IOM International Organization for Migration

# Emerging Good Practices

## in Migration and HIV Programming in Southern Africa

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## FOREWORD

With far more migrants in the world, today than ever, carefully managed migration is a powerful force for development. Human mobility in southern Africa impacts on the individual health of migrants, as well as the public health of host communities. This, coupled with the highest prevalence of HIV globally, means that migrants and those affected by the migration process in southern Africa are particularly vulnerable to HIV (UNAIDS, 2010).

A better understanding of the relationship between HIV and human mobility in southern Africa is essential for the development of appropriate measures for HIV prevention, treatment, care and support to reduce HIV vulnerability among host communities as well as migrant communities.

The aim of this document was to identify, assess and document emerging best practices based on work done under the IOM's Partnership on HIV and Mobility in Southern Africa (PHAMSA). PHAMSA projects are based around a comprehensive HIV model, and implemented in migration-affected communities in collaboration with implementing partners (IP's) in Swaziland, Mozambique, Lesotho, South Africa and Zambia within the mining and agricultural sector.

This report analyses the activities implemented thus far and their impact in terms of capacity-building and community mobilisation. This enables the identification of specific interventions that are emerging as promising practices to reduce HIV vulnerability within migration-affected communities in the southern Africa region and promote regional exchange of knowledge and skills to scale up HIV responses among affected communities.

This report is designed to help governments, public health practitioners, civil society, academics and other stakeholders to respond to the needs of migrants, their families and those they interact with.

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# LIST OF ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired immunodeficiency syndrome |
| **AMS** | AIDS Management Standard |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **BCC** | Behaviour Change Communication |
| **CAT** | Community Action Team |
| **CHAMP** | Comprehensive HIV/AIDS Management Programme |
| **DOTS** | Directly Observed Treatment |
| **EU** | European Union |
| **FGD** | Focus-Group Discussion |
| **GDA** | Global Development Alliance |
| **HBC** | Home-Based Care |
| **HIV** | Human Immunodeficiency Virus |
| **HPSD** | Health Promotion and Service Delivery |
| **HTC** | HIV Testing and Counselling |
| **HTT** | Hoedspruit Training Trust |
| **IEC** | Information, Education, Communication |
| **IOM** | International Organization for Migration |
| **ISO** | International Organisation for Standardisation |
| **M&E** | Monitoring and Evaluation |
| **NERCHA** | National Emergency Response Council on HIV and AIDS (Swaziland) |
| **NGO** | Non-governmental organization |
| **PHAMSA** | Partnership on HIV and Mobility in Southern Africa |
| **PLWHA** | People Living with HIV/AIDS |
| **PMTCT** | Prevention of Mother-to-Child Transmission |

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| **RSSC** | Royal Swazi Sugar Corporation |
| **SADC** | Southern African Development Community |
| **SBCC** | Social and Behavioural Change Communication |
| **SDC** | Sibambene Development Communication |
| **SGJN** | Sonke Gender Justice Network |
| **STI** | Sexually Transmitted Infection |
| **SWABCHA** | Swaziland Business Coalition on HIV/AIDS |
| **TB** | Tuberculosis |
| **TSA** | Technical Support Assistant |
| **UN** | United Nations |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNDP** | United Nations Development Programme |
| **UNFPA** | United Nations Population Fund |
| **USAID** | United States Agency for International Development |

# GLOSSARY OF TERMS AND KEY CONCEPTS

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| ***AIDS Mangements System (AMS):*** | The AMS provides guidance for effective HIV/AIDS management for southern African businesses by providing a framework for companies to manage the impact of HIV/AIDS. The AMS supports businesses to continually improve the effectiveness of their HIV interventions by, among other things, looking at key components such as the scope of an HIV/AIDS programme, formulating a policy on HIV/AIDS, conducting a risk assessment, conducting audits and reviewing audit findings by senior management. (http://www.amsi.org.za/documents) |
| ***Best/good practice*** | "A Best/Good practice on HIV and AIDS is a body of knowledge about an aspect of HIV prevention, treatment or care that is based on practical experiences and lessons learnt in a maturing field that can be replicated to improve the quality of an intervention that has as its objective the mitigation of one aspect of the HIV epidemic." (SADC, 2008) |
| ***Change agent*** | A person recruited and capacitated to engage in a concerted programme of action in a given community, to empower members of the community to effect beneficial individual and social change as defined within the community to enhance their well-being. |
| ***Contractor*** | An organization to which specific job functions are outsourced by organizations such as RSSC. They also employ workers under various conditions such as part time, seasonal etc. |
| ***Contract worker*** | A worker who is employed by a contractor. The worker may be employed as a permanent, temporary or seasonal worker. |
| ***Dialogue*** | Within the IOM social and behavioural change communication approach, dialogue is a non-threatening tool used to elicit details about needs, to communicate information and to provide feedback to beneficiaries. It is a key process that can take several forms, from one-to-one conversation to focus-group discussions (FGD), to informal talks during other activities such as building of communal gardens. It is a participatory process that allows beneficiaries to share experience, information and concerns and is facilitated by a change agent. |
| ***Drivers of the HIV epidemic*** | The term "drivers" relates to key factors that increase people's vulnerability to HIV infection (UNAIDS, 2008a). In southern Africa these include multiple and concurrent partnerships (MCPs) by men and women with low consistent condom use, low levels of male circumcision, male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness, untreated viral STIs. Underlying these drivers are the social and structural factors such as high population mobility, stigma and discrimination, human rights violations, inequalities of wealth, cultural factors and gender inequality that render people vulnerable to HIV infection. |
| ***Gender*** | Refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women (i.e. society's idea of what it means to be a man or woman). These attributions can change over time and from society to society. |

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| ***Health promotion and service delivery (HPSD) model*** | IOM's health promotion and service delivery model is based on health promotion and community development theory. It strives to address both the contextual and individual barriers to behaviour change that impact on a person's HIV vulnerability. The model provides a framework for project development and implementation. |
| ***HIV prevalence*** | Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. |
| ***Implementing partner*** | An organization supported by IOM to implement HIV prevention, care and support interventions in migration-affected communities as guided by IOM's health promotion and service delivery model. |
| ***Lekgotla*** | A traditionally male-only forum in Lesotho where community challenges and issues are discussed. |
| ***Lobola*** | An African traditional custom whereby the groom-to-be's family provide gifts or money to the bride-to-be's family, before marriage. It is used as a starting point to begin uniting two families. It can be compared to "asking for the woman's hand in marriage". |
| ***Migrant (including internal migrants)*** | At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where a decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without the intervention of an external compelling factor.<br>The term therefore applies to persons, and family members, moving to another country or region to better material or social conditions and improve the prospect for themselves and their families (IOM, 2004b). |
| ***Migrant worker*** | According to International Migration Law, a migrant worker is a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national (IOM, 2004b). However, within southern Africa, internal and cross-border migrants have similar vulnerabilities so within the scope of the IOM migration health programmes no distinction is made between cross-border and internal migrants. |
| ***Migration*** | The process of moving either across an international border or within a state. It encompasses any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people and economic migrants (IOM, 2004b). |
| ***Mobile population*** | People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons (IOM 2002). |
| ***Mobile worker*** | A worker who is forced by the nature of his/her job to move. Sectors that employ such persons include: transport (e.g. truck drivers), fisheries, informal cross-borders traders and state officials, including military personnel and immigration officials. |

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| ***Multiple and concurrent partnerships (MCPs)*** | Overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner (UNAIDS, 2009). |
| ***One Man Can*** | An intervention that promotes the involvement of men and boys in taking action against domestic and sexual violence, and healthy and equitable relationships that men and women can enjoy (Sonke Gender Justice Network). |
| ***Permanent employees*** | Workers employed in permanent positions who are considered critical/ core for the day-to-day running of the organization. For instance, human resources and administrative personnel. |
| ***Seasonal worker*** | A worker employed for a period of time to perform specific functions related to a particular season, such as harvesting, cutting, planting, weeding and so on. |
| ***Spaces of vulnerability*** | Spaces of vulnerability are locations where people's health is at high risk. Health vulnerability stems not only from individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns and interventions must consider and target both migrants/mobile populations as well as the communities with which they interact, such as families in migrant-sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass through or originate from and may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements. |
| ***Social and behavioural change communication*** | A process of public and private dialogue through which people define who they are, what they want, what they need and how they can act collectively to meet those needs and improve their lives. It supports processes of community-based decision making and collective action to make communities more effective and it builds more empowering communication environments. |
| ***Social determinants of health*** | The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. The circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices (Commission on the Social Determinants of Health, 2007). |
| ***Technical Partners*** | To support capacity building and empower implementing partners. IOM contracted specialised technical agencies whose role was to train, mentor and support implementing partners. Technical partners areas of expertise were 1) Gender and the involvement of men and 2) Social and behavioural change communication. |
| ***Temporary workers*** | Workers employed on a short-term basis, to perform any kind of job as required by the employer. Also referred to as casual workers. |

# 1. EXECUTIVE SUMMARY

The International Organization for Migration's (IOM) regional programme, Partnership on HIV and Mobility in Southern Africa (PHAMSA), ran from March 2007 until end October 2010. The aim of the programme was to reduce the vulnerability of migrant and mobile populations to HIV and AIDS in the Southern Africa Development Community (SADC) region. This was done by establishing partnerships with key stakeholders in southern Africa.

The PHAMSA programme targeted labour migrants in the construction, transport, commercial agriculture, fisheries, mining and informal cross-border trade sectors and consisted of four distinct, yet interrelated, components: advocacy for policy development; research; technical cooperation and regional coordination and on-the-ground pilot projects.

IOM advocates for a "spaces of vulnerability" approach to HIV programmes, based on the understanding that health vulnerability stems not only from individual knowledge and behaviour, but also from a range of environmental factors specific to the unique conditions of a place, including the relationship dynamics between mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns, and interventions must consider and target both migrants/mobile populations as well as the communities with which they interact, including families in migrant-sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work and pass-through or originate from (IOM, 2010b).

This document assesses and documents on-the-ground pilot projects in which IOM, in collaboration with partners in Swaziland, Mozambique, Lesotho, South Africa and Zambia, implemented a multi-faceted HIV response in migration-affected communities. The goals of these pilot projects were:

- To build capacity in the region to implement comprehensive HIV programmes as guided by the IOM's health promotion and service delivery (HPSD) project model;

- To reduce vulnerability to HIV and to mitigate the impact of AIDS among migrant and mobile workers, their families and the communities with which they interact through social and behavioural change interventions.

The projects – implemented in six different sites in southern Africa – targeted migrants, their families and the communities with which they interact, in the commercial agriculture and mining sectors. The projects all used a health promotion and community development framework by tailoring IOM's HPSD model, which IOM has been implementing since 2005. The model was piloted first in 2005 in Hoedspruit, South Africa. In 2007 it was expanded into five other sites in the region.

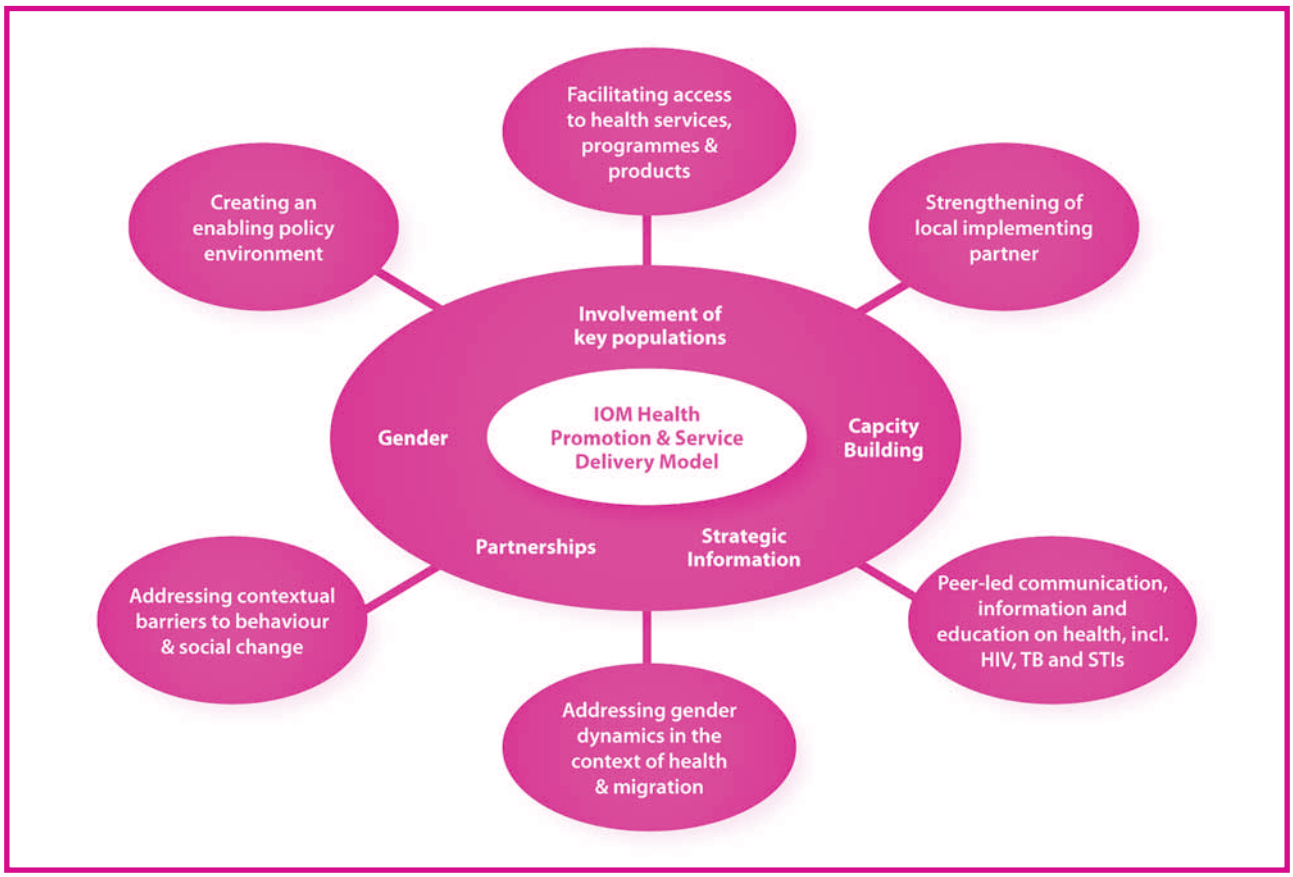



**Figure 1: IOM Health promotion and service delivery model.**

The HPSD model is based on health promotion and community development theory, and strives to address both contextual and individual barriers to behaviour change. The model provides a framework for project development and implementation, shown above. Details af the different components are discussed in section 4.4 (pg 20-21) .

Key to the model is social and behavioural change communication (SBCC), which is a rights-based approach that seeks to provide an opportunity for positive change through communication. This bottom-up approach empowers project beneficiaries to identify barriers to social and behavioural change and to take action to address these barriers. The approach facilitates local on-the-ground processes, rather than broad health messages, by recognizing that there is a difference between social marketing and social change

Central to the process are “Change Agents” (CAs). CAs are members of the target community who have committed themselves to driving the change process and who are capacitated with skills to enable them to engage with their peers in a structured manner. CAs are recruited and oriented in all sites and are the core of the communication and empowerment process. They (a) disseminate HIV/health-related information and promote adoption of healthier and positive behaviours and practices amongst their peers and communities, (b) engage in dialogue with peers to identify challenges in the community, (c) develop strategies to address the challenges, and (d) promote action for change.

This review aimed to assess: (a) the impact of each of the projects, and (b) the effectiveness of the IOM HPSD approach as a framework for addressing HIV vulnerabilities within migration-affected communities.

Using the SADC Framework for Best Practices (2008) to assess the projects and the model, IOM intend to share lessons from HIV interventions that are proving to be successful in migration-affected communities. The process of documentation included assessing seven key areas: effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability.

Key findings from this assessment and documentation process include:

- Using the HPSD model as a framework to guide local partners ensured a common vision and objectives but allowed for each intervention to be adapted to their own context so as to make them specific and relevant.

- The approach to social and behavioural change communication within the context of migration and HIV took social change to the local level. This enabled people in migration-affected communities to own the entire communication process as well the actions taken by the project in their name to address identified needs and build local partnerships to address barriers to change.

- The projects enabled beneficiaries to be empowered as communicators – rather than traditional peer educators – and as such respond to localized needs.

- The bottom-up approach to social and behavioural change has sparked renewed passion amongst "HIV-fatigued" communities, since it responds to real needs rather than providing traditional HIV awareness and prevention interventions (IEC, didactic peer education and so on)

- Addressing gender-specific vulnerabilities to HIV and AIDS within a migration context encouraged both men and women to promote action to address harmful gender practices.

- Identifying and targeting cultural gatekeepers (for example, traditional healers and leaders) is key to supporting and promoting social and behavioural change at the community level.

- By building a network between implementing and technical partners, lessons have been shared between different organizations working in similar fields in the region. Actively promoting learning and exchange saw the partners sharing and learning from each other, which has led to replication of tools and processes.

- Taking a sectoral focus (mining and commercial agriculture) not only allowed partners to learn from each other but also provided strategic information from across the region on common challenges and vulnerabilities faced by the different sectors.

- Private and civil-society partnerships and the lessons learned from these mutually beneficial arrangements need to be documented, shared and costed to support replication.

- Promoting the work of on-the-ground projects and programmes is a useful advocacy tool for policy development.

- The projects provided an opportunity for evidence to be gathered about marginalized groups – migrants, their families and communities affected by migration. This information can be used to: (a) ensure relevance and effectiveness, and (b) at a national and regional level to support awareness raising, advocacy and resource mobilization.

## 1.1 Recommendations

Realizing that all projects and programmes can improve in terms of performance, a number of recommendations specifically regarding project implementation and advocacy were identified. The key recommendations are as follows:

### *Advocacy and Policy*

1 At the national level there is a need for greater advocacy on migrant's health rights. Using the evidence and experience gathered through the implementation of these projects, IOM and partners should lobby and advocate with government and non-government institutions (such as local clinics and municipal health departments, police, home affairs, local business, traditional leader and healers) for the needs and rights of migrants and communities affected by migration.

2 IOM and partners should advocate for health services that are migrant-sensitive. Migration data should be used to inform health systems planning and implementation, whilst creating an inclusive approach to public health service delivery.

3 IOM and partners should advocate with regional and national sectoral bodies and governments to establish public/private partnerships to learn from and replicate the model in strategic geographical and sectoral sites such as mining, transport, agriculture and construction sectors.

