed**

Rapid assessments on sex work and HIV were carried out in five towns in Namibia in October 2011. The aim was to engage sex workers in assessing the barriers to HIV prevention and treatment and proposing relevant solutions in five towns in Namibia, to build the capacity of sex worker leaders and organizations at the national and local levels, and to foster community participation and empowerment approaches.

The 17 sex workers trained to conduct the assessments in Kalkrand, Katima Mulilo, Oshikango, Walvis Bay and Windhoek conducted 29 focus group discussions with 212 sex workers.

**Common issues identified**

A number of issues were raised in most or all of the towns, including that sex workers faced stigma from health care providers and the community, had a preference for traditional medicine, experienced violence from a number of sources, such as police and private security forces, and were vulnerable to extortion and abuse from police officers. However, the way in which these affected the sex workers differed for each location.
Lessons learnt and recommendations

A number of recommendations can be offered to the relevant ministries, non-governmental organizations (NGOs), United Nations (UN) agencies and donors:

• The findings should be used to address issues identified in each town.
• Sex worker associations and empowerment should be supported in the five towns.
• The process should be replicated in other parts of Namibia. Particular attention should be paid to towns where there are no planned programmes.
• The findings will be used to raise awareness and advocate for national-level action.

Kalkrand

Kalkrand is a small town on the road between Windhoek and Keetmanshoop. It is a common stopping point for trucks and it has bars, shebeens and a service station. The Kalkrand team organised three focus group discussions and met 25 sex workers. One of the focus group discussions was attended exclusively by male sex workers, and the other two by women. The age range of participants was 18-40 years old and, for the majority of them, sex work was their only source of income.

Participants in all three of the group discussions talked about the frequency of stigma from within the community, which leads to insults, to the exclusion of sex workers from community activities and in some cases to violence. Many participants said that they had experienced difficulties in getting the police to take seriously their complaints about abuse from other sources. As one participant stated, “the only ones treated well are those who can bribe [the police] or are friends with [the] police.” It was noted that transgender sex workers are a particular target for abuse from within the community.

Almost all of the participants said that their work environment was not safe. Because most clients are truck drivers, they spend little time in the town, making it difficult for sex workers to assess whether they are prone to violence. At the same time, most paid sex in Kalkrand takes place in the veld (open field) since there are no hotels or other establishments, making it easier for clients to get away with violent acts or refusing to pay.

“Sometimes if you want condoms there is nothing [available], so [using a] plastic [bag] or unprotected sex seems the only way. We need more condoms at hotspots or just [to] leave some for safety at homes or in the shebeen or club.”

“We keep our illnesses to ourselves. We can’t go to the clinic because [then] the whole of Kalkrand will know you are sick or have an STI.”

“We use Savlon or Dettol to treat STIs, or traditional medicine.”
Sex workers said they often found it difficult to find condoms, in particular free condoms, resulting in high levels of unprotected sex with clients.

Access to health services is problematic. There is only one clinic in Kalkrand, and in all three group discussions the sex workers said they did not feel that confidentiality would be maintained. Thus they typically seek alternatives. Some travel to a nearby town, Mariental, to get health care, but given the distance involved, it is also common to ignore symptoms or to self-medicate.

**Priorities and recommendations**

The discussions provided momentum to make improvements. These are as follows:

The group of male sex workers expressed a wish to meet with female sex workers to work together and build a joint response to some of the problems.

Working to change the behaviour of local health care workers towards sex workers, and to ensure confidentiality for sex workers so that they access reliable health care and treatment, was also proposed.

The team met with the village councillor to discuss the issues of stigma and abuse of sex workers, as a promising route to working towards improving the situation.

In Kalkrand, mapping where services and sex work locations are is straightforward due to the town’s small size. However, any programmes developed for the town should take account of the fact that the volume of sex work fluctuates, with far higher numbers at certain times of the year.