4 IOM should consider developing the project sites as regional and/or sectoral learning centres that provide lessons and evidence that can be shared with others working in spaces of vulnerability nationally and regionally.

5 IOM should develop a regional dissemination and partnership strategy for the health promotion and service delivery model.

### *Programmatic*

1 There is enough success identified in all the project sites to warrant the scaling up of the model, and IOM should document and disseminate tools that could be used to assist others develop or implement projects in spaces of vulnerability.

2 IOM and partners should build on the success of the social and behavioural change communication approach, which has brought people together to discuss their own vulnerabilities, particularly within a context of mobility and migration, and links HIV and gender to non-traditional HIV interventions such as life skills and food security.

3 Sustainability is a key challenge, and IOM and the projects need to focus on developing sustainability plans.

4 Partners' role in advocacy on issues around gender, migration and HIV needs to be defined and capacity built to enable partners to influence local, national and regional policies and programmes.

5 Institutional and senior management ownership of the approach is critical for the sustainability of projects by partners. IOM should, when establishing partnerships, put in place specific management and institutional capacity building processes that will assist the project and staff to be better integrated. This is especially evident with private-sector partners.

# 2. INTRODUCTION

## 2.1 Context

The IOM regional programme, PHAMSA, aimed at reducing the vulnerability of migrant and mobile populations to HIV and AIDS in the Southern African Development Community (SADC) region by establishing partnerships with and among key stakeholders in southern Africa. The first phase of PHAMSA was implemented from 1 January 2004 to 28 February 2007, and positioned itself as the lead programme in the field of HIV and mobility in southern Africa. The second phase of PHAMSA (PHAMSA II) built on valuable lessons learned from this first implementing period and ran from 1 March 2007 to 31 October 2010. It targeted labour migrants in the following sectors: construction, transport, commercial agriculture, fisheries, mining and informal cross-border trade, and consisted of four distinct yet interrelated components: advocacy for policy development, research, technical cooperation and regional coordination and on-the-ground pilot projects. IOM advocate that in order to address the health vulnerabilities that are caused as a result of migration a "spaces of vulnerability" approach needs to be taken.

> "Spaces of vulnerability" is based on an understanding that health vulnerability stems not only from individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns, and interventions must consider and target both migrants/mobile populations as well as the communities with which they interact, including families in migrant-sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass-through or originate from and may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements (IOM, 2010b).

IOM has been implementing on-the-ground pilot projects using the health promotion and service delivery model since 2005, initially in the Hoedspruit site (South Africa) and then, in 2007, expanding to the five other sites. The health promotion and service delivery model is based on health promotion and community development theory, and strives to address both the contextual and individual barriers to behaviour change that impact on an individual's HIV vulnerability. The model provides a framework for project development and implementation.

The projects, which have been implemented in five SADC countries, aims to reduce HIV vulnerability and mitigate the impact of AIDS in specified sectors (namely, commercial agriculture and mining). IOM works with implementing partners who apply the model so as to respond to local needs. The model has been applied in both migrant-receiving and migrant-sending sites.

**Table 1: List of sites, implementing partners and target groups**

| Geographical Location | Implementing Partner | Target Group |
|---|---|---|
| South Africa, Limpopo Province, Hoedspruit | Hoedspruit Training Trust, Hlokomela (HTT) | Seasonal and permanent farm workers |
| Swaziland, Simunye | Royal Swaziland Sugar Corporation (RSSC) | Contract and seasonal workers |
| Mozambique, Tres de Fevererio | TEBA Development | Mine workers, ex-mine workers and their families |
| Lesotho, Leribe | TEBA Development | Mine workers, ex-mine workers and their families |
| Zambia, Eastern Province, Katete | CHAMP | Agri industry employees (cotton ginnery) and surrounding community |
| Zambia, Solwezi (Copperbelt) | CHAMP | Mine workers and surrounding community |

These sectors and partners were selected following a process of (a) analysis of research and assessment findings, (b) consultation, and (c) participatory project development.

## 2.2 Good-practice Documentation: Sharing "What Works"

The efficient use of resources is essential for the implementation of development related projects and programmes. Inefficient or ineffective interventions can result in wasting time and money. The documentation of "good practices" is an attempt to allow organizations to learn from the successes and challenges of others without wasting resources. The need to scale up activities has made the sharing of "good practices" a greater imperative than ever because it reduces the chances of large-scale replication of error and re-invention of the wheel (SAfAIDS, 2009).

SADC's Strategic and Business Plans on HIV and AIDS advocate the sharing of best practices between and within member states (SADC, 2008). A call for the scaling up of "best practice" in southern Africa was officially made in the Maseru Declaration on combating HIV and AIDS where it was recognized that: "within the SADC Region there have been successes and Best Practices in changing behaviour, reducing new infections and mitigating the impact of HIV and AIDS, and that these successes need to be rapidly scaled up and emulated across the SADC region."

In response to these calls and growing evidence that organizations need to learn from each other's experiences, UNAIDS and SADC began documenting "best practice" in 1997, with their "best-practice collection". The best practices reported in this publication are modelled on the original SADC HIV and AIDS best-practice framework.

### *"Good" vs "Best" Practice*

Whilst "best practice" has been widely used as the terminology to describe an exemplary programme, there are concerns that the term "best" is exclusive and implies a rigid system that cannot be improved upon. There have been discussions internationally on this view and since we documented "emerging" projects, we chose to use the term "good". The "best-practice" criteria nevertheless remain relevant

and for the purposes of this report, the terms “good practice” and “best practice” can be used interchangeably.

### *The Seven SADC Best-practice Criteria and Definitions*

The SADC Framework for Best Practice defines the primary objective of a best-practice document as a “practical instrument that facilitates sharing within and between member states in order to assist local authorities to scale up interventions based on what is known to work – through documenting, understanding, and appreciating good experiences; facilitating learning of what works and what does not, sharing experiences; and assisting replication of small and successful interventions on a larger scale” (SADC, 2008). The seven criteria and their definitions have been reproduced below as provided by SADC (2008) and used in this document:

- **Effectiveness:** A best practice must have clear objectives guided by identified community needs obtained through a baseline study and there must be evidence that it is achieving these objectives. The community should participate at every stage of the project, from its inception to its implementation, monitoring and final evaluation.

- **Ethical soundness**: An ethical practice is one that upholds social principles and professional conduct. An intervention is a best practice if it does not violate human rights, respects confidentiality as a principle, embraces the concept of informed consent, applies the “do no harm” principle, and works together towards the protection of the interests of vulnerable groups.

- **Cost effectiveness**: Cost of delivery for a cost-effective programme is proportionate to available resources, that is, “the capacity to produce desired results with a minimum expenditure of energy, time or resource”. The intervention should have in place cost-saving and reduction systems. The programme should provide a standard package of HIV prevention, treatment or care at a reasonable cost. This should result in an improvement in the quality of life of an increased number of community members. Efficiency measures the capacity of a programme to produce desired results with the minimum expenditure of energy, time and resources.

- **Relevance:** All interventions need to take cognizance of the specific context in which they are taking place, noting cultural, religious and other norms, as well as political systems and the socio-economic environment in so far as they affect vulnerability, risk behaviour, or the successful implementation of a response.

- **Replicability:** Inherent in a best practice is its ability to be copied/adapted and its need to discover interventions that set an example.

- **Innovativeness:** A best practice may demonstrate a unique and/or more cost-effective way of implementing a programme or responding to an issue. The programme itself could also be unique.

- **Sustainability:** Sustainability is the ability of a programme or a project to continue, and to continue to be effective, over the medium and long term. This can be strengthened through community ownership of the project and through skills transfer. Sustainability should take into cognizance financial sustainability, marketing and awareness building of the project.

# 3. METHODOLOGY

SADC's Framework for Best Practice (SADC, 2008) was used in documenting PHAMSA's health promotion and service delivery model and projects. This practical tool was developed to facilitate sharing of best practices among SADC member states in order to scale up interventions based on what is known to work, and to encourage the replication of small and successful interventions on a larger scale. It therefore involves the rigorous assessment of a project in seven key areas (referred to as good-practice criteria), that is effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability. This framework is broad and all encompassing; thus, in documenting these particular good practices. The consultant, contracted by IOM to assess the model and the projects, developed more specific criteria and standards to fit the theme of migration, HIV and development in southern Africa as reflected in the Key Assessment/Analysis Tool: Scorecard (Appendix).

The consultant used qualitative and participatory research methods such as individual interviews, focus-group discussions, project document reviews and direct observation to collect the data, which was analysed using the seven best practice criteria given above. The consultant also reviewed existing literature on the various projects, covering information on the organizations, communities and beneficiaries, as well as relevant national and regional literature on migration, HIV and development.

The key questions asked in this good-practice documentation process were designed to extract important aspects relating to programming for HIV and mobility in southern Africa, to determine whether or not the model, IOM and its implementing partners are following, employs appropriate standards of engagement and responds in an innovative way to the challenges faced by migration affected communities. These questions are:

1) Does the organization fulfil the standards of good practice, namely, good management, replicability, community participation and cutting-edge interventions?

2) If so, how does the organization achieve the standards of good practice?

## 3.1 Tools

The IOM contracted consultant developed and used four key tools in the documentation process:

- Interview guide for conducting key informant interviews
- Interview guide for focus group discussions for communities and beneficiaries
- Interview guide for project/programme implementers
- Good-practice scorecard

The questions contained in these tools were designed to draw out the relevant information required to adequately score organizations. Intrinsic in all four tools are the seven criteria for identifying good practices.

## 3.2 Fieldwork

A liaison person for each project was identified. This person facilitated the necessary meetings and visits by the consultant, and assisted with interpretation and translation of data on site. The consultant spent four days conducting fieldwork at each site, reviewing literature, making direct observations, taking photographs where appropriate and carrying out interviews and focus group discussions. The consultant interviewed a wide range of stakeholders, from beneficiaries and programme implementers to significant community members, local leaders and relevant representatives from local government structures. The document analysis process consisted of examining a variety of materials, including concept notes, workshop and annual reports, evaluations and monitoring and evaluation (M&E) instruments. The interviews were guided by the previously mentioned interview guides.

## 3.3 Analysis and Conclusion

Following data collection, a good-practice scorecard was used to measure and analyse data within the scope of good-practice programming. The scorecard was designed to ensure compatibility with international standards, to allow for comparison with other good-practice projects, and to offer insight into the strengths and weaknesses of the particular programmes – allowing programme feedback for consolidation. This publication brings out not only emerging good practices and lessons learnt at the programme and regional level but also captures the stories and lives of individuals directly affected by the migration process and the projects.


Men enjoying a recreational activity (darts) in the evening in Katete, Zambia.

# 4. PARTNERSHIP ON HIV AND MOBILITY IN SOUTHERN AFRICA (PHAMSA)

## 4.1 Population Mobility and HIV

Southern Africa, which has the highest prevalence of HIV globally, also experiences high levels of population movement and the link between mobility and HIV is an important part of the region's epidemic. The region continues to bear a disproportionate share of the global burden of HIV: 34 per cent of people living with HIV/AIDS (PLWHA) in 2009 globally resided in 10 countries in southern Africa (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe); 31 per cent of new HIV infections in the same year occurred in these 10 countries, as did 34 per cent of all AIDS-related deaths (UNAIDS, 2010: 28). At the same time, southern Africa experiences high levels of population movement, voluntary and forced, amongst diverse groups, including seasonal and contract labour migrants, irregular migrants, families of migrants, refugees, trafficked persons and mobile workers such as truck drivers and mine workers. Furthermore, migrants have loved ones back home, who may face their own vulnerabilities.

Many of the factors that influence the spread of HIV, such as unequal distribution of resources, unemployment, political instability and conflict, also drive migration in the region. Migrants and those impacted by the migration process are made vulnerable to HIV infection and other health risks for multiple reasons. For instance, those living with the virus face obstacles accessing care and support services. In addition, the circumstances faced by migrants while on the move, whether voluntary or involuntary, legal or irregular, can increase the risk of HIV infection. There are three key issues that link mobility and HIV: (a) mobility can make migrants vulnerable to high-risk sexual behaviour because of the conditions they face during the migration process; (b) mobility makes migrants more difficult to reach, whether for prevention education, condom distribution, HIV testing or post-infection treatment and care; and (c) migrants' multi-local social networks create opportunities for sexual networking. A better understanding of the link between HIV and population movement in southern Africa is essential to develop effective HIV and AIDS interventions and strategies.

Gender is an important dimension when discussing the linkages between migration and migrants' health. Anecdotal evidence reveals a striking increase in migration by women, who had traditionally remained at home while men moved in search of paid work (UNFPA, 2006). A significant number of these migrant women move independently to fulfil their own economic needs; they are not simply joining a husband or other family members. Due to women's traditionally weaker economic and social position, women can become vulnerable to HIV as they resort to income-generating activities such as sex work. Many jobs available to women subject them to poor working conditions, including abuse or harassment. Female workers on farms, who often outnumber men as seasonal labourers, have been known to exchange sex for food or jobs (IOM, 2004a). Moreover, the social construction of gender and sexuality underlies HIV vulnerability of migrants and mobile workers. Gender norms which support the tendency to have many sexual partners and endorse multiple and concurrent sexual partnerships are often found to exist among migrant men, exacerbating HIV vulnerability.

It is against this background that, in 2007, IOM launched phase II of its Partnership on HIV and Mobility in southern Africa (PHAMSA).

## 4.2 History of the Project

IOM's regional HIV programme, PHAMSA, aimed to reduce the vulnerability of migrant and mobile populations to HIV and AIDS in the SADC region by establishing partnerships with and among key

stakeholders in southern Africa. The first phase of PHAMSA was implemented from 1 January 2004 to 28 February 2007, and positioned itself as the lead programme in the field of HIV and mobility in southern Africa.

The second phase of PHAMSA (PHAMSA II) built on valuable lessons learned from the first implementing period. PHAMSA II ran from 1 March 2007 to 31 October 2010, and targeted labour migrants in the following sectors: construction, transport, commercial agriculture, fisheries, mining and informal cross-border trade. The programme consisted of four distinct yet interrelated components:

1) Advocacy for policy development: IOM advocated for regional, national and sectoral policies that contributed to a reduction of HIV incidence and the impact of AIDS among migrant and mobile workers and their families. This was achieved by working with and lobbying national and regional policymakers, international organizations, members of the media and civil society to raise their awareness on HIV dynamics for labour migration and to integrate relevant issues in their national strategic plans on HIV and AIDS, regional HIV plans, and UN Development Assistance Frameworks (UNDAFs).

2) Research and learning: IOM worked to increase knowledge and understanding of the HIV dynamics of labour migration in the region. Research findings are being used to develop evidence-based programmes, to influence policymakers and to inform the wider public. In addition, IOM worked with universities and research organizations in and outside the SADC region that focus on health and migration. Researchers investigated the links between population mobility and HIV with a focus on concurrent sexual partnerships and sexual networking patterns.

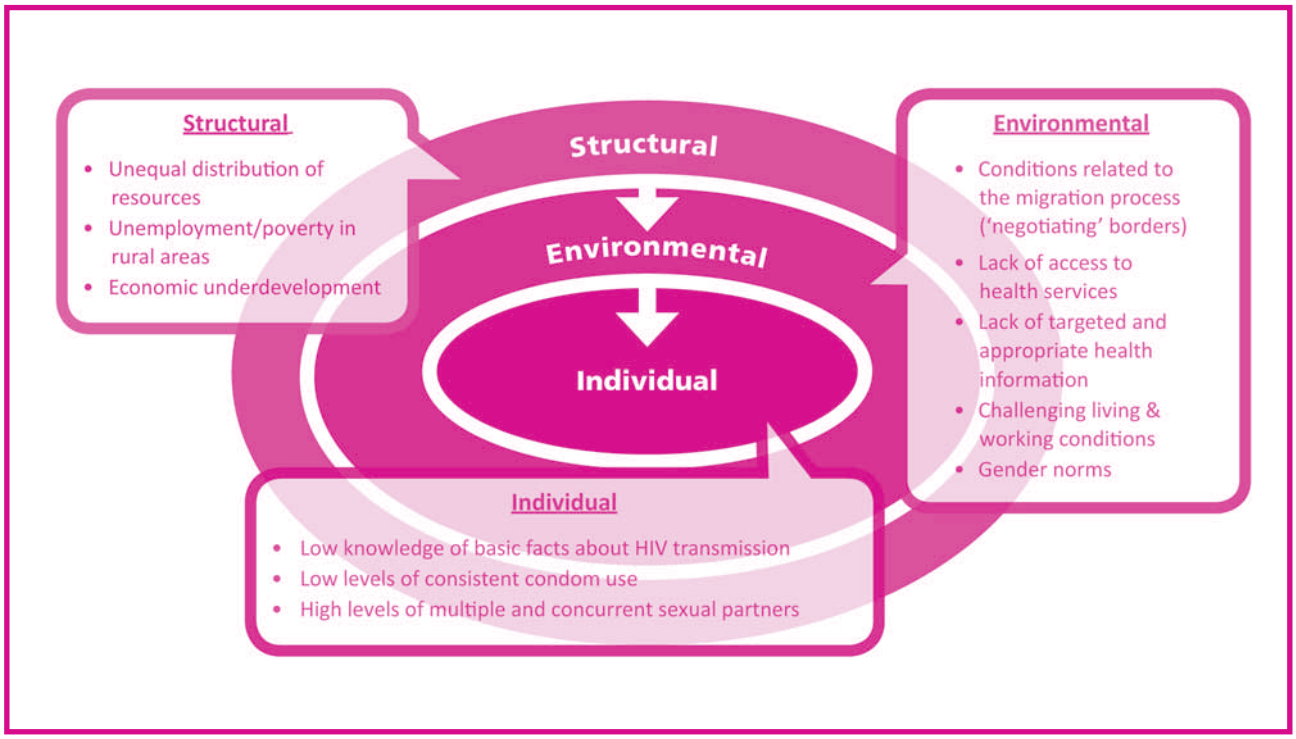
3) Regional coordination and technical cooperation: IOM aimed to strengthen coordination and cooperation among partners involved in HIV and mobility issues in the region through workshops, meetings and study visits, amongst others. It also provided partners with technical assistance on the HIV dynamics of labour migration.