Perhaps the biggest challenge for follow up in Kalkrand is that it is not included in any of the major programmes on sex work and HIV being run by NGOs or international partners in Namibia. In order to keep up the momentum, it will be necessary to look for alternative sources of funding to support what has been started there.

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Developing a national EMTCT of HIV plan in Rwanda

The government of Rwanda has developed a national strategic plan for the elimination of mother-to-child transmission (EMTCT) of HIV by 2015, in collaboration with its partners in the fight against HIV.

Rwanda is one of 13 countries in East and Southern Africa (ESA) to develop an EMTCT plan. The Rwandan plan is comprehensive in that it involves all four prongs of EMTCT, and it is currently being adapted at the district level. The target of this plan is to reduce new paediatric HIV infections by 90 per cent by the end of 2015 and the overall population-based MTCT rate to 2 per cent at 18 months.

This will be achieved by focusing on the four MTCT prongs, as follows: preventing HIV infection in women, preventing unintended pregnancies in women living with HIV, providing ARV treatment and treating women living with HIV and their families.

Preventing HIV infection in women

The first prong is the primary prevention of HIV infection among women of reproductive age. This aims to prevent men and women of reproductive age, particularly adolescent girls, from contracting HIV. Different strategies will be used, including ABC (Abstinence, Being Faithful and reducing number of sexual partners approach, consistent and correct Condom use), prevention and early treatment of sexually transmitted infections (STIs), HIV testing and counselling, male circumcision and prevention of blood-to-blood transmission.

Preventing unintended pregnancies in women living with HIV

The second prong is preventing unintended pregnancies among women living with HIV. This addresses the long-term family planning and contraceptive needs of women living with HIV. It includes preventing HIV transmission from a woman living with HIV to her infant, early ANC visits and routine provision of HIV testing and counselling during ANC, labour, delivery and the postpartum period. The policy encourages the involvement of male partners in the national PMTCT programme.

Providing ARV treatment

The third prong involves the provision of triple ARV therapy (HAART). In November 2010, Rwanda adopted the new ARV regimen for the use of ARVs in PMTCT. All HIV-positive pregnant women will receive triple ARV therapy (HAART), starting as early as possible during pregnancy for women eligible for life triple therapy, and from 14 weeks of pregnancy for women not eligible for life treatment.

Treating women living with HIV

The fourth prong is providing appropriate treatment, care and support to mothers living with HIV, and also to their children and families. Rwanda promotes the systematic enrolment of all HIV-positive pregnant women and children in the comprehen-
sive treatment, care and support programme (which includes check-ups, counselling, ARV and other treatment, and breastfeeding advice) and promotes the integration of care and treatment programmes within PMTCT settings.

**Accelerating the implementation of EMTCT**

After Rwanda’s First Lady, Jeannette Kagame, launched the national EMTCT initiative in May 2011, the Rwanda Biomedical Center (RBC) and partners in PMTCT saw the need to develop a national plan to provide a framework to accelerate the implementation of EMTCT.

The strategic plan took three months to be developed, from December 2011 to February 2012. The process was led by the HIV clinical prevention unit of the RBC, which actively involved the Technical Working Groups (TWGs) for clinical prevention, district health workers, UNFPA staff in charge of family planning or family planning/HIV integration, and networks of People Living with HIV (PLHIV).

The development of the strategic plan had four stages.

**Establishment of technical working sub-groups**

Firstly, four technical working sub-groups were set up in July 2011 to look into the performance of prevention of mother-to-child transmission (PMTCT), including its achievement, gaps and challenges, and to outline priority interventions and key indicators for EMTCT. RBC and its partners then carried out a gap analysis for the PMTCT programme.

**Comprehensive bottleneck analysis of the PMTCT programme**

Secondly, a full assessment of the current PMTCT programme was undertaken in November and December 2011 to better understand and evaluate programme performance as well as to identify and address any challenges, gaps and bottlenecks. It also aimed to provide evidence-based strategic guidance for priority interventions to achieve the goal of elimination.