4) On-the-ground pilot projects: Taking a regional and sectoral approach, IOM worked with partners to reduce HIV incidence and the impact of AIDS among labour migrants, their families and those with whom they interact in Lesotho, Mozambique, Namibia, South Africa, Swaziland and Zambia. A comprehensive health-promotion and service delivery model was rolled out in several migrant-receiving and migrant-sending sites in the region. It built the technical and organizational capacity to implement social and behavioural change interventions/strategies effectively and to share lessons learned, challenges and best practices between the different implementing partners regionally. IOM has been implementing these projects since 2006.

## 4.3 IOM's Approach to HIV

IOM's "spaces of vulnerability" approach differentiates it from many migrant-focused interventions. This approach is based on an understanding that health vulnerability stems not only from individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns, and interventions must consider and target both migrants/mobile populations as well as the communities with which they interact, including families in migrant-sending communities. Spaces of vulnerability are places where migrants and mobile populations live, work, pass-through or originate from and may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres and emergency settlements.

**Figure 2: Multi-level approach that looks at reducing individual risks by addressing individual and environmental factors and taking into account structural issues that increase HIV vulnerability.**




## 4.4 IOM's Health Promotion and Service Delivery Model

Through consultation and work with different groups of migration-affected populations, IOM identified a need to develop, highlight and implement interventions that have an impact on addressing HIV vulnerabilities within migrant settings. It was during this implementation of IOM's PHAMSA programme that a framework called the "IOM health promotion and service delivery (HPSD) model" was developed and implemented. This model was applicable in migration affected communities and demonstrated how interventions could be packaged to address the different levels of HIV causation. See Figure 1 (page 10) for the different components of the Health Promotion and Service Delivery model.

The HPSD model provides a structure for project design and implementation. It brings together health promotion and community development theory coupled with lessons learned from implementing HIV responses on the ground in migration-affected communities. It provides guidance on how interventions can consider and address individual, environmental and structural factors that impact on HIV vulnerability in a specific setting. It is not rigid or prescriptive but instead attempts to provide partners and IOM with a guiding approach on how to develop and implement interventions that address local health vulnerabilities. The model has evolved over the years and has been refined to respond to the emerging trends on the ground.

Each of the components of the model (as shown in the following table) do not operate in isolation but are interrelated and support and build on each other.

## Table 2: IOM health promotion and service delivery model (2010)

| | Components | Outcome | Example Activities |
|---|---|---|---|
| 1 | Facilitating access to health services, programmes and products | Improved and increased access to health services for target population (i.e. migration-affected populations) | Establishment of referral systems<br>Capacity building of health-service providers on migrants' rights to health |
| 2 | Strengthening of local implementing partners | Increased capacity of partners to implement and sustain migration health interventions | Capacity building on substantive issues such as migration, gender and social change<br>Capacity building on programme management related issues such as financial management and M&E<br>Partnership building to leverage support/ services |
| 3 | Peer-led information, education, communication on health, including HIV, TB and STIs | Increased and improved understanding of migration and health, and increased awareness of the social determinants of health amongst the target population | Capacity building of peers to become agents of change<br>Development and implementation of social and behavioural change communication (SBCC) interventions |
| 4 | Addressing gender dynamics in the context of health and migration | Increased and improved understanding of gender, health and migration issues amongst the target population | Identification of harmful and helpful gender practices<br>Involvement of men as role models and influencing their health-seeking behaviour<br>Interventions that empower women, involve men and encourage couple communication should be considered<br>Capacity building of gender advocates |
| 5 | Addressing contextual barriers to social and behavioural change | Reduced health vulnerabilities by addressing identified social determinants of health amongst the target population | Identification of contextual barriers (i.e. food insecurity, adult and financial literacy, income generation interventions and so on) |
| 6 | Creating an enabling local environment | Local environment (workplace, village, municipality and so on) that supports and enables the implementation of sensitive health services to migrants and communities affected by migration | Development of workplace policies<br>Partnerships with key stakeholders<br>Advocacy campaigns |
| | **In addition key issues or approaches are mainstreamed:** | | |
| | Gender | Although there is a specific gender intervention partners are supported to ensure that gender in considered and mainstreamed in all the other components of the model. For instance under facilitating access to services is couple counselling promoted, are men supported to be involved in prevention of mother to child programmes? | |
| | Involvement of key populations | Ensuring that key populations such as migrants and people living with HIV are involved in the project design and implementation. | |
| | Capacity Building | Every component of the model includes an aspect of capacity building both at the implementing partners and individual level. In order to support sustainability capacity building is mainstreamed in each component. | |
| | Strategic information | The model includes facilitating and supporting partners to collect and analyse strategic information so as to inform their project activities. Strategic information such as base line assessments, regular monitoring, most significant change stories etc. | |
| | Partnerships | The model recognises that not one organisation can or should provide everything. The model promotes the building of partnerships at the local level that support service delivery, capacity building, resource mobilisation and advocacy. | |

Key to the HPSD model is social and behavioural change communication (SBCC), a rights-based approach that seeks to provide an opportunity for positive change through communication. This bottom-up approach empowers project beneficiaries to identify barriers to social and behavioural change and to take action to address these barriers.

A key resource in this process is the change agent (CA). Change agents are members of the target community who have committed themselves to driving the change process and who are capacitated with skills to enable them to engage with their peers in a structured manner. CAs are recruited and oriented in all sites and are the core of the communication and empowerment process. They (a) disseminate HIV/health-related information and promote adoption of healthier and positive behaviours and practices amongst their peers and communities, (b) identify challenges through dialogue with peers, (c) develop strategies to address the challenges, and (d) promote action for change.

## 4.5 Project Technical Partners

The following technical partners provided support to all the IOM implementing partners in the areas of social and behavioural change communication (SBCC) and gender, especially male involvement.

### *Sibambene Development Communications (SDC)*

Sibambene specializes in communication for development and has worked closely with IOM's implementing partners in the different sites across southern Africa. Their role has been to design the social and behavioural change communication strategy and to support local implementing partners. Support for implementation begins with an assessment of local opportunities for change and the development, together with the implementing partner, of a detailed set of implementation guidelines covering all aspects of the programme: collective identity making with change agents, systematic local communication planning processes, the conducting of directed and deliberate dialogue and the development of local communication instruments. A comprehensive set of learning modules covering all stages of the implementation process was developed.

The greatest challenge has been to shift away from top-down "teach and tell" information dissemination to enable the voice of communities to be heard, and to nurture the development of safe and trusted spaces where communities and individuals experience real choice. Through coaching and mentoring on site and remotely, implementing partners (IPs) have learnt to trust people's capacity to find ways to address the challenges they face. Sibambene's role included affirming the IPs in their efforts to empower local communities, and to encourage them to affirm the change agents and communities with whom they interact. Sibambene has provided access for the IPs to current research and knowledge around such key issues as gender identities in connection with increased vulnerability to HIV, health belief systems and health seeking practices, as well as to the latest research, approaches to SBCC and materials produced by institutions such as C-Change, SAFAIDS and Soul City. Sibambene has enabled a sharing of experiences across the sites and encouraged the uptake of the good practices that have emerged in each of the sites. Perhaps most importantly, Sibambene has been constantly available to offer support and advice when requested and has repeatedly affirmed the IPs and the communities as leaders in the field who have much to teach. Sibambene observed that after one year of implementation all sites succeeded in setting up rigorous systems for communication and participation; within two years the projects had built social cohesion and had become household names in their localities and trusted leaders of development and change.

### *Sonke Gender Justice Network (SGJN)*

Sonke Gender Justice Network (SGJN) is a South African based NGO founded in 2006. It works across Africa to strengthen the capacity of governments, civil society organizations and United Nations agencies to involve men and boys in preventing gender-based violence (GBV), reducing the spread and impact of

HIV and AIDS and promoting gender equality and social justice. Their work builds on activities carried out by the Men as Partners network. SGJN's vision is to "create a society in which men and women can enjoy equitable, healthy, and happy relationships that contribute to the development of a just and democratic society".

As a technical partner to IOM, SGJN provide training of trainers and technical assistance on the implementation of the One Man Can campaign, a flagship programme that focuses on developing male role models and encourages men at all levels of society to take a stand and be involved in the struggle for gender equality, oppose gender-based violence and be more involved in initiatives geared towards reducing the spread and impact of HIV and AIDS. SGJN, in partnership with IOM, developed an "Action Oriented Training Manual on Gender Migration and HIV". This training manual is a tool used to: (a) build the capacity of IPs and other organizations to address specific gender and HIV vulnerabilities within migrant settings, and (b) develop strategies and programmes that contribute to broader social change. The manual was designed to be used both as a train the trainer (ToT) tool and as an "on-the-ground" guide for facilitators.


Traditional healers welcoming guests for a focus group discussion in Mozambique.

# 5. EMERGING GOOD PRACTICES IN MIGRATION AND HIV IN SOUTHERN AFRICA

The following section looks at each of the IOM on-the-ground pilot projects that implemented the health promotion and service delivery model. The projects worked in two sectors, mining and agriculture and were implemented by different types of implementing partners, private sector, local, national and regional organisations.

### Table 3: IOMs on the ground pilot projects

| AGRICULTURE | | MINING | |
|---|---|---|---|
| **Partner/Site** | **Private Sector/NGO led** | **Partner/Site** | **Private Sector/NGO led** |
| RSSC (Swaziland) – sugar plantations | Private sector | TEBA Mozambique – mine worker sending community | Corporate social responsibility arm of private sector |
| HTT (South Africa) – citrus and game farms | NGO | TEBA Lesotho – mine worker sending community | Corporate social responsibility arm of private sector |
| CHAMP – Katete (Zambia) – cotton ginning | NGO with strong corporate linkages | CHAMP – Solwezi (Zambia) – copper mine | NGO with strong corporate linkages |

For each implementing partner we give a brief background to the project(s), we look at practical examples of how they applied the model accompanied by the success and challenges they faced, we go on to analyse why each project could be considered as good practice and finally reflect on the way forward for each project. In addition, as each project formed part of a regional programme we also consider the regional relevance of each project.

## 5.1 TEBA Development: Mozambique and Lesotho

TEBA Development is the corporate social responsibility arm of TEBA Limited, a service organization primarily responsible for the recruitment of mine workers for the South African mining industry. Since 2002 TEBA Development's HIV response has primarily focused on providing home-based care (HBC) for HIV-affected ex-mine workers.

In 2005 IOM and TEBA Development (Lesotho) worked together to try address the HIV challenges faced by mine workers and their families. In 2007, building on this partnership, TEBA Development's regional office partnered with IOM to pilot a holistic response to HIV in mine worker sending communities. Mozambique (Xai Xai) and Lesotho (Leribe) were selected as pilot sites, with the aim that lessons learned in these sites could be replicated in other mine worker sending communities in southern Africa. The projects targeted mine workers, their families and communities they interact with and although implemented in different countries they used the HPSD model as the framework for implementing activities.

The role of the TEBA Regional Office was to provide financial and technical oversight and support to the country projects. All budgets, reports and technical assistance was coordinated through the TEBA Regional Office based in Johannesburg, South Africa,

### *Regional Relevance of the TEBA Projects (Mozambique and Lesotho)*

As a regional organization, TEBA Development works with mine worker sending communities in four southern African countries (Lesotho, Mozambique, South Africa and Swaziland). The projects have provided TEBA Development with an opportunity to broaden its health response in mine worker sending communities

in the region. Their regional role provides a platform to replicate the HPSD model in other mine worker sending communities. Using the lessons learned in Mozambique and Lesotho, TEBA Development have already started to apply the model to other mine worker sending communities in South Africa.

By working in mine worker sending areas rather than with the migrants directly, the projects have built a better understanding of the health vulnerabilities faced by migrant-sending communities. By furthering our understanding of how migrant-sending communities are spaces of vulnerabilities, the projects have provided IOM, partners and stakeholders with evidence that can be used to advocate for the adoption of the "spaces of vulnerability" approach.

At the national level the projects have been embraced and their achievements have resulted in the government and additional communities requesting that they be replicated. The unique approach of the HPSD model promotes community ownership and addresses all aspects of the beneficiaries' lives, suggesting that the approach can be adopted at the SADC level to assist member states to respond to HIV within context of migration.


## *IOM and TEBA in Mozambique*

### *Programme Inception and Description*

TEBA Development selected Tres de Fevereiro as the pilot site for the project since its community is severely impacted by migration and HIV. The community's main source of income is from remittances of mine workers who work in South African mines. It is a rural community situated about 250 km from the capital, Maputo, and 15 km south of Xai-Xai, the provincial capital of the Gaza Province, Mozambique. Tres de Fevereiro has a population of approximately 18,000–20,000. Households depend on subsistence farming and there is no medical facility in the village; the nearest hospital is in Chicumbane, approximately 15 km away, where free public health services are available but the transport costs to reach Chicumbane are prohibitive. This situation impacts negatively on health-seeking behaviours among community members (UNDP, 2006).

In Tres de Fevereiro, gender and cultural dynamics have an impact on the health of community members. Beneficiaries and stakeholders reported that polygamy is common, as is the practice of "wife inheritance", whereby the brother-in-law inherits the wives and children of a deceased husband. Young girls marry in their early teens and begin child bearing as young as 12. Women appear to have limited power in making substantive decisions in the absence of their migrant husbands.

TEBA Development's ongoing home-based care (HBC) programme provides treatment and referral and day-to-day HBC, but only for ex-mineworkers. The TEBA/IOM project complemented the HBC programme primarily with HIV-prevention interventions by addressing some of the community's barriers to health-seeking behaviour.

The overall goals of the **National HIV/AIDS Strategic Plan (PEN II) (2005–2009) in Mozambique** are to prevent the spread of HIV infection, to provide access to treatment for PLWHA and to mitigate the health, socio-economic and psycho-social impact of HIV and AIDS on individuals, families, communities and the nation at large. The PEN II describes internal and cross-border migratory movements as a socio-economic factor that contributes to the spread of the HIV/AIDS epidemic in the country. PEN II acknowledges mobile populations as one of the most vulnerable groups. It includes the following as mobile populations: truck drivers, construction workers, practitioners of artisan fishing and seafarers.

The project responds to the national HIV/AIDS strategic plan and priorities by targeting migration-affected communities and specifically addressing their HIV vulnerabilities.

### *IOM Health Promotion and Service Delivery Model*

TEBA Development tailored the HPSD model to the needs of the Tres de Fevereiro community and employed a full-time project coordinator whose role was to facilitate implementation of the project in partnership with the community and other stakeholders.

The project recruited and trained a total of 250 change agents (CAs) from the community and included ordinary community members (84), traditional healers (99) and community/traditional leaders (67). They received a range of training, on topics including gender, migration and HIV, and communication skills. With support from Sibambene, they developed a local name, Txivirika (meaning "to move and change"), and created a local and easily identifiable image – "the red army" – as their t-shirts are coloured red.

The following table considers each component of the model and how it was implemented, alongside some of the successes and challenges faced within the Tres de Fevereiro community.

## Table 4: Implementation of HPSD model in Tres de Fevereiro, Mozambique

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| **Facilitating access to health services, programmes and products** | • Due to limited access to health services the project built the capacity of change agents (CAs) in HIV Counselling and Testing (HCT), thereby bridging a capacity gap within the local hospital. In addition, CAs were trained on universal precautions in order to protect themselves and their clients.<br>**"we feel like we are fat … with all the trainings and teachings that we have got from the project"**<br>• Traditional healers now form an important referral link with the health system and are reaching out to communities.<br>• CAs have been trained by the Ministry of Health on HIV and AIDS information, HBC, prevention and DOTS (TB treatment) so that they are able to support people in accessing and adhering to treatment.<br>• Through a partnership with Right to Play, a local NGO, CAs were trained in malaria prevention and mosquito net distribution.<br>• Increased and improved condom use has been reported amongst the community members due to increased availability, knowledge on how to use them and their acceptance by the community. |
| **Strengthening of local implementing partners** | • Through capacity building facilitated by IOM and its technical partners, TEBA's capacity has been improved specifically within the field of migration, gender, HIV, M&E and SBCC.<br>• The project has impacted positively on TEBA's profile within the community.<br>• Recognizing the value and impact of the project, TEBA have been proactive in their attempts to scale up the project in other areas by independently approaching other donors for funding.<br>• A major challenge is the apparent clash of cultures between the business arm of TEBA (TEBA Ltd) and the development approach (TEBA Development and IOM). Whilst in development work projects need to spend on a consistent basis as per agreed work plans and budgets, business culture promotes spending as little as possible as long as results are produced. Consequently, internal systems, procedures and practices have, on occasion, hampered delivery.<br>• TEBA's vertical project structure lends itself to projects that work in isolation and are not fully integrated. This has been recognized as a challenge and proactive steps are being taken to try and address it, such as more involvement of the TEBA country manager and the TEBA finance manager in project management and implementation.<br>• Given the need and demand for the project, TEBA needs to develop a long-term strategy, and accompanying resource mobilization plan, for consolidation and replication. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| **Peer-led information, education, communication on health, including HIV, TB and STIs** | • TEBA have used a variety of methodologies and approaches to reach out to the community not only in Tres de Fevereiro but also within the Xai Xai district. They have used public gatherings, dialogues, drama and radio programmes (three 30-minute slots per week), which has resulted in the increased visibility of the project and numerous requests for the project in areas which it does not currently reach.<br>• A systematic and transparent process of recruiting CAs using specified criteria enabled the coordinator and volunteers to communicate their expectations. This helped to ensure everyone clearly understood their different roles within the project and reduced the dropout rate due to unmet expectations, frustrations and disappointments.<br>• CAs, as the core of the project, have initiated dialogue on a range of issues, including gender-based violence (GBV) and cultural practices.<br>• CAs use a range of communication tools, such as drama, radio, murals and billboards, to stimulate action for change.<br>• CAs have been trained on radio presentation and have a weekly phone-in show during which the community discuss HIV, gender and migration. |
| **Peer-led information, education, communication on health, including HIV, TB and STIs** | • The formation of community action teams (CATs) was guided by issues identified during peer-led dialogues. Illiteracy within the community prevented community members from accessing information and services. To address this, a CAT was formed and advocated for a learning space. Government supported the community by opening the primary school for adult literacy evening classes<br>• People living with HIV/AIDS (PLWHA) have been recruited and trained as CAs. This involvement of PLWHA is addressing stigma whilst also serving to motivate, empower and encourage PLWHA. |
| **Addressing gender dynamics in the context of health and migration** | • Training in gender for CAs and the community has resulted in shifts in attitudes, especially with regard to gender roles. The caring role that has traditionally been the sphere of women has now been embraced by men who, after undergoing HBC training, are also doing care visits to bed-ridden patients.<br>• Using an action orientated approach to gender, migration and HIV, the project capacitated the Department of Gender and AMIMO (Association of ex-mine workers) to implement gender activities within the community and elsewhere in the province.<br>**"before I did not know what gender is but now I know …"**<br>• By deliberately involving both men and women in all activities, the project raised awareness on gender norms.<br>• Drama and other communication tools have been used to address gender and cultural issues, such as GBV.<br>• Using the skills and knowledge gained through the project, traditional healers and leaders, as custodians of local culture, are countering harmful gender practices, for example by promoting consistent condom use. |
| **Addressing contextual barriers to social and behavioural change** | • The project considered other social determinants of health that were faced by community members. Some of the barriers to social and behavioural change identified by the project include culture, poverty and illiteracy. These are being addressed. For example:<br>**"This project is different in that it gives people something that lasts for longer and not just food"**<br>  • Traditionally some women needed to approach their husbands for permission to go for HCT; when the husbands were not available women had to wait until their return home. The community have recognized this barrier and have taken action to support women in accessing health services.<br>  • Previously, in wife inheritance and the accompanying cleansing ceremony (when the widow has to have unprotected sex with a surviving member of the late husband's family), it was said that if a condom was used in the ceremony it would be invalid. Traditional healers are now distributing condoms and promoting their use in this ceremony. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| **Addressing contextual barriers to social and behavioural change** | • Food insecurity and sustainable livelihoods have been tackled by partnering with HOPE (an NGO that provides start-up loans to individuals and organizations to run income-generating projects). The project has trained CAs in income generation (chicken rearing, agricultural gardens and business management.<br>• Mainstreaming the concept of migration health throughout the project has created a more open dialogue on migration and its impact on the community. |
| **Creating an enabling local environment** | • By working with traditional healers and community/traditional leaders, the project has strengthened its credibility, relevance and acceptance within the community.<br>• By involving the local government structures in project implementation, the project has been able to access a number of resources and has elevated its profile within the wider Gaza Province. This ownership by government will support sustainability and replication.<br>• To build on its successes, the project needs to share its work more proactively and create more linkages for networking with other like-minded organizations at provincial, national and regional levels. |

## *Why Is This Project a Good Practice?*

According to SADC, for a project/programme to be considered a good practice it has to be successful in at least seven areas. This project scored above 80 per cent**,** implying that it is indeed an emerging good practice.

### *Effectiveness*

The project has included local government officials in activities; they are able to monitor work at the community level and help facilitate trainings.

Using well-established communication and feedback mechanisms, the project reaches out to the community through radio, drama and public gatherings. Feedback on the projects' regular radio programme indicates that radio is an effective way to communicate and encourage people to get tested and access health services.

By involving key community stakeholders such as traditional healers and leaders as CAs, attitudes within the community are changing as they embrace modern health-care systems. For instance, traditional healers are now distributing and promoting condoms, referring clients to hospital and doing home visits for their clients.

### *Ethical Soundness*

The project has high ethical standards as it supports active participation of all community members and thus captures the needs of the community. Local community members, including local leaders, have been empowered to lead, design and implement the project so that they control their own destinies.

By building local skills and transferring knowledge, the project works within the boundaries of professional conduct and promotes sustainability.

The project has supported a rights-based approach that now sees traditional healers maintaining client confidentiality.

## *Cost Effectiveness*

The project is cost effective because, according to the project implementers, there has been an increase in the number of people/clients who are accessing services without an increase in resources. People are coming to collect condoms from CAs, even those from areas not covered by the project.

## *Relevance*

The project has been relevant to the needs of the individuals and of the community by responding to real barriers and concerns identified by the community, rather than applying a standard HIV information dissemination approach. The continual process of dialogue and feedback ensures that the project remains relevant.

The project fits well into the national strategy, which specifically identifies mine workers, migrants and mobile workers as high-risk vulnerable groups who need targeted interventions. The project has increased knowledge on HIV and AIDS and gender whilst also addressing contextual barriers such as food security and cultural practices.

## *Replicability*

By using a model to guide the project design and implementation, the project can be easily replicated in other sites. It also uses tools and mechanisms that are adapted to the local context. To support replication, documentation of key processes is critical, for instance on how to recruit, train and mentor CAs.

The Community Action Team (CAT) approach that brings a group of community members together to address a specific issue has proved to be very effective and could be replicated in other sites. All such activities are applied in a systematic manner following the model and can be replicated elsewhere.


Food garden for the change agents in Tres de Fevereiro, Mozambique.

### *Innovativeness*

TEBA Mozambique has been highly innovative in a number of ways, for example the linking health and development to HIV is unique in the district. In addition, engaging and training traditional healers and leaders has challenged traditional norms and practices and they are now actively engaged in promoting healthier lifestyles. Community ownership has been strengthened by directly involving the local district government in project initiatives such as the Community Action Teams.

### *Sustainability*

Sustainability considers not only financial issues but also local ownership, skills transfers and so on. At the community level this project has transferred skills to change agents and the community has been strengthened to take responsibility to identify and address barriers to its development.

At the institutional level, further support is needed within TEBA to fully integrate the approach into their other development and HIV responses but this has been recognized and action has been initiated.

## *Building on What We Have Learnt*

The nature of the TEBA Mozambique project is such that the project is continually learning and evolving. A key lesson that can be shared is the critical role traditional leaders and healers have in assisting in building the credibility and sustainability of the intervention. There is a need for this type of intervention and there is demand for the project to be replicated in other sites.

On an institutional basis TEBA needs to improve its integration of its different health-related programme and thus increase transparency, both internally and with stakeholders, in terms of usage and allocation of resources.

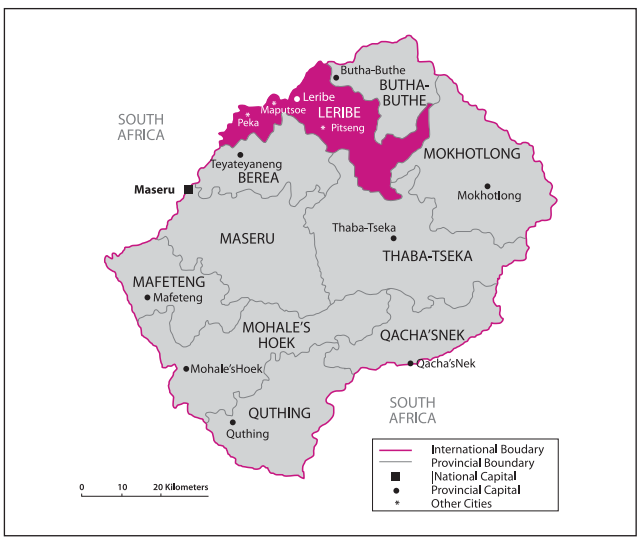
To strengthen the project a strategy on partnerships and advocacy should be developed. In addition although there is a plan by the community to form an association, a more concrete sustainability plan is required.

Although there is a plan by the community to form an association a more concrete sustainability plan needs to be developed and implemented.

### *IOM and TEBA in Lesotho*

#### *Programme Inception and Description*

Leribe District is the second largest in Lesotho, with a population of approximately 450,000, and borders the Free State Province, South Africa (United Nations, 2009). Lesotho has a high prevalence of HIV (23.8 per cent – UNAIDS, 2010) and Leribe District is considered a "hot spot" due to its geographical location on the border, its garment factories that employ mainly female workers, and its history as a mine worker sending community.



A baseline survey in late 2007 identified three councils within the Leribe District on which to focus – Maputsoe, Litjotjela and Maisa-Phoka. Project implementation started in February 2008. The survey identified several challenges faced by the local community, including gender, cultural practices, food insecurity and the impact of migration on social cohesion.

As in Mozambique, TEBA Development Lesotho has ongoing projects for returning mine workers in Lesotho, including a home-based care project which was supported by a food security intervention. The TEBA/IOM project sought to compliment and expand HIV interventions to current and ex-mine workers, their spouses and their communities.

The project responds to the national HIV/AIDS strategic plan and priorities by targeting migrant populations.

> The **Lesotho National HIV and AIDS Strategic Plan (NSP) (2006–2011)** acknowledges that migrant populations, including sex workers and other vulnerable groups, are highly vulnerable to HIV infection. It recognizes that migrant populations live on the fringe of society largely due to their occupations and that they tend to have limited access to HIV information and services. In addressing the vulnerability of migrant populations to HIV and AIDS, the NSP seeks to reduce the vulnerability of migrants to HIV infection and to the impact of the AIDS epidemic. The objective of the NSP in respect of migrant populations is to ensure that migrants access HIV and AIDS services for prevention, treatment, care and support, and impact mitigation.

### *IOM Health Promotion and Service Delivery Model*

From the outset TEBA Development in Lesotho integrated the IOM project within their HIV response and tailored the HPSD model to the needs of the community.

To ensure community ownership, the project created its own local identity, “Falimeha”, meaning “to be observant” or “to rise above adversity”, whilst the change agents were called “malikhomo”, meaning “trusted one”. Originally 45 change agents were recruited and trained. Currently 37 are still active.

When the project started it used the traditional approach of mobilizing people for activities. After some time it was noted that participation of community members was weak. The project reviewed its approach and adopted the HPSD model whose bottom-up approach ensured much stronger community ownership and participation and helped to re-energise an HIV fatigued community by ensuring the project responded to their real needs holistically. For instance the community identified and prioritized food insecurity as a barrier to health and TEBA used this as an entry point for the project.

The following table considers each component of the model and how it was implemented, alongside some of the successes and challenges faced within the Leribe district.

## Table 5: Implementation of HPSD model in Leribe, Lesotho

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Facilitating access to health services, programmes and products | • Through engaging in dialogue with change agents (CAs), community members are now encouraged to access health services, such as STI treatment and HTC, and receive follow up support.<br>**"There is a man who had defaulted from TB treatment. He became a CA, tested and resumed treatment and is now in good health"**<br>• The project took the "lead by example" approach by encouraging CAs to get tested and if HIV+ to adhere to treatment.<br>• The project has been integrated into the TEBA HBC programme. CAs are provided with HBC kits and are trained in basic HBC and monitoring of clients.<br>• Support groups for ex-mine workers in the three councils have been established and ex-mine workers have been trained in positive living, treatment literacy and gender dynamics. |
| Strengthening of local implementing partners | • In Lesotho, TEBA Development has an ongoing HBC project, which has added a prevention dimension to its activities.<br>• In order to build internal capacity on migration, gender and HIV, TEBA staff has been trained with the support of Sonke Gender Justice Network, which has resulted in stronger organizational ownership of the project.<br>• Through training provided by IOM, TEBA is now employing a more structured M&E approach allows the project to measure impact on people's lives and gather (qualitative and quantitative) data.<br>• Technical support from Sibambene on social and behavioural change has built the capacity of TEBA staff, who are now integrating the bottom-up approach to community engagement in other TEBA project activities. |
| Peer-led information, education, communication on health, including HIV, TB and STIs | • The 37 CAs conduct regular dialogues in the community and facilitate discussion with and amongst men and women on gender, migration and HIV. They fuse drama and poetry to increase the project's visibility and raise awareness. There has been visible and tangible evidence of the transfer of knowledge to communities. Anecdotally it has been reported that as a result of the project the number of people coming for HIV testing and seeking treatment for other diseases has increased.<br>• CAs included ex-mine workers, local councillors, chiefs (traditional leaders), youths and other community members. By involving community gatekeepers, the ownership of the project has increased.<br>• The project has taken a conscious strategy to always involve PLWHA in all aspects of work, as CAs as well as in support groups. For instance a CA living with HIV presents a weekly radio show that tackles issues on migration, HIV, gender and stigma.<br>• A specific "Men as Champions" group has been established that focuses on challenges relevant to men, particularly ex-mine workers.<br>• CAs also engage youth in discussions and through recreational activities.<br>• The project established Community Action Teams (CATs) for the different communities in the district. Their mandate is broad and embrace issues such as crime prevention, HIV, gender, migration and human trafficking.<br>• The project's dialogue process addresses stigma and discrimination actively with the facilitation of CAs, who are seen as community role models. Community members report a reduction in stigma and discrimination.<br>• In a community with low skills and high unemployment, trained CAs are more able to access employment and the project is seen as an entry point for remunerated work. For example, the Department of Local Government employed some CAs to work in gully reclamation and road works projects. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Addressing gender dynamics in the context of health and migration | • The project has created an enabling environment for men and women to engage in dialogue in order to address daily challenges around culture and gender norms.<br>• Initially the project envisioned that the Ex-Mine Workers Association would take the lead on issues of gender and male involvement but their limited capacity meant they were unable to sustain full involvement. As a result the project decided to work from within the community and selected community men to spearhead the "male involvement" activities. These men, who include ex-miners, are known as "Men as Champions" and form part of the local CATs. These CATs undertake campaigns that are of interest to men, including issues of human trafficking, domestic and gender-based violence (GBV). They also facilitate focus-group discussions and one-to-one sessions.<br>• Through dialogues and outreach activities, "Men as Champions" have helped other men in the community to view themselves differently. This group is opening up opportunities for men and women to participate as equals in public activities and forums. For instance, women now participate in lekgotla, a traditionally male-only forum which discusses community challenges and issues.<br>• Training the community in gender and making the community aware of HIV-prevention methods has helped ex-mine workers to work with others and their families, especially their wives. According to ex-mine workers interviewed, women were never consulted when making household decisions but this is starting to change. |
| Addressing contextual barriers to social and behavioural change | • The project has addressed contextual barriers that impact on health, such as food security, culture, gender (including GBV) and mobility. These have been addressed in part through the introduction of key-hole gardens, which, whilst providing nutritional support, also provide a safe space for women and men to discuss domestic challenges and agree on mutually acceptable solutions.<br>• Currently the project has constructed 466 key-hole gardens, each of which feed an average family of five to eight people. They have been unique, cost effective and beneficial to the communities as they have proven to be a non-threatening space for community dialogue and to address gender roles.<br>• Surplus vegetables are shared with vulnerable groups in the community, whilst income raised through selling of the vegetables is used to support orphans and vulnerable children. |
| Creating and enabling local environment | • At the community level the creation of key-hole gardens has created a space where dialogue between men and women can happen, whilst at local councils traditional leaders have been trained in gender, migration and HIV. As the custodians of culture traditional leaders are better placed to advocate for change, especially as some of them are also change agents.<br>• The project has assisted in forming a more positive relationship between the community and the government. The project, its CAs and HBC are seen by government as key community resources, able to access remote and marginalized communities.<br>• Building on its work, the project is expanding its target groups to include other migrant groups such as factory workers. |

## *Why Is This Project a Good Practice?*

According to SADC, for a project/programme to be considered a good practice it has to be successful in at least seven areas. This project scored above 80 per cent, implying that it is indeed an emerging good practice.

## *Effectiveness*

The project is effective since its programme priorities respond not only to national priorities but are determined by the community through regular meetings with CAs.

The project has strengthened the community in terms of HIV prevention through knowledge transfer and behaviour change. CAs are reaching out to the community in different forums – buses, factories, murals and public gatherings – and consequently the community ownership of the project is strong.

The project has taught the community about gender and where previously men were the decision makers, men and women are now working together to agree on decisions that affect them and their families. Project beneficiaries reported that cases of GBV have been reduced and they attribute this to the capacity building and dialogues. The work of Men as Champions is challenging traditional gender roles within the family and community, whereby men are now assisting with household chores and women can now participate in the construction of gardens previously the preserve of men. Where once wives of migrant mine workers had to wait for their husbands to return before making family decisions, now women are empowered and encouraged to make decisions for the family even in their husband's absence.

**"I have power because of the spinach and beetroot. I am now knowledgeable and can now use gloves to attend to patients and also community has changed"**

The role of culture has been consciously included in dialogues and has led to rediscovery of lost cultural values of togetherness. According to the project beneficiaries interviewed, before the project was introduced men did not like using condoms and viewed their roles in the family as absolute. Men also viewed themselves as "macho" and "infallible" due to cultural beliefs and teaching. The project introduced dialogues and showed how these views impacts on the family. Family members are now able to talk together and make mutually beneficial decisions.

**"HIV and AIDS would have swept the whole village if project was not present"**

The project has been integrated within the national TEBA HBC programme and this has led to the acceptance/demand for the project to be expanded to the rest of Leribe district and at a national level.

## *Ethical Soundness*

TEBA Development and its staff are viewed by the community as accountable and transparent as they provide regular feedback to the community. The bottom-up approach used ensures that the project remains ethical and involves the community in the decision-making process. In addition, the project identified a group of ex-mine workers that were particularly vulnerable and built their capacity on issues of migration, gender and HIV. Transfer of skills is evident at the community level and initiatives such as key-hole gardens are addressing real community challenges.

**"Before the project was introduced we used to bury about seven people a month in Litjotjela but this has changed and can now go for months without an HIV-related death in the community"**

## *Cost Effectiveness*

Cost saving through the integration of the different TEBA Development health projects is evident as resources are shared and used to maximum efficiency. CAs, who are unpaid, have supported peers to access services such as HCT, antiretrovirals (ARVs) and condoms. Key-hole gardens are a minimal resource intervention which has helped improve the nutritional status of people.

## *Relevance*

By targeting migrants and their families, the project responds specifically to the national strategic HIV-prevention plan. As some CAs are local councillors the project is also aligned to and acknowledged by local government.

Traditional leaders are core to the project both as CAs and as custodians of culture, and ensure the project remains relevant to the needs of the community, specifically food security.

## *Replicability*

The project is replicable as it uses a conceptual framework (HPSD model) that can be applied in other similar settings. Involvement in the project has continued to grow and more community members are engaging in community dialogues and accessing HCT.

The types of activities undertaken by the project can be replicated in other sites. For example, using different low-cost opportunities to disseminate information (such as murals and buses), constructing key-hole gardens as a tool not only to address food security but also to create a space for sharing information and knowledge.

## *Innovativeness*

The TEBA Lesotho project has demonstrated innovativeness in number of ways. For instance, the transfer of knowledge through peer-to-peer dialogues and discussion rather than traditional information giving has increased relevance as well as community ownership.


Key-hole garden in Lesotho.

The project addresses environmental and structural drives of the HIV epidemic by taking a developmental approach and addressing practical issues such as food security, culture and gender.

By capacitating community members as CAs who can provide a range of services and support – such as HBC and HIV prevention – the project addresses access to health services in a particularly hard-to-reach community.

By opening a space to discuss the link between HIV and gender, a number of deeply entrenched harmful social practices and norms have been addressed. For instance, HIV is now being discussed openly with children.