**Consultative meeting for the development of national EMTCT strategy**

Thirdly, several consultative meetings were organized with members of the Technical Working Groups to identify priority programme areas for accelerated EMTCT programme implementation. RBC organized a strategic planning workshop in December 2011 to share the findings of the analysis with partners and district health workers and to carry out an analysis of evidence-based bottlenecks for the PMTCT programme, as well as to define key outcomes and outputs for the EMTCT strategic framework.

The workshop was attended by over 40 participants from the Institute of HIV and Disease Prevention and Control (IHDPC), the Rwandan Biomedical Center (RBC), Technical Working Group (TWG) members, district health workers, and representatives from other governmental institutions.

**Involving networks of people living with HIV in the EMTCT strategy**

Finally, networks of women and girls living with HIV were consulted at a meeting, to ensure that PLHIV networks contributed to the development of the EMTCT strategy. This was organized by IHDPC and UNAIDS. More than 25 network members attended.

The next stage is to develop an EMTCT plan in all 30 districts, which will be endorsed by the district authorities.

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Zimbabwe’s Behaviour Change Programme: a unique approach

In Zimbabwe, four out of five HIV infections are due to sexual transmission in relation to multiple sexual partnerships (including concurrent), sero-discordance in long-term partnerships and transactional sex.

A National Behaviour Change Strategy (NBCS) was developed in 2006 under the leadership of the National AIDS Council. It had four key outcome areas – creating an enabling environment for behaviour change, increased adoption of safer sexual behaviour and reduction in risk behaviour, increased utilization of HIV prevention services, and improved national and sub-national institutional frameworks to address behavioural change.

Since 2007, a large-scale Behaviour Change Programme has been implemented in 26 out of 61 districts of Zimbabwe through eight NGOs contracted by UNFPA. In order to increase community capacity to address HIV risk and underlying socio-cultural norms, traditional, political and religious leaders received training as role models and advocates, while community members attended a community course using the Love & Respect manual along the lines of the stepping stones model.

The community course consisted of core sessions moving from personalized risk perception towards building skills for HIV prevention. Since 2010, the programme has been scaled up nationwide. The application of a nationwide model of behaviour change promotion, implemented in two phases, offers unique opportunities for evaluation. Initially it covered 40 per cent of the country (2007-2009) and later the whole country (2010-2011).

Research and M&E were conducted alongside the intervention to demonstrate the programme’s impact, based on a multi-method evaluation, and to inform future programming in the Behaviour Change Programme and other HIV and AIDS interventions.

Objectives of the M&E and research measures

The impact of the National Behaviour Change Programme was measured using various methods. Firstly, a baseline survey was carried out in four provinces in 2007. In each province, four districts were covered, of which two were focus districts where the National Behaviour Change Programme was implemented with ESP or EC support, while the two others were districts without such additional support (non-focus districts). A total of 4879 respondents aged 18 to 54 participated in the survey, including 2948 women and 1931 men.

Secondly, an interim survey was carried out in four focus districts and two non-focus districts in 2009. The same focus districts were used as they had been randomly selected for inclusion at baseline and they were sited in the provinces where implementation of the National Behaviour Change Programme had been progressing well according to programme monitoring and in line with the programmatic plan. The non-focus districts were selected from those surveyed at baseline in each of the survey provinces. A total of 2746 people were sampled during the survey, 64 per cent of whom were female.

Thirdly, an independent qualitative review was carried out in selected districts in 2009 through key informant interviews, focus group discussions (FGDs) involving leaders, community facilitators and community members, and participant observation of community sessions.

Fourthly, antenatal care (ANC) data relating to 2006-2009 for women aged 15-24 years was taken from the initial focus and non-focus districts. In an impact assessment in 2011, the different study results were synthesized and the potential impact was estimated in terms of infections averted.