### *Sustainability*

In terms of the project's sustainability we need to consider not only financial resources but also sustainability of skills and knowledge. By creating a local identity coupled with local ownership the project is acknowledged and accepted within the community and the surrounding area. Consequently, the bottom-up approach to social and behavioural change has been mainstreamed into the community's decision-making forums such as lekgotla.

By building the capacity of the community to respond to the challenges of migration, HIV and gender, the community is well placed to sustain their activities.

**CAs gain recognition in the community**

Change agents have been commissioned to do dialogues in the community and the direct result of their work has been the recognition that they provide solutions to health problems. In addition to condom distribution, change agents also put posters in public places and as a result the communities are now requesting services like dialogues. More specifically, a school has requested a key-hole garden to assist in feeding orphans.

The project is recognized nationally, through presentations at different forums; the National AIDS Council supports the expansion and replication of the project and has offered to assist with resource mobilization.

As an institution, the capacity of TEBA Development has been increased and improved so that it is willing and able to sustain and expand the project.

## *Building on What We Have Learnt*

This project has been evolving since its inception. From the start of the project it was realized that the traditional top-down approach to HIV education was not appropriate in mine worker sending communities so a bottom-up approach to social and behavioural change was adopted. In addition, a key lesson was the need to recruit CAs that were representative of the community so as to ensure that peers are able to talk to peers.

Social change is a long-term process that requires community participation at all levels (youth, traditional leaders, PLWHA and so on). The project supported the community to identify the desired change, acknowledge the barriers to this change and facilitate action to promote change.

Communities continue to grow and identify new barriers to change. Consequently, capacity building needs to be ongoing and responsive to the needs of the community. For instance, the need to initiate income-generating activities has been identified; these would further unify the community, create a platform for dialogue, attract other community members and spread the message on gender, migration

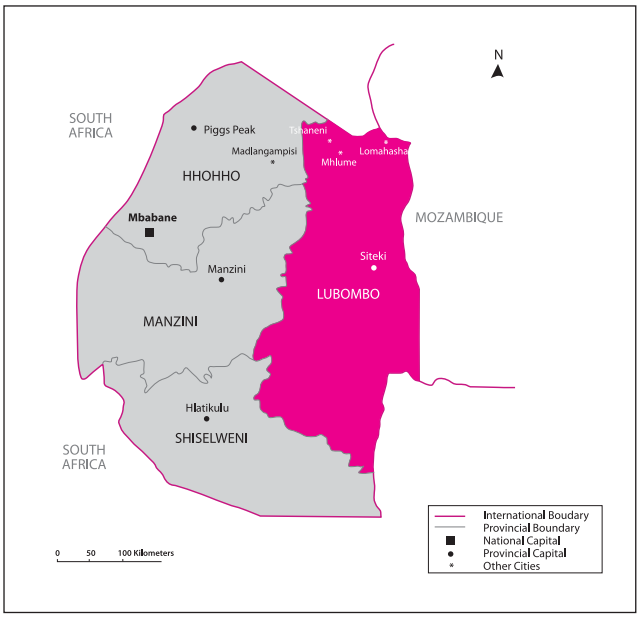
and HIV. Where as the need to capacitate health service provides on patients' rights and responsibilities addresses a barrier to accessing health care.

The success of this project suggests that its approach to social and behavioural change needs to be scaled up to cover more areas. This could include exchange visits between villages for information sharing and capacity building.

## 5.2 Royal Swaziland Sugar Corporation (RSSC) Swaziland

### *Programme Inception and Description*

In 2007, IOM partnered with RSSC to develop a project in Swaziland that would work with the seasonal and contract workers in the commercial agriculture sector. Like the other IOM pilot projects, a conceptual framework was used that considered the contextual causation of HIV infection, as well as individual behaviour.




At 25.9 per cent, Swaziland has the highest adult HIV prevalence in the world (UNAIDS, 2010). RSSC is one of the largest employers in Swaziland, located in the north-eastern part of the country. It employs an estimated 5,000 workers, including permanent, seasonal and contract workers, with operations in Mhlume and Simunye Sugar Estates. Since 2002 RSSC has been implementing a comprehensive HIV programme, including prevention, treatment, care and support. However, seasonal and contract workers were excluded from the programme.

In IOM's partnership with RSSC, the project has been designed to include workers that traditionally no one considers, that is the seasonal workers and those employed by contractors as well as the local communities that live in and around the sugar estate. This has greatly enhanced the local reputation of RSSC, who is viewed as "a socially responsible employer".

### *Regional Relevance of RSSC project*

In the region the commercial agriculture sector relies on seasonal and contract labourers, who are frequently excluded from health-related workplace policies and programmes. This project has demonstrated the necessity of responding to their needs – both for internal and cross-border migrants. In implementing the project, IOM enabled RSSC to reach out to its workers previously not covered by its HIV policy and programmes. In this way the project provides an example to other private-sector companies of how to respond to the needs of their seasonal and contract workers.

From the start, the project had to challenge the business culture of RSSC, which focuses on productivity and profit, with the project's developmental approach, which acknowledges that social and behavioural change is a long-term process. The lessons learnt during project implementation are relevant to other private-sector companies in the region who face a similar challenge.

The HIV vulnerability of seasonal and contract workers is linked to their insecure employment status, a

situation faced by many workers across southern Africa. This project has demonstrated that it is not only possible but also necessary for the private sector to consider all those who contribute to the success of their company and not just those they directly employ. The project can be replicated not only in similar contexts but can also be used as an advocacy tool at the national and regional level to engage the private sector and government in lobbying for the inclusion of contract and seasonal workers in national plans and priorities.

### *IOM's Health Promotion and Service Delivery Model*

The project built on and complemented the existing RSSC HIV policy and programme by reaching out to seasonal and contract workers. Consistent with other sites, the project was able to implement the different components of the health promotion and service delivery model to varying levels of success. However, unlike the community-based responses in Lesotho and Mozambique, this project involved a target group that was difficult to access, had insecure employment status and a low literacy level.

To address this, the project recruited and trained 68 change agents from those employed as seasonal or contract workers. The project recognized that there would be a high turnover in CAs, who would not necessarily return to RSSC the next season. Consequently, they had to train new CAs on an annual basis. To ensure consistency in messaging and approach, the CAs worked collaboratively with existing RSSC peer educators.

The following table considers each component of the model and how it was implemented, alongside some of the successes and challenges faced by the RSSC seasonal and contract workers in the project.

Obrian Fungai Nyamucherera © IOM 2011


Murals as an advocacy tool at a central shopping and trading centre within the estates in Swaziland.

## Table 6: Implementation of HPSD model in RSSC, Swaziland

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Facilitating access to health services, programmes and products | • The project identified that seasonal and contract workers struggle to access the RSSC wellness clinics due in part to their employment status and the opening times of the clinics. Consequently, these workers prefer to access the free government health service that is available a short distance from the estate.<br>• RSSC have initiated a series of wellness days which offer primary health care services for blood pressure, diabetes and so on, and are open to all employees regardless of contract type.<br>• RSSC, with funding from Global Fund, provide antiretroviral treatment (ART) for all employees. This is available to seasonal and contract workers.<br>• The project has partnered with other organizations to bring health services and products, such as HTC, STI screening, condoms and so on, to the seasonal and contract workers.<br>• Support groups have been established for workers. These support groups are facilitated by an external partner. |
| Strengthening of local implementing partners | • The IOM partnership has enabled RSSC to strengthen its response to HIV and AIDS. RSCC are now able to reach out to seasonal and contract workers, as well as contractors and community members.<br>• In addition, the approach advocated by the model has helped consolidate RSSC's response to HIV – their programme has been expanded to address individual, environmental and structural level drivers such as gender and culture.<br>• The project falls under the mandate of the HR department, whose staff members have been trained on issues of gender, migration and HIV, and SBCC. In addition, all RSSC permanent peer educators have been included in all project trainings.<br>• By including the finance department in M&E trainings, the project has built stronger corporate ownership, which has resulted in improved internal relations and reporting.<br>• There is a challenge in harmonizing the operating procedures of RSSC, as a business, with the developmental approach of the project. For example, the internal control mechanisms help ensure transparency and accountability but can, in turn, impact negatively on implementation, for example hindering access to transport and delaying sign off by management for activities.<br>• There was a period of time when the project had no coordinator. However, it was noted that during this transition period CAs continued to function and facilitate dialogues. |
| Peer-led information, education, communication on health, including HIV, TB and STIs | • CAs have been allocated specific time to talk to their peers on a weekly basis. This is complimented by dialogues and one-to-one sessions with peers and community members around the estate.<br>• Different themes and topics have been identified and addressed, such as culture, gender dynamics, lack of economic empowerment (for women), accommodation and lack of access to health facilities due to user fees.<br>• PLWHA are involved in the implementation of the project – they facilitate dialogues and assist in the establishment of support groups.<br>• The benefits of the programme for CAs have been knowledge of their own HIV status and behaviour change, whilst for the beneficiaries' their awareness of HIV has increased, along with condom use and HCT uptake.<br>• The partnership between IOM and RSSC has brought targeted inclusive interventions. For example, a billboard was developed that included real workers and community members and addressed local concerns about consistent and correct condom usage.<br>• In order to build the capacity and confidence of CAs, an exchange visit to another IOM pilot site (Hoedspruit Training Trust) was arranged; this proved to be catalytic in the start up of the project. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Addressing Gender dynamics in the context of health and migration | • Gender dynamics within the estates was identified as a barrier to change. Through capacity building on gender, migration and HIV and the promotion of men as role models, the project is addressing sexual and reproductive health issues.<br>• Gender-based violence as an issue has been highlighted through murals and dialogues; the community are reporting fewer incidences of GBV.<br>• RSSC has even made some inroads in female empowerment through their training on gender and how to demand safe sex from partners. |
| Addressing contextual barriers to social and behavioural change | • Low literacy was addressed through adult literacy classes. Learners have managed to come consistently to trainings over the last two years and are now able to utilize information materials.<br>• Because seasonal and contract workers do not have financial security the issue of how best to utilize their limited financial resources was recognized as a health vulnerability, since some workers engaged in transactional or paid sex work. To address this, the project piggy-backed on RSSC's existing financial literacy programme and assisted seasonal and contract workers to access this training.<br>• The project has also been able to work towards addressing barriers to social and behavioural change through dialogues on culture, gender, lack of economic empowerment, accommodation and lack of access to services. Although the project has recognized barriers such as accommodation and poverty, will require a multi-stakeholder commitment. |
| Creating an enabling local environment | • There is a strong ownership of the project within RSSC. The project is incorporated into their internal Integrated Management Systems and is audited according to the international standards of the AIDS Management Standard (AMS), which helps to ensure that implementation is transparent and effective.<br>• There is a tripartite committee consisting of management, the staff association and trade unions, which provides strategic direction and monitors all RSSC HIV projects and programmes.<br>• The project has made the HIV and AIDS programme more comprehensive by addressing not only individual behaviour but also environmental and structural factors.<br>• RSSC's policy requires contractors to adhere to RSSC HIV stipulated standards. However, contractors have not been monitored to ensure they stick to this requirement. RSSC recognize this and are considering how to address this gap.<br>• As part of the attempt to reach all employees every year, there is a deliberate effort to communicate the HIV and AIDS policy to all employees to make sure they are all aware of their entitlements. The model has been used to advocate for the rights of workers to health and the contractors are now making time for workers to attend dialogues and awareness sessions/campaigns – something they denied the workers in the past.<br>• Government and the private sector have acknowledged the importance of addressing the needs of migrant workers and appreciate the project's response to the needs of a very relevant and neglected group of people. They are keen to see how the approach could be exported to other similar contexts. |

* http://www.amsi.org.za/documents

## *Why Is This Project a Good Practice?*

According to SADC, for a project/programme to be considered a good practice it has to be successful in at least seven areas. This project scored 70 per cent and qualifies to be considered an emerging good practice worth replicating and sharing with stakeholders.

## *Effectiveness*

RSSC have been effective in addressing identified barriers and have been able to reach out to their target group of seasonal and contract workers and the community with which they interact.

The project has been integrated into the operations of the organization and this has guaranteed management support and oversight.

As in the other IOM pilot projects, the role of the change agents has been critical. Change agents were recruited on a voluntary basis and their role was to facilitate peer-led communication with other workers on issues relating to HIV prevention. This included facilitating discussions on sensitive gender and cultural issues as well as promoting access to services such as HCT.

A challenge, as in many workplaces, is ensuring that sufficient time is allocated for peer-to-peer communication. In the project peer-to-peer communication frequently happened outside normal working hours in hostels, at recreational activities and change agents report that more people are using condoms, accessing HCT and are open about their status.

A key strategy of the project was to develop partnerships. For instance, SWABCHA (Swaziland Business Coalition on HIV and AIDS) has partnered with the project and participated in project activities such as campaigns and provision of health education, care and support. By working closely with government through National Emergency Response Council on HIV and AIDS (NERCHA), RSSC has established a good practice in terms of addressing migration and its impact on health. Government has indicated keen interest and support for the project and is kept informed through regular reports.

## *Ethical Soundness*

RSSC have observed ethical standards such as compassion, solidarity, confidentiality, consent, responsibility and tolerance during the development and implementation of the project. However, RSSC at the moment have no way of enforcing the HIV and AIDS policy on contractors to ensure that seasonal and contract workers' needs are met and rights upheld. RSSC recognize this and are reviewing their partnership with contractors so as to enhance the relationship and promote adherence to the HIV policy.

## *Cost Effectiveness*

Administration costs for the project were shared between IOM and RSSC. RSSC was able to leverage internal resources to support the project implementation, such as office-related costs, management (financial and substantive) and staff costs.

It would be important for the project to determine how much is spent on reaching a single person so as to measure the cost effectiveness of the project and thus assist in replication. In addition, a resource mobilization strategy needs to be implemented to assist with project expansion.

## *Relevance*

The project identified a neglected and marginalized group (contract/seasonal workers) and demonstrated how they can be included in an HIV intervention. The project has been guided by a communication plan that is regularly reviewed and that guides project activities including topics to be addressed and discussed and thus keeps the project relevant to the realities faced by the target group. This bottom-up approach allows for beneficiaries to be actively involved in the project planning and implementation.

Since partnering with IOM, RSSC's profile has improved as they are seen as employers who care for their workers. RSSC staff interviewed also indicated that productivity levels have improved because workers' well-being is considered.

## *Replicability*

The project has helped the community develop messages that communicate the change they want to see in their lives. For example, the participatory development of posters and a billboard ensured that the messages and images used were relevant. This approach can be replicated. The billboard has united the workers in a way that is helping some employees to disclose their HIV status. The success of the billboard (Figure 3) is demonstrated by contractors requesting that billboards be erected in strategic places within the estates to serve as an awareness-raising and advocacy tool.

The project has managed to increase access to services (HCT and condoms) through outreach campaigns and has introduced adult and financial literacy to all employees.

**Figure 3 :The inclusive billboard located in the middle of the sugar estates**


Billboard in the sugar estates in Swaziland.

## *Innovativeness*

The RSSC/IOM project in Swaziland is innovative in a number of ways. The HSPD model is holistic, responsive to needs and covers numerous aspects of HIV-prevention, access to health services, gender dynamics and cultural issues. The model addresses real life issues and thus gives activities depth and substance.

The project caters for migrant workers and mobile populations and has facilitated transfer of knowledge, incorporating non-traditional HIV responses such as adult and financial literacy.

The project has created a demand for HCT service. Partners such as Family Life Association of Swaziland (FLAS), who operate a mobile HCT service, report increased client numbers.

The RSSC/IOM project is the only pilot project that has subscribed to AMS. RSSC are audited according to International (ISO) standards, making their project innovative and ensuring adherence to high standards.

## *Sustainability*

There are different ways to look at sustainability. One way is to consider whether the organization is able to continue as it is. Another way is to consider if it would be able to continue if funding stopped. By mainstreaming a number of issues such as gender dynamics, proactively engaging with contractors to consider HIV policies for non-RSSC employees and by linking the project to the AMS process, RSSC has ensured some form of sustainability.

However, if funding were to cease, current activities may not continue as they are. Some marketing of the project to external stakeholders has taken place but this is limited as there is a reluctance to share the project and the model with other stakeholders in Swaziland. This needs to be addressed as RSSC could use its experiences to lead the national response to gender, migration and HIV. There is a need to source other long-term funding streams and to market the project at relevant forums and with key stakeholders.


Change Agents engaging with peers at their usual place of meeting in Swaziland.

## Building on What We Have Learnt

The project has learnt a number of key lessons that should be shared, including the need and importance of involving senior managers in planning the project so as to assist in both implementation and sustainability.

The project has made a deliberate plan to create partnerships with other key service providers and stakeholders, which is an important strategy in terms of building boarder national ownership of the project as well as sustainability.

As one of Swaziland's largest private-sector companies, RSSC have a critical role to play in leading the HIV response within the corporate sector. It is important to share a concrete strategy on lessons and experiences with key stakeholder such as government and the national business coalition on HIV. Government has recognized that there is a gap in ownership of the national response to HIV, especially in terms of migration, and the RSSC/IOM approach addresses this gap.

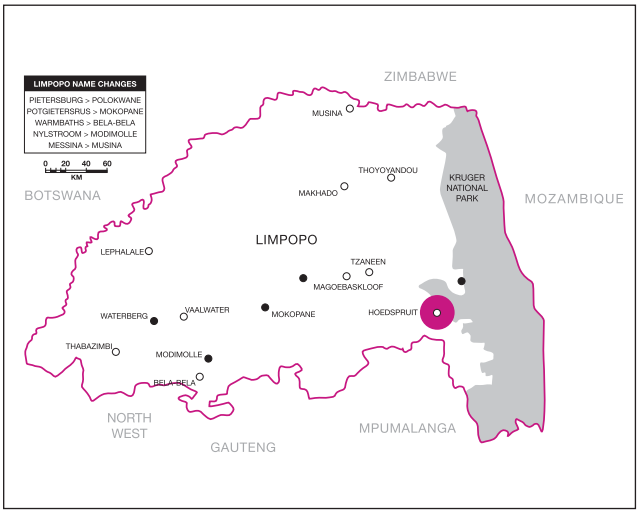
As with the other IOM pilot projects, behaviour change is a long-term process and consequently the project should be considered a long-term intervention.

Building on this, RSSC should consolidate learning from what has worked so far before up-scaling or expanding the project to other sites. A strong information sharing and advocacy strategy on the project and about gender, migration and HIV needs to be implemented. There is potential for this approach to be suitable for other migration-affected workplaces such as the textile industry in Matsapha.

During the up-scaling process the project should consider how to integrate other health issues such as TB, maternal health and child care and should investigate how to link the project to migrant-sending areas so as to ensure support for migrants when they return home.

## 5.3 Hoedspruit Training Trust (HTT) Hlokomela : South Africa

### *Programme Inception and Description*




The Hlokomela project is based in the farming community around Hoedspruit, in Maruleng Local Municipality, Limpopo Province, South Africa. The project was introduced by the Hoedspruit Training Trust (HTT), a community-development initiative formed in 1996 involving community members, farmers and farm workers in various development projects. From about 1992 the forerunner of HTT, the Rural Foundation, supported a farm workers health programme, Hlokomela, in which farm workers were trained as lay health workers to address some of the health issues on farms. These health workers became known as "Nompilos" (Zulu for "Mothers of Life") and their core duty was to provide primary health care to fellow farm workers. However, as the effects of HIV became more evident, HTT realized the need for a much more comprehensive programme to tackle the problem in the area.

In 2003 the IOM conducted a study of HIV vulnerability among migrant farm workers on 12 commercial farms in the Hoedspruit and Burgersfort areas. The study found, among other things, very high levels of migration and mobility of workers due to the seasonal nature of work, alarming levels of unsafe sexual behaviour, low condom use and low levels of HIV awareness (IOM 2004a). IOM identified the HTT Hlokomela programme as a potential partner in addressing these issues and formed a partnership in 2005 which supported a pilot project on 18 farms.

Using its local knowledge, experience in farm health care and vision for a comprehensive response to HIV, HTT and IOM implemented a multi-faceted programme that focussed on meeting the many development needs of farm workers. This approach became the forerunner of the health promotion and service delivery model.

In 2005, at the start of the project no-one on the farms was living openly with HIV whilst at present there are about 400 patients on ARVs and 1,000 that do not yet need medication.[1] From 18 change agents in 2005 the project now has 59, 38 of whom are paid a stipend by the Department of Health. Change Agents, as in the other pilot projects, are a key component of the programme and have been equipped to facilitate dialogue and share information about health and wellness with their fellow farm workers and the wider community. HTT has focused on awareness, counselling and testing, provision of ARVs, gender dynamics, food security, a herb garden, wellness programmes and recreational activities such as soccer and netball.

"Project has taught and changed the perception of farm workers to be responsible for their own health…"

As the longest running IOM pilot project the HTT site has been used as a learning site, through which experiences and lessons learned are shared.

The project responds to the South African national AIDS strategic plan and priorities by targeting labour migrants.

**The HIV and AIDS and STI National Strategic Plan (NSP) for South Africa (2007–2011)** provides a guiding framework to the national multi-sectoral response to the AIDS epidemic. The primary aims of the NSP are to reduce the number of new infections by 50 per cent by 2011, and to mitigate the impact of the AIDS epidemic by expanding, among others, access to treatment, care and support to 80 per cent of all people diagnosed with HIV by 2011. It identifies population mobility and labour migration as one of the drivers of the AIDS epidemic and recognizes the vulnerability of mobile populations to HIV. It acknowledges that individuals who engage in mobile forms of work or migrant labour face increased risk of HIV-infection. Mobile populations described as vulnerable to HIV in the NSP include informal traders, long-distance truck drivers, sex workers, cross-border migrants, seasonal agricultural workers and migrant workers (mine workers, construction workers and uniformed personnel).

### *Regional Relevance of HTT, Hlokomela Project*

HTT has implemented the project in a way that is not only relevant to the farming community in Hoedspruit, but can also be replicated in similar contexts in southern Africa. By working in partnership with other service providers, including government, HTT has facilitated farm workers' access to health services and products through weekly scheduled mobile clinic outreach. This partnership approach demonstrated that bringing together organizations, with their own particular mandates and skills, can deliver a coordinated response on the farms that ensures not only improved usage of limited resources but also provides a holistic range of services to an often marginalized community.

1 As of the time of field work – August/September 2010

As the initial IOM pilot project, the regional relevance of the Hlokomela project has been felt first hand by other project partners. HTT pioneered the implementation of the project components; this has been replicated in other countries and their experiences and tools have been shared amongst the partners in the region. This learning centre role could be expanded to provide support to other organizations working in migration-affected communities, particularly those in commercial agriculture.

Hlokomela's strong advocacy and profile raising strategy, particularly at the national and sectoral level, is a good practice that should be extended to the regional level.

### *IOM's Health Promotion and Service Delivery Model*

HTT's Hlokomela project has been able to implement and pioneer some of the key components of the HPSD model. Experience suggests that the HPSD model can be replicated with the involvement of a passionate local driver, local buy-in from farmers and workers, key stakeholders (such as government) and funding.

HTT implements an HIV project focusing on prevention, care and treatment and takes a broader health approach to wellness. The project combined activities from all the different components of the model. Of particular importance is the role of the change agents.

**Thokozile** (not her real name) was sick since 2007 and tested positive for HIV in 2008. She was then referred to HTT at Bavaria Estate at which time her CD4 count was 33. In January 2009 she started to take ARVs. She says "Hlokomela has given me a new life and rescued me from the grave." Although at the beginning it was tough she did not want to die without trying. Since starting treatment she has found a boyfriend who is also HIV+ and they are living together and living positively. "In the community," she says, "people used to get sick and go to the hospital countless times without getting better. But since Hlokomela started to do outreach on the farms and the clinic opened people are getting treatment and getting better. Men now have fewer partners or have one partner, and women have also reduced their sexual partners on the farms."

The following table considers each component of the model and how it was implemented, alongside some of the successes and challenges faced within the Hoedspruit farming community.

## Table 7: Implementation of HPSD model in HTT, South Africa

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Facilitating access to health services, programmes and products | • Given the rural nature of farms and the historical marginalization of the farming community, access to health services has been costly and inconsistent. By working closely with government and other partners Hlokomela has established clinics, developed a close referral and support group system for HIV and TB patients and on each farm a health focal point is available.<br>• The establishment of clinics, through additional funding from Right to Care, has resulted in about 400 patients on ARVs. The success of taking the clinics to the farms has been recognized, for example by the Department of Health's accreditation of the clinics. Patients from as far as Phalaborwa, about 100 km from Hoedspruit, come to Hlokomela for treatment.<br>**"staff are responsive and they have the right attitude. In other clinics they are abrasive and rough"** |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Facilitating access to health services, programmes and products | • Through wellness clinics many people now know their status, TB patients have been detected, and ARVs and condoms have been provided to everyone. A Prevention of Mother to Child Transmisison programme has also resulted in all children that have been born to HIV+ mothers being HIV negative (12 patients had delivered HIV-negative babies by August 2010).<br>• As with many HIV projects, funding for non-HIV medical supplies is problematic. In addition, the mobility of seasonal workers makes tracking of patients and adherence difficult.<br>• The project facilitates access to primary health care on 28 farms through fellow farm workers trained as home-based carers. |
| Strengthening of local implementing partners | • HTT has grown substantially since 2005, not only in terms of staff compliment but also in terms of skills and capacity. With support from IOM, skills in report writing, M&E and financial reporting have improved and this has greatly assisted in transparency and accountability.<br>• With annual strategic planning meetings, Hlokomela considers its capacity on a regular basis and has enabled these meetings to consider how best to structure their staffing.<br>• HTT has been able to fundraise and get other funders to support the organization. For instance, Right to Care, a South African non-profit organisation that builds public- and private-sector capacity for the clinical care and treatment of individuals living with HIV and associated diseases, support clinic staff, medical supplies and medical equipment whilst the Department of Health and Social Development supports HTT with ARVs, caregivers transport costs and allowances. HTT recognize that they need to expand their funding base particularly in terms of core costs, such as salaries and administrative costs.<br>• Currently, farmers provide support to the project in kind, in the forms of transport, uniforms and so on, but in the longer term farmers should consider how to support the project financially. |
| Peer-led information, education, communication on health, including HIV, TB and STIs | • CAs, as the key peer-to-peer communicators, have been empowered through capacity building and regular mentoring to provide correct information to their peers on HIV/AIDS, STIs, TB and other health issues.<br>• The project works with 59 CAs on 59 farms who engage in dialogues on health and socio-cultural issues and practices, such as gender dynamics in relationships, multiple and concurrent partnerships. The project uses a range of communication tools such as face-to-face dialogues, print and mass media (billboards, murals), developed through the participation of farm workers and public media (radio, press). The CAs have quarterly themes which guide the monthly talks and meet at least twice a month for sharing feedback.<br>• Change agents have become coordinators in their own right by setting up focus groups of about 10 farm workers on every farm. This ensures that more farm workers directly participate in the peer-led communication activities. This process has led to increased and open discussion on HIV-related issues and there are reports from change agents that more people are living positively with HIV.<br>• These groups have chosen to call themselves “Gingirikani” (a Xitsonga word meaning “working with great effort”). The Gingirikani’s role is to discuss farm workers issues and challenges specifically relating to HIV and social issues and to identify actions that farm workers, farmers and HTT can take to address the challenges.<br>• In order to address stigma and discrimination, HIV ambassadors, who are all farm workers living with HIV, have been identified to mobilize people, and talk about adherence and ARVs.<br>• The most significant changes observed are within farm workers and change agents themselves. Self esteem and confidence has grown and they are now talking openly and confidently about HIV and GBV. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Peer-led information, education, communication on health, including HIV, TB and STIs | • HTT has also established a system to recognize and motivate the different stakeholders in the project. Every year, an awards ceremony is held for different categories such change agents and farm owners. |
| Addressing gender dynamics in the context of health and migration | • Gender intervention, targeting men, and providing training and mentoring of male role models with the aim of addressing issues such as GBV, faithfulness to one-partner, sex workers and poor health-seeking behaviour in men have been critical interventions of the project.<br>• The initial "male" focussed gender programme has grown and Hlokomela are working with women ("One Woman Can") and local school children. The gender programme has challenged some of the traditional and cultural practices, including how traditional justice systems addresses GBV and challenges stereotypes.<br>• HTT has noticed that through these interventions, women have become aware of their rights, and men are becoming more involved in supporting their partners in seeking health services. |
| Addressing contextual barriers to social and behavioural change | • The 2004 study identified a number of contextual barriers including lack of recreational activities, accommodation, harmful cultural practices related to gender norms and food insecurity.<br>• Through dialogues, farm workers have identified various activities like soccer, netball, traditional games and a choir to provide healthier recreation options. These activities have also increased social cohesion within a community which is often isolated from the mainstream.<br>• Communal and herbal gardens have been established to provide food security and nutritional support to those in need, including those taking ARVs and TB treatment. |
| Creating an enabling local environment | • From the start the project leaders realized that many farms did not have HIV or wellness workplace policies and thus gave no structure to their HIV response. HTT work with all their partner farms to develop HIV policies, which they review annually. Through CAs, farm workers also make contributions to these policies, and are communicated using various means such posters and DVDs.<br>• In terms of the wider environment, Hlokomela has identified other key stakeholders whose involvement and support greatly assisted project implementation, for example government at the local, district and provincial levels, traditional leaders and healers, who have all contributed to the success of the project.<br>• According to local government officials the project has brought health services closer and contributed to the overall development of the community. The local municipality has a limited capacity to address the problem of HIV on farms, and thus relies on HTT to take this role. HTT has a leading role in the local AIDS committee and has been asked to support the municipality to extend a wellness programme to council employees.<br>**"Without them (HTT) we would not be able to deal with it" (Maruleng Municipality)**<br>• The organization has been recognized as a leading NGO in the province and there is substantial programme visibility at a national level through awards and television. |

**Hlokomela Gains Provincial and National Recognition**

HTT has been successful not only in the eyes of the local community but has been recognized at a national level. Below are some of the awards and recognition that it has received:

- Hlokomela received the prestigious Silver Impumelelo Innovations Award in 2008, a national award granted by South Africa's Impumelelo Innovations Award Trust to recognize innovation in government and public–private partnerships, which enhance the quality of life of poor communities and address key developmental issues of national concern.
- Maruleng Municipality nominated Hlokomela as the best Non-Profit Organisation in the Mopani district. Hlokomela won the award in August 2008, ahead of 43 others nominated.
- Christine du Preez, director of Hlokomela, was nominated and selected as a finalist in the individual category "The Southern Africa Trust and Mail and Guardian 2008 Drivers of Change – Investing in the Future" awards.
- Hlokomela received a cash award from the Mopani District Executive Mayor Charity Cup 2008 in July 2009.
- Awarded the "Investing in the future" award by Mail and Guardian's annual NGO award ceremony in 2009.

## *Why Is This Project a Good Practice?*

According to SADC, for a project/programme to be considered a good practice it has to be successful in at least seven areas. This project scored 85 per cent, showing that it is truly a good practice.

### *Effectiveness*

**"HTT has made farm management treat the workers in a special way…. People are now willing to get tested because of knowledge…."**

HTT has set very clear objectives, outputs and outcomes, and systems have been put in place to monitor progress and evaluate impact. The overall objective of the HTT is to improve the health and reduce the vulnerability of migrant and permanent farm workers and their families in the Hoedspruit area to HIV and AIDS, TB, and other chronic health conditions through improved knowledge, awareness, access to services and healthier living conditions. HTT is realizing their goal; access to services has increased: through the peer-led communication process, farm workers are getting information on HIV and other health issues, and also participating through regular dialogues on issues and barriers to behaviour change.

Various interventions, such as support groups, have improved the quality of life of farm workers. Working hand-in-hand with farm management as well as farm workers has ensured that there is broad community ownership.

HTT's comprehensive response shows how effective coordination, coupled with strong partnerships, can tackle underlying HIV vulnerabilities whilst also providing a range of HIV services to an often marginalized community.

The project has been effective in ensuring that beneficiaries are involved in the project, including farm workers living with HIV. This has ensured that communication messages used in murals and billboards are relevant and where possible include images of workers from the farms.

## *Ethical Soundness*

According to the SADC criteria, an intervention is a good practice if it does not violate human rights, respects confidentiality as a principle, embraces the concept of informed consent, applies the "do not harm" principle and works towards protection of the interests of various vulnerable groups. This project has demonstrated all of the above and is inclusive in its approach, ensuring that all people are included by programme.

**"Project has been confidential in its operations leading to success in reaching out to the people and the employers through the Nompilos ..."**

HTT has set clear policies and processes for ensuring confidentiality of their clients and the information they share. CAs sign a code of conduct and are taken through a structured induction process to ensure that they understand their role and ethical issues related to it.

Participation, inclusion and ownership are some of the core values that the project upholds. Farm workers, through their CAs, have a voice in how the project should be run. The project also works to ensure that PLWHA are empowered, educated and included as key stakeholders.

The local community, including farm workers, farm owners, traditional healers and leaders are also included as stakeholders.

## *Cost Effectiveness*

The project is able to do more work using fewer resources because of instituting financial and procurement processes that are cost effective, such as regular financial monitoring and budget tracking.

There has been an increase in the number of people in the farms who are being tested for HIV, and more are coming to support groups and the clinics with no corresponding increases in funding.

Government is now contributing ARVs to the clinic, thus making it sustainable to provide ART to farm workers if funding from donors dries up.

**"Project has reached people in the community at the level that makes them come out and seek better health choices. Cultural barriers have been broken by the project and it has restored the dignity of the African people. This has shown better value of themselves ... as a people ..."**

The project has also been cost effective in improving the quality of life of workers to the benefit of the employers, who have observed improved productivity due to less absenteeism. The project has also helped the farm owners reduce their loss of skills due to death by assisting workers to be on treatment and receive psychosocial support.

## *Relevance*

All interventions are based on a needs assessment conducted as part of the baseline survey to ensure that the project addresses the expressed needs and knowledge gaps of the client community.

The bottom-up approach to project design and implementation ensures local ownership and participation. This is demonstrated by the continual growth of the project and the increased number of farm workers able to access services.

Through an ongoing system of community dialogues, the project is able to identify and address emerging issues.

On a broader level, Hlokomela's approach to HIV care and prevention on farms is in line with the national HIV and AIDS Strategic Plan (2007–2011), which identifies prevention, treatment, care and support, human rights and social mobilization as the five key activities in the fight against the disease. In this way HTT contributes to the overall national response to HIV.

Cognizant of the impact of migration and mobility within the commercial agriculture sector, the project has a strong focus on mainstreaming migration throughout all activities to bring about understanding of associated vulnerabilities and therefore build in appropriate responses.

## *Replicability*

The Hlokomela project was the learning site for the health promotion and service delivery model, and the lessons generated by HTT have already been replicated in the other IOM pilot projects in the region and in other farming communities in South Africa. This pioneering project is providing many organizations in South Africa and beyond with key lessons and tools that can be used to replicate this response to HIV and migration. For instance, HTT has hosted other organizations on exchange visits, documented lessons learnt during implementation, and has adjusted the project activities accordingly.

## *Innovativeness*

The project is innovative in a number of ways as it has brought farm workers together as a community through its "farm workers care for each other" motto. Farm workers, who are often considered as having low or no social standing, are now recognized and acknowledged as key members of the community.

The project has developed a strategic partnership with the local newspaper that keeps the Hoedspruit community informed about the activities of the project. This builds visibility and broader community ownership.


Murals within the farms in Hoedspruit, South Africa.

As in the other projects, the CAs are a core resource of the project. After building their capacity and confidence, they are now considered leaders and role models on the farms and in their communities. The Gingirikani focus groups demonstrate the CAs' empowerment as this innovative approach was developed by CAs themselves, who now oversee and coordinate the Gingirikani activities.

### *Sustainability*

Through the partnerships and networks that have been built, HTT has managed to receive support to enable continued delivery in the project, specifically in terms of ARVs, which the Department of Health and Social Development has committed to provide to the clinics for 2012.

Project uptake by the farmers has been remarkable, and they have been able to institutionalize some of the aspects of the interventions through their workplace policies and programmes. Most importantly, the empowerment of the CAs goes beyond the scope of any project, into communities where they are recognized as leaders and role models – an outcome that will be with them for the long term.

Other NGOs have also benefited from HTT's work through training that they received, and are incorporating HTT's lessons into their own work. In an attempt to achieve some form of sustainability, the products from the herbal garden are being marketed as far away as Cape Town. The direct benefit of the garden has been in the form of paying for some staff salaries.