Fifthly, a Modes of Transmission (MOT) analysis was undertaken in 2010. Moreover, UNFPA supported a case study on HIV decline in partnership with Harvard University and the Imperial College London in 2010. In an impact assessment in 2011, the different study results were synthesized and the potential impact was estimated in terms of infections averted. And lastly, in 2011 a final evaluation survey was conducted in
the same four provinces (baseline and interim survey) in 16 districts (eight Phase I and eight Phase II districts) included in the baseline survey. To ensure that data were captured on coverage of other areas (31 districts that commenced programming in 2010), the geographic scope of the survey was increased by including the cities of Harare and Bulawayo and the remaining four provinces.

The challenges faced

The measurement of impact was conducted through a series of population-level, cross-sectional surveys. The survey results indicated the positive effect of the interventions on planned programme outcomes and impact. Conclusive proof of the impact of the National Behaviour Change Programme, however, could only be determined by large-scale longitudinal studies, which are very costly and might have prevented actual services from being implemented.

Measurement and demonstration of the impact of a single intervention can be difficult where there are other interventions and other factors that can influence changes.

Results

The 2009 qualitative review documented a number of individual stories of behaviour change and community-level normative changes, including reported improvements in communication in marriage, partner reduction and openness about HIV status. It found that the programme was theoretically sound, culturally appropriate and generated an impact.

The 2009 interim evaluation survey suggested that individuals exposed to the programme were more likely to have fewer current sexual partners (2+ vs. 0 partners OR 0.82, p=0.003), were more likely to use condoms (OR 1.31, p=0.033) and were more likely to have tested for HIV (OR 1.56, p<0.001).

Respondents in focus districts of the programme (versus those from non-focus districts, while controlling for the 2007 base-line) had fewer current sexual partners (2+ vs. 0 partners AOR 0.49, p<0.001), were more likely to have a high knowledge of HIV (AOR 1.46, p=0.039) and to have heard a leader speaking out against men having extramarital relations (AOR 1.76, p<0.001).

HIV prevalence among ANC attendees in the focus districts declined from 14.8 per cent to 12 per cent while remaining stable at 11.4 per cent in non-focus districts. After controlling for baseline prevalence and socio-demographic factors, HIV prevalence among ANC attendees in focus districts was 24 per cent lower than in non-focus districts (AOR 0.76, CI 0.53-1.09; p=0.131). While not statistically significant, it has been estimated based on a number of other hypotheses that this level of impact would translate into around 40,000 HIV infections averted at a cost below US$300 per infection averted. Yet clearly, this estimate needs to be viewed with much caution.

Objectives of the M&E and research measures

There are three lessons to be learnt from this intervention:

It is important to plan for programme evaluation and set aside sufficient funds. The national evaluation of the Behaviour Change Programme was planned and included in the budget of the three serial population-level, cross-sectional baseline, midterm and final surveys. These made it possible to evaluate the programme over a period of time and demonstrate the emerging impacts.

The Behaviour Change Programme was based on the National Behaviour Change Strategy 2006-2011 and thus it was implemented as a national programme. This made it possible for the programme evaluation to benefit from other evaluative national data such as the antenatal care data of 2006-2009, which provided data for the number of people tested for HIV.

The national approach of the Behaviour Change Programme implemented by Zimbabwe can potentially be replicated by other nations in a similar setting or with high HIV prevalence.
The available evaluations and reports on the programme make it possible for other nations to learn from and adapt it to their settings.

**Conclusion and recommendations**

A comparison of the baseline and interim surveys indicates that over time, there have been a number of changes in attitude towards HIV and risk-reducing behaviours. These changes were more pronounced in communities where the National Behaviour Change Programme is being implemented vigorously. Of note, there has been an increase in HIV testing, an increase over time of the age at first sex, a reduction in the number of sexual partners (lifetime, in last year, and current) and an increase in reported condom use. Further analysis of the final evaluation survey (2011) is currently underway to better determine the impact of the programme.

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