## *Building on What We Have Learnt*

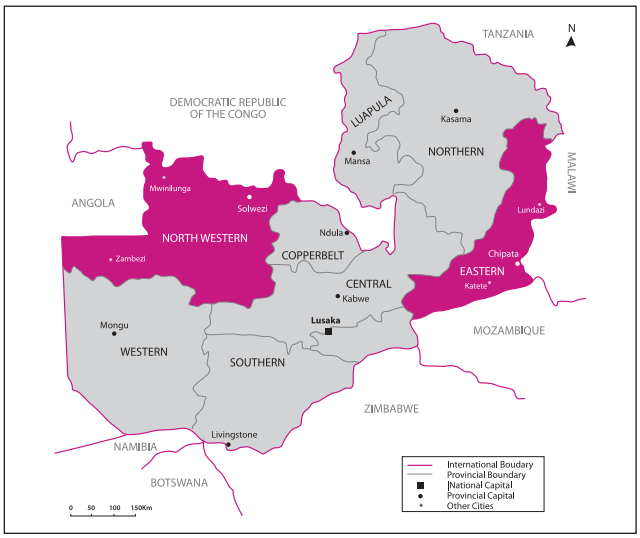
The richness of the project and successes gained have brought to the fore critical learning points, which will add value to future projects targeting similar communities. For example, for a project to be sustainable it must be led by the community and be responsive to the needs of the target group. By addressing contextual barriers such as gender, and by creating a supportive environment, behaviour change can be supported, although this requires a long-term vision and approach. Whilst building local capacity and through a process of continual support and recognition, farm workers are doing HIV-related work with little supervision from HTT.

There is a need to extend HTT's service to other farming communities in the province and to include other at-risk groups such as sex workers. In addition, linking the project to migrant-sending villages and communities and strengthening the relationship between the municipality and the project would further strengthen the project's impact.

HTT should also consider accreditation for its trainings so that training can be extended to other organizations and individuals.

## 5.4 Comprehensive HIV/AIDS Management Programme (CHAMP): Zambia

CHAMP is a Zambian non-profit organisation which implements workplace HIV programmes for companies in the Global Development Alliance (GDA). The GDA is a public–private partnership between the Government of Zambia, the United States Agency for International Development (USAID) and Zambia's largest agribusiness and mining companies. CHAMP provides HIV prevention and care programmes, including condom distribution, HIV testing, care and treatment for employees of the companies under the partnership in Zambia.




**The Zambian National HIV and AIDS Strategic Framework (NASF) (2006–2010)** seeks to prevent, halt and begin to reverse the spread and impact of the HIV and AIDS epidemic by 2010. The NSF identifies high population mobility as one of the key drivers of the epidemic. It identifies vulnerable mobile populations as comprised of refugees, long-distance truckers and migrant workers, cross-border traders, fish mongers and uniformed security personnel. The NASF provides specific HIV-prevention strategies that might be used to target mobile populations.

Of the different components of the HPSD model, the IOM/CHAMP project decided to focus on four since the others were already being addressed in CHAMP projects. Specifically, the projects focussed on:

- **Strengthening of local implementing partners;** both CHAMP directly and the GDA companies where the projects were implemented;
- **Peer-led communication:** Social and behavioural change through a programme of local communication, which combined face-to-face communication (dialogues), the participatory development of communication tools (billboards, murals and so on), and the use of public media (radio, press), to reduce vulnerability to HIV; and
- **Gender, migration and HIV:** Gender intervention, targeting men, and providing training and mentoring of male role models with the aim of addressing issues such as GBV, faithfulness to one partner, sex workers, and poor health-seeking behaviour in men;
- **Addressing contextual barriers to social and behavioural change.** Recreational activities to improve the quality of life for workers include soccer, netball, games, a soccer league and darts.

Through this IOM pilot project CHAMP recruited three Technical Support Assistants (TSAs) focusing on migration issues. One was based in Katete, one in Solwezi, and one in Lusaka to coordinate activities. Each of the field-based TSAs established change agent networks in the local communities, and conducted ongoing sensitization with members of the migrant and non-migrant populations.

Over the two years, CHAMP headquarters staff – as well as representatives from the two GDA companies – received training in gender, migration and HIV, SBCC and Most Significant Change monitoring and evaluation. CHAMP headquarter staff then conducted internal trainings with all CHAMP staff and in some cases staff from GDA partners, which took the concepts and approaches forward in their own organizations.

> CHAMP has integrated components of the model into the work of other companies in the Global Development Alliance, such as Mopani Copper Mines, Konkola Copper Mines, First Quantum Mining and Operations Limited (formerly Bwana Mkubwa), Copperbelt Energy Corporation, Kansanshi Mine, Dunavant Cotton Zambia Ltd, Zambia Sugar and Mkushi Farmers Association. This cascade approach to other partners under this public–private partnership is not only cost effective but is sustainable in that it promotes approaches that have been proven to work.

The institutional capacity-building component has been a particular success. From the onset, CHAMP mainstreamed the IOM's HPSD model into their other projects. The result has been a more sustainable approach than stand-alone or parallel programming. This has meant that the GDA companies that were not part of the CHAMP/IOM programme are incorporating aspects of model, and through this a large number of formally employed people in Zambia are being reached.

The gender, migration and HIV component has been integrated by CHAMP into the HIV programmes of other companies in the GDA in Zambia and the One Man Can approach is becoming increasingly utilized in Zambian companies working with CHAMP. This institutionalization meant that the partnership between IOM and CHAMP should focus on technical rather than financial support, and funding for project implementation ended in July 2010.


Obrian Fungai Nyamucherera © IOM 2011

Mural at the local district hospital advocating for reversal of gender roles in Solwezi, Zambia.

CHAMP established a partnership with IOM to reduce HIV incidence and the impact of AIDS among migrants, mobile populations, their families and those with which they interact through on-the-ground interventions and enhanced programme capacity in two GDA sites in Zambia. The partnership targeted the mining sector through Kansanshi Mine, Solwezi (North-Western Province), and commercial agriculture sector in Dunavant Ginnery, Katete (Eastern Province). The projects conducted under this partnership have been identified as emerging good practices because not only have they demonstrated the importance of private-sector and civil-society partnerships in responding to HIV but also they have helped the companies to have more inclusive HIV programmes, including contract and seasonal workers.

To respond to the challenges of gender, migration and HIV, the project rolled out a series of gender, migration and HIV trainings. GDA partners have been trained as trainers. This ensured that the trainings will be rolled out to their workers in the respective partner companies.

This project is an example of how institutionalization of a programme – in the context of a public–private partnership – can lead to more sustainable development practices. The main focus of the CHAMP–IOM project has been to mainstream key aspects of the HPSD model into existing projects, and thereby ensure continuation after funding ends. In this way, the model has reached some of the largest companies and formal sector employers in Zambia, which continue to implement some components – most notably gender, migration and HIV.

The integration of key components of the HPSD model, especially gender and social change within CHAMP, demonstrates that established organizations can learn new approaches and apply them to existing projects. This integration of the model could be replicated in other regional and national organizations already operating in migration-affected communities.

The CHAMP/IOM partnership directly responded to the priorities of the Zambian National HIV and AIDS Strategic Framework by working with identified vulnerable groups such as migrant workers.

### *Regional Relevance of the CHAMP Projects*

The projects in Zambia are a clear example of the success of private-sector and civil-society partnerships that make a difference both to the workers (health services and information) and company (productivity). The projects have helped the companies to provide essential services to migrant workers who are not usually included in HIV programmes. This approach can be replicated throughout the region, where operations in both the mining and agricultural sector are widespread and attract migrant workers from within and outside the respective countries.

The project in Solwezi has been able to address the vulnerabilities of mine workers and the surrounding communities. It has shown that in mining situations the model can be applied to good effect, not only through informal dialogues on gender, HIV and migration but also through recreational activities and formal trainings on issues such as gender. By partnering with civil society, the project has demonstrated that mining companies throughout the region can benefit from forming such partnerships.

In addition, the project in Katete, which targets seasonal and contract agricultural workers in the cotton industry, has shown its relevance at national and regional levels by further demonstrating that the model can be applied in a diverse range of commercial agricultural settings.

### *IOM, CHAMP and Kansanshi Mine (Solwezi)*

#### *Programme Inception and Description*

Solwezi town is the administrative capital of North-Western province; it lies about 750 km from Lusaka. The province has one of the lowest HIV prevalence in Zambia, which may be partly due to relative isolation prior to mining, or the fact that the Kaonde people of this province have tended to practice male circumcision. Kansanshi Mine, is about 20 minutes drive from Solwezi town, and has a suspected high HIV prevalence due to a variety of factors, including migration and multiple and concurrent partnerships. The mine is a high security area and accessing the workers is difficult even for the project because the company prioritizes productivity.

Although not generalizable to the whole mine, most Zambians working on the mine who were interviewed came from Copperbelt Province and Lusaka. Contractors for the mine are recruited from other provinces and from abroad, with most expatriate employees coming from Australia, Indonesia, Philippines, Malaysia, South Africa and Zimbabwe. Half of all skilled workers are migrants, and the recruitment of lower-skilled workers has generally been by word of mouth rather than through a formal recruitment structure. Most workers are male although there are some women in administration and in a few other parts of the mine, like the processing plant, and some work as cleaners, dumper truck drivers and engineers. The Technical Support Assistants attended safety meetings (for 30 minutes in the morning and at lunch time), at which they spoke to workers about gender, migration and HIV.

#### *IOM Health Promotion and Service Delivery Model*

The Solwezi project targeted mine workers, truck drivers and sex workers as well as the local community. Implementation of the project was within a difficult context: access to mine workers is challenging due to work schedules and staff turnover. However, the project managed to train 400 change agents (200 in the plant and 200 in the community). The majority of the CAs' work has been with the community because of limited access to mine workers while on the mine. Workers were reached through the TSA, who gave informational talks during the daily safety briefings.

The following table considers each of the four components that were implemented, alongside some of the successes and challenges faced within the Solwezi area.

**Table 8: Implementation of HPSD model in Solwezi, Zambia**

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| **Strengthening of local implementing partners - First Quantum Minerals Ltd** | • The project has established partnerships with the Department of Health and migrants are able to be referred to the hospitals and get treatment. In addition, this partnership enabled first-aid kits to replenished.<br>• The project also belongs to the district AIDS taskforce, which was formed to provide a network of referrals in Solwezi area.<br>• By involving traditional leaders in the project, local ownership has been built. |
| **Peer-led information, education, communication on health, including HIV, TB and STIs** | • The project trained workers as peer educators, CAs and counsellors on HCT, gender, migration and HIV, and SBCC.<br>• The project facilitated focus-group discussions and one-to-one conversations on the topics of culture and condom use, which were identified as some of the greatest barriers to social and behavioural change. |

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| **Peer-led information, education, communication on health, including HIV, TB and STIs** | • CAs were trained to sensitize community on gender, migration and HIV, distributed IEC materials, condoms and provided HIV testing and counselling.<br>• The project TSA's were trained to facilitate dialogues and ensure that beneficiaries develop community action plans. The mines facilitated a series of TB and STI screening sessions with the assistance of change agents.<br>• The focus on prevention, which has been consistent throughout the project, has resulted in multiple benefits for the migrant community. The project has helped mine workers to protect themselves and helped to dispel myths on STIs and HIV. There has been reported behaviour change in relation to multiple and concurrent partnerships, faithfulness, condom use and gender dynamics.<br>• Some workers have taken the project forward and have formed an organization called "Love Youth Initiative Network", which focuses on youth empowerment and development for young people in Solwezi. |
| **Addressing gender dynamics in the context of health and migration** | • The project combined gender trainings with radio spots, murals and banners, through which issues of gender were highlighted. People report that men are embracing more domestic responsibilities.<br>• The trainings have brought families together and initiated discussions that were previously taboo in the community.<br>• Men report that they are taking on a more caring role within their families as a result of capacity building activities conducted. |
| **Addressing contextual barriers to social and behavioural change** | • The changing dynamics within the mining sector has resulted in retrenchments and a high turnover of staff. Many mine workers have limited job security due to their short employment contracts and this presents a barrier to social and behavioural change as there is constant need to re-train and sensitize new employees.<br>• However, the project has been successful in addressing some of the other contextual challenges that mine workers and the surrounding communities face, such as alcohol abuse and boredom through recreational activities such as netball, football and pool tournaments.<br>• The mine has also supported the formation of support groups at the community level and the mine has bought seedlings and equipment for income-generating activities. |


Focus group discussion with women at the market in Solwezi, Zambia.

## Why Is This Project a Good Practice?

According to SADC, for a project/programme to be considered a good practice it has to be successful in seven areas. This project scored 68 per cent, implying that it is an emerging good practice.

### Effectiveness

The project started in 2008 and targeted migrants – mostly truck drivers and mine workers. Change agents were trained and went to the field to raise awareness on gender, migration and HIV.

**"The project needs to be marketed vigorously since workers change a lot and need to be sensitized in HIV"**

Some of the barriers to social and behavioural change have been related to gender and culture, for example men having multiple and concurrent partnerships, a lack of entertainment, peer pressure and alcohol abuse. These challenges have been addressed through community dialogue and gender trainings with male mine workers.

Through focus-group discussions with men and women, the project encouraged partners to listen to each other, and treat one another more equally. As a result, the community reported that men were sharing domestic duties with their spouses.

The surrounding community appreciated the project and does not want it to stop because the project did follow–ups, unlike other organizations, which were described as being interested only in statistics. The project has enabled the communities to discuss their own issues and develop action plans.

### Ethical Soundness

Following a mapping exercise, the project realized that it should not focus purely on mine workers but needed to include the Solwezi town, surrounding communities and the workplace. In the workplace, stigma and discrimination on the basis of the HIV status has been reduced because of the development of a code of conduct which states that if found guilty of stigma and discrimination a worker can be dismissed from employment.

### Cost Effectiveness

As the project formed part of an existing CHAMP workplace programme, pooling of resources has helped to ensure the cost effectiveness of the project. Gender, migration and HIV trainings are being supported by the mine, with the company paying workers overtime for the time they attended this training.

### Relevance

This project is relevant in that it addresses an area neglected by the National Strategic Plan.

By using a consultative and participatory approach, traditional leaders have accepted the programme and have indicated that they want the programme to be maintained and expanded to the surrounding community. The project has also proven to be relevant to the needs of the workers by introducing recreational activities which they now organize themselves.

### *Replicability*

The rate at which the project has been able to be absorbed and implemented by CHAMP and the mining company shows that it is replicable and is already being replicated with other CHAMP partner companies.

The mine, since the closure of the project, has continued to support gender trainings.

The project has brought a lot of positive influence since the meetings on HIV were integrated in the morning safety talks. Some of the workers have formed an organization called "Love Youth Initiative Network", which focuses on youth empowerment and development for young people in Solwezi.

### *Innovativeness*

CHAMP in Solwezi has been innovative in that it provides a holistic approach that is not offered elsewhere in the community. Unlike other HIV interventions it is not focused solely on HIV counselling and testing statistics. In particular, the focus on men and empowering men to be positive role models was a new approach, which has been embraced by the mine workers.

### *Sustainability*

As previously mentioned the institutional sustainability of the approaches has been made possible by CHAMPs integration of the gender, migration and HIV and social and behavioural change communication.

The project has been handed over to the mine to take forward, supported by the CHAMP provincial team. The gender component has been taken forward successfully but other components are lagging behind due in part to limited resources. The mine has however continued to contribute to community outreach focusing on health promotion and development and this is an opportunity for CHAMP to continue to provide technical support to the focal persons appointed by the mines.

## *Building on What We Have Learnt*

Lessons can be gleaned from both the challenges faced by the project and its successes. A key lesson is that health is determined by the interaction between many external and social factors. The private sector need to ensure that they have in place mutually supportive programmes that address both the social and health needs of the workers since the health of the work force impacts on productivity.

The mines, together with other GDA partners, have committed to continue with gender, migration and HIV training but these should be complimented by other activities such as social and behavioural change communication and increased recreational activities.

## *IOM, CHAMP and Dunavant Ginnery Project (Katete)*

### *Programme Inception and Description*

Katete is the smallest district in Zambia's Eastern Province (population 1.5 million), and the town of Katete is the main urban centre in the district. The small town, with a population of about 200,000, lies about 500 kms east of Lusaka, on the main road to the Malawian border. Katete has limited infrastructure but boasts a number of small shops and restaurants, a health clinic, local government offices and a hospital. The main source of employment in the town is the cotton ginnery that draws its seasonal and permanent employees from the small, local, peri-urban communities of Chibolya and Soweto. Chibolya and Soweto have an estimated population of 1,400 and 1,100 respectively and both areas have limited access to health services/products.

In Katete, CHAMP partnered with Dunavant Enterprises. Dunavant Zambia is part of American-owned Dunavant Enterprises Inc., the largest privately owned cotton merchandiser in the world. Although Dunavant operates for only six months a year, as ginning is dependent on the cotton season, and offers work to less than 1,000 people, the ginnery is almost the sole source of formal employment for residents, and the main reason why migrants, mostly truckers, move through the area.

The ginnery operates for 24 hours a day, in three eight-hour shifts, and the highest concentration of people is found on site when shifts change (06h00, 14h00, 22h00). All cotton processing is completed by late November; this is followed by two months of maintenance with a skeleton staff and a virtual shutdown until the next season, which starts in June.

### *IOM Health Promotion and Service Delivery Model*

The CHAMP/Katete project was implemented in three places (the workplace and the two feeder communities of Chibolya and Soweto). The major activities were dialogues on gender, stigma and discrimination, orphans and vulnerable children support, ART adherence and PMTCT.

**CHAMP/IOM Project: The Dunavant View**

The project has created a good image of the company to local government, the community and other stakeholders as it targeted migrant workers and helped the organization respond to the challenges they face. The project has enhanced the corporate responsibility arm of the company and they now recognize the need to include migrant workers in their HIV interventions. The company recently recognized the importance of recreational activities as a means to support their workers, and have taken over the organisation of some of the games.

Twenty CAs were trained to conduct dialogues and HIV counselling and testing (HCT). The dialogues focused on gender, migration and HIV. To compliment the work of the CAs, the CHAMP TSA conducted educational talks when employees started their shift, and provided HIV tests when required.

The following table considers each of the four components that were implemented, alongside some of the successes and challenges faced within the Katete context.

## Table 9: Implementation of HPSD model in Katete, Zambia

| HPSD Component | Example Activities, Successes and Challenges |
|---|---|
| Strengthening of local implementing partners – Dunavant | • The project has worked together with management and has encouraged mangers and supervisors to undergo HIV testing. In addition, management has been trained on workplace policy development and peer education.<br>• The project supported Dunavant to strengthen its HIV response especially in regards to the inclusion of migrant workers in HIV interventions. |
| Peer-led information, education, communication on health, including HIV, TB and STIs | • Traditional and religious leaders accepted and supported the project having been sensitized before the project was introduced to the communities.<br>• The CA have been capacitated on how to engage in non-threatening dialogue. This bottom-up approach to social and behavioural change has helped project beneficiaries to embrace the project.<br>**"Through CHAMP I now know HIV. I used to have a lot of partners but have since changed …"**<br>• CAs were able to interact with the community and help them identify solutions to their problems. According to CAs, workers and community members have come to understand HIV and are changing their behaviour. For instance, they are now accessing HIV counselling and testing services and some are disclosing their HIV status; consequently, stigma and discrimination have been reduced. |
| Addressing gender dynamics in the context of health and migration | • The project sensitized the wider community and workers on gender using different tools of communication.<br>• The project trained focal points in the community as trainers to facilitate gender, migration and HIV dialogues and action within the community.<br>• A major achievement has been that men report they are now taking on more domestic duties and are supporting their partners attend hospital to access antenatal care.<br>• Through a radio slot on local Radio Maria, based in Chipata, the project has initiated discussions on gender, migration and HIV. |
| Addressing contextual barriers to social and behavioural change | • Some of the barriers to social and behavioural change in Katete included attitudes to condom use, boredom, alcohol abuse, harmful cultural and traditional practices, multiple and concurrent partnerships and mobility.<br>• These barriers were addressed through information dissemination, recreational activities, dialogues and community mobilization.<br>• In Katete, the recreational activities have provided a platform for wider community engagement on gender, migration and HIV as darts, netball and football teams participate in tournaments with other communities.<br>• Recreational activities (six netball, six football teams and one darts team in the community) have reduced the levels of boredom previously experienced in the community and some of the teams have played in provincial and district tournaments. |

## *Why Is This Project a Good Practice?*

According to SADC, for a project/programme to be considered a good practice it has to be successful in at least seven areas. This project scored 65 per cent, showing that it is an emerging good practice.

## *Effectiveness*

The project is comprehensive and looks at workers as people in a holistic manner. It has been integrated well by CHAMP into their other USAID-supported activities.

CAs in Katete were engaged through their position in society and have in turn engaged in dialogues both within the community and the workplace.

Since the project ended there has not been an official handover of the project and CAs to Dunavant, and this has impacted negatively on sustaining project activities.

## *Ethical Soundness*

Ethical soundness is mostly a function of careful engagement with the communities, making sure that their needs are being met and that they are, in essence, in charge of the intervention which affects *their* lives. This was achieved through a bottom-up approach to social and behavioural change. The project staff responsible for this project were accountable, transparent and respectful towards the beneficiaries.

## *Cost Effectiveness*

As with the Solwezi project, the project formed part of an existing CHAMP workplace programme, which meant that pooling of resources helped to ensure its cost effectiveness. For instance, the project has been able to increase the number of workers and community members accessing health services such as HTC and ART, which are provided under other CHAMP projects.

According to the project implementers, due to the work of CAs, in January 2010 there was a surge in the number of people who went to the local hospital for HIV counselling and testing (an increase from an average of two to five people per day to 80 people per day).

Obrian Fungai Nyamucherera © IOM 2011

Female change agents and beneficiaries at a focus group discussion in Katete, Zambia.

### *Relevance*

The project was relevant to the community since it helped address the problem of migration and HIV. Traditional and religious leaders accepted and supported the project, having been sensitized before the project was introduced to the communities.

### *Replicability*

The project has achieved a level of replicability as both migrant workers and communities have adopted the concept of recreational activities as a tool to address some of the boredom barriers they faced. The communities have formed teams for darts, soccer and netball. These teams not only compete in Katete but also with other professional teams in the province.

The success of the work of CAs in the community has been such that one of them has been allowed by the district hospital to monitor infant's growth and when appropriate refer infants to the hospital. This routine checking of weight, height etc. was normally conducted at the local hospital but by devolving it to a CA in the community the hospital's limited capacity has been alleviated and health services have been made more accessible to the community.

CAs within the community have continued to operate, giving motivational talks and distributing condoms. This is evidence that low-cost initiatives are replicable and can lead to sustainable community action.

### *Innovativeness*

As with other IOM pilot projects, the project has been innovative in a number of ways. Activities such as focus-group discussions and recreational activities have reached out to the masses, whilst the sharing of views through dialogue has helped individuals realize their own responsibilities in terms of health. The recreational activities have also created employment for other members of society.

### *Sustainability*

Even though the project has ended, the community view the project as their own and have continued to organize activities. However, within the workplace the sustainability of the project is low as the project requires a person on the ground to coordinate and monitor activities.

## *Building on What We Have Learnt*

As with most projects, lessons are learnt through what has been successful and what has been challenging. A key lesson is that community ownership is central in facilitating sustained community action.

Even though the project has ended, community members and workers are enthusiastic about the project and there is a need to do a formal handover to the Dunavant so that they can take the project forward. As a representative from the community said, "We still want this project here because HIV is real and people still need information and encouragement".

# 6. REGIONAL RELEVANCE OF IOM PILOT PROJECTS

There is frequent debate as to what defines a regional programme. IOM considers a regional response to include work in multiple sites at the national level coupled with regional coordination from a central body whose role is to ensure exchange of experiences and lessons. At the regional level IOM use an overall framework for project development and implementation (the HPSD model), harmonize systems and tools including M&E, facilitate a network of organizations working with migration-affected populations, are documenting and disseminating lessons learned and are providing regional mentoring and support. At the national/local level IOM and its partners are institutionalizing understanding on migration health, applying a targeted/local model within migrant sites (sending and receiving) and building national awareness of the issues of migration health.

The IOM pilot projects have pioneered a relevant intervention in migration-affected communities that is showing real signs of success and impact. The pilot projects documented as emerging good practices in this document demonstrate that regional programmes are well placed to promote information sharing, learning and facilitate sharing across countries in response to common regional challenges such as HIV and migration. Regional programmes such as IOM's PHAMSA programme therefore have a key role in facilitating effective adaptation, replication and learning by promoting that which has been successful at local levels to the regional and international levels.

Using regional resources and technical expertise, IOM was able to support different implementing partners to adapt the model and its components to their local context. The pilot projects focused on two sectors – mining and agriculture – and worked different types of partners (see Table 10). By doing so they were able to assess if the approach is effective in a variety of settings and thus if it was replicable in similar contexts across the region. By specifically targeting both migrant-receiving and migrant-sending communities, the pilot projects provide evidence of the concept of "spaces of vulnerability" and how health vulnerabilities are similar in the different types of communities affected by the migration process.


Communal garden to supplement nutritional supplements for patients in Hoedspruit, South Africa.

## 6.1 Regional Strategic Frameworks and Declarations

The SADC region where the projects have been implemented has been guided by various regional frameworks and declarations, which have in turn guided the implementation of the pilot projects. The HPSD model promoted by IOM responds directly to some of the recommendation or principles set out in these frameworks and declarations:

### Table 10: Regional and national frameworks and declarations relevant to the PHAMSA pilot projects

| Declaration/ Framework | Brief Description | How the Model Responds/Supports |
|---|---|---|
| The African Union Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases, 2001 | AIDS was declared a state of emergency on the African continent, and accorded the fight against it the highest priority in national development plans. The Declaration called on state parties to strengthen ongoing successful interventions and to develop new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at regional, national and continental levels. | This declaration specifically states, "we note that special attention should be given to migrants, mobile populations, refugees and internally displaced persons in national and regional policies". The IOM's HPSD model and its application in the different sites in southern Africa is a response to this. The model gives the migrants and mobile populations special attention by looking at their vulnerabilities as individuals and also the context within which they live and work. The pilot projects have generated enough evidence of success; their replication across southern Africa can assist in ensuring that countries are able to abide by the declaration. |
| SADC HIV and AIDS Strategic Framework (2009–2015) | The most recent Strategic Framework and Programme of Action (2009–2015) was approved by SADC ministers in charge of health and HIV/AIDS in November 2008. It includes a strong priority on harmonization of cross-border health policies and practices, and specifically focuses on migrants and mobile workers as a particularly vulnerable group. | The IOM's HPSD model has been implemented as pilot projects in five southern African countries, which has contributed towards the development of a single, coordinated response to migrants/ mobile workers and HIV in the region. The pilot projects have successfully implemented good practices in addressing the special needs of migrant and mobile populations; these can be shared and replicated.<br>The model has contributed positively towards the harmonization of policies for "responding to regional issues of HIV and AIDS, focusing on migrant/mobile labour", as advocated by the framework. |
| SADC Declaration on HIV/ AIDS, 2003 (Referred to as "Maseru Declaration") | This Declaration states that halting and rolling back HIV infection constitutes a top priority on the SADC agenda, and is an integral part of the regional programme of eradicating poverty. Although migrants or mobile populations are not specifically mentioned, article 3c of the Declaration makes reference to the needs of people living close to national borders: "Enhancing the regional initiatives to facilitate access to HIV/AIDS prevention treatment care and support for people living along our national borders including sharing of best practices." | Migration impacts on HIV prevalence in many countries in southern Africa and accordingly this declaration calls for regional initiatives to respond to this challenge.<br>The PHAMSA project is an important contribution to the response to migration and HIV in the region and through this document shares emerging good practices for replication in whole and in part in line with the components of the Maseru Declaration. |

| Declaration/ Framework | Brief Description | How the Model Responds/Supports |
|---|---|---|
| (Draft) SADC Policy Framework on Population Mobility and Communicable Diseases | Developed in early 2009, the Policy Framework provides guidance on the protection of the health of cross-border mobile populations with regard to communicable diseases. Specifically, it calls for the following: (1) Regional Harmonization and Coordination; (2) Equitable access to health services by cross-border mobile populations; (3) Coordinated regional public health surveillance and epidemic preparedness; (4) Information, education and health promotion for mobile populations; (5) Operational research and strategic information; and (6) Legal, regulatory and administrative reforms | The IOM PHAMSA project targeted labour migrants in different sectors and consisted of four distinct yet interrelated components: (1) advocacy for policy development, (2) research and learning, (3) regional coordination and technical cooperation, and (4) on–the-ground pilot projects (see page 19 for more information). The IOM pilot projects' comprehensive health-promotion and service delivery approach has built the technical and organizational capacity of partners to implement a comprehensive HIV response in migration affected communities and shares lessons learned, challenges and best practices between the different implementing partners regionally and contributes to the response to HIV and migration in line with the framework. |
| National Strategic Plans on HIV/AIDS in SADC Countries | All SADC countries have some form of National Strategic Framework and/ or Plan that specifically addresses HIV/ AIDS. Many of the national strategic HIV/ AIDS plans include statements about the particular vulnerabilities facing migrants and mobile populations, and the importance of responding to their particular needs. Furthermore, the various national strategic HIV/AIDS plans reflect a commitment to a human-rights approach to programming. This includes attention to the rights of participation and inclusion, non-discrimination and equality, and the universality and inalienability of rights. | As indicated in the specific country projects, the IOM pilot projects contribute to the response on migration and HIV in the respective countries and respond directly to national strategic plans and priorities.<br>The projects have contributed in a unique way because their success is an opportunity for the different countries to replicate the approach in part or fully in similar contexts. |

## 6.2 At a Regional Level: Emerging Good Practices Identified

Using the HPSD model as a guide, IOM has been able to stand out as the only regional project since 2005 that has responded to the needs of migrants and mobile workers in both migrant-sending and receiving sites in a holistic structured manner. The model has evolved as lessons have been learnt from what is experienced on the ground so as to identify common interventions, challenges and success. If we consider the SADC good-practices criteria, the model itself can be considered an emerging good practice as it is evidence based and responds to community needs, uses a bottom-up approach, which actively engages and promotes community participation, is replicable and innovative.

Below are some of the emerging good practices that have been "pioneered" and/or have been identified during this documentation process.

### *6.2.1 IOM's Health Promotion and Service Delivery Model*

Though there may be debate around what defines a model, IOM's HPSD model is in fact a framework that helps to guide and structure a health response in migration-affected communities. It pulls together theories and experiences from different health and community development interventions and packages them so as to provide a more comprehensive and integrated health response that tackles not only individual drivers of the HIV epidemic but also environmental and structural drivers.

By using a model across the six sites to guide project development and implementation, the model provided a common vision and objective but allowed for each intervention to be adapted to the local context so as to be specific and relevant. The six components shown in Figure 1 (page 10) were implemented in nearly all the sites, and local conditions and contexts were respected by all the implementing partners.

As shown in this publication, the success of the HPSD model in responding to gender, migration and HIV in the pilot projects calls for its adaptation in similar contexts in southern Africa where "spaces of vulnerability" exist. Organizations can adapt and learn from what has been done by the different implementing partners to replicate in whole or in part aspects that may work for them.

The model has brought together the different country projects into one unified regional approach coordinated and supported by the IOM regional office in Pretoria. A standardized approach to capacity building, M&E, gender and strategic communication by IOM, SGJN and SDC also ensured a greater regional perspective. However, further work on identifying key indicators for the model would assist in simplifying M&E and help IOM in analysing country-level responses at the regional level.

Although the model has been used to address specific HIV vulnerabilities, the model is such that it can be used and adapted to other health vulnerabilities faced by migration-affected communities such as malaria, TB, reproductive and maternal health. The HPSD model can be applied anywhere in the region as it takes into account culture, religious and community contexts and needs. For instance, the projects have not only been relevant but have addressed gender dynamics as appropriate within the context of migration and HIV and initiated steps towards sustainable social and behavioural change.


A nurse demonstrating how to take ARVs to a patient in Hoedspruit, South Africa.

### 6.2.2 *Social and Behavioural Change Communication*

The communication approach designed for the IOM pilot project sites took the concept of social and behavioural change communication (SBCC) further than any other known SBCC intervention. At its core, SBCC is a process through which people decide for themselves what to change, and how, and what they need in order to be able to do so – a definition crafted by the Consortium for Social Change Communication in a process led by the Rockefeller Foundation and supported by UNAIDS.

SBCC interventions to date have been largely campaign driven, materials driven and media driven – where face-to-face interactions have been limited in number or duration, and/or to a pre-determined message, where communication materials have been researched and developed with a degree of consultation and participation, but where delivery remains, in general, through conventional public media channels of radio and press. Research has shown this approach has limited impact in marginalized communities.

By contrast, the IOM approach applied the concept of SBCC, within the context of migration and HIV, at the local level, and enabled people in migration-affected communities to directly own the communication process and the actions taken by the project and build local partnerships to address identified barriers to change. In the pilot project sites, communication was grounded in a systematic ongoing process of participation and capacity building, which was made possible through regular, planned face-to-face engagement between the IPs and the CAs, and between CAs and the community they represent. Communication tools (billboards, posters, murals, invitations, calendars, T-shirts) were identified by the project, according to need, and developed through participation, to create and market its presence, and to support local action. The projects used public media (radio, in particular, and local press where present) to project the voice of the participants, their actions and interventions to the broader community.

All the projects have demonstrated that HIV interventions that ignore developmental needs of target communities are ineffectual. The projects have highlighted that communities affected by the migration process, especially migrant-sending areas, need to acknowledge the impact migration has on them.


Change agents at their usual meeting place for dialogues and other attending a training. (Swaziland)

This innovative approach to SBCC should be utilized more widely in the HIV response, especially within migration-affected communities where social cohesion is often missing and where, by bringing members of the community together to decide their own futures, a stronger sense of community is formed.

### 6.2.3 *Change Agents: The Next Generation of Peer Educators*

The traditional role of a peer educator has been to provide information to peers. However, this approach has limited impact and the need for peer education to evolve into a more dynamic process of communication has been recognized. The IOM change agent model enables peers to become communicators rather than educators and as such respond to local needs rather than predetermined assumptions.

CAs are the heart of the SBCC approach to health promotion at the local level. They guarantee local ownership through establishing the identity of the local project, its core values and its vision for change. They then promote this identity and these objectives by using every channel of communication at their disposal – ongoing face-to-face dialogue and engagement, drama and song, radio, murals and billboards, sports and cultural events, food gardening and savings clubs, the local press – to reinforce this ownership.

CAs represent the community in the project and the project to the community. They are a constant presence at the workplace and in the community and are a source of inspiration, accurate and appropriate information and provide a link to services and resources. They meet regularly to plan the project's many activities and they implement the programmes on the ground. They hold the project and its staff accountable and ensure that appropriate support and direction is given. They engage in structured, constructive dialogue with their co-workers and community members and they feed back to the project what they have learned from the community, so that the project consistently reviews and reflects its approach and responds appropriately to local needs.

Through empowerment, support and acknowledgment, CAs are leaders and role models to their peers. They are there when someone is sick at night and they are there when someone needs a condom. They promote and support social cohesion through their actions, energy, skills and commitment.

### 6.2.4 *Gender*

Since gender is an important dimension of the HIV epidemic in southern Africa, the IOM pilot projects made a conscious effort to address the intersection of gender and HIV at individual, community and organizational levels. The IOM pilot projects promoted dialogues with men and women and their gender-specific vulnerabilities to HIV and AIDS within a migration affected community. This served as a common approach across the six sites, although each site addressed specific gender dynamics that were relevant locally. The dialogues educated men on the ways in which gender roles and relations encouraged them to act in ways that put themselves and their sexual partners at risk and encouraged both men and women to promote action to address harmful gender practices. These dialogues facilitated important behavioural changes and were successful in all the project sites. The project beneficiaries report tangible changes in their views towards gender roles. For example, in Lesotho, men are now able to sit with women in one fora and discuss their shared HIV-related concerns, something which was unheard of before the project was introduced. Dialogues have promoted sustainable positive changes in social and cultural attitudes since it is the participants who decide what and how to change. The CAs and the communities in the different sites have benefited from trainings in gender dynamics and this has resulted in shifts in attitudes especially with regard to gender roles.

### 6.2.5 *Regional Exchange and Learning*

One of the key strategies used by the IOM project to achieve success has been the promotion of learning and exchange of experiences between the sites in the different countries. The promotion of learning and exchange saw representatives from the different sites converging in Hoedspruit at HTT at various junctures. This has led to the replication of instruments such as the billboards of community members, which was pioneered in HTT but perfected in Simunye, Swaziland, by RSSC. Promotion of learning and exchange has seen practices such as recreational activities like soccer and netball being implemented in Zambia.

A peer-to-peer review using Most Significant Change methodologies allowed for the representatives from different projects to visit, interact and review the work of another partner in the region. This cross-sharing and peer-review process strengthened the network of partners implementing the project and highlighted common approaches, successes and challenges. It is important for regional/multi-country projects to be able to deliberately direct partners towards learning opportunities to maximize the use of resources and reinforcing the practice of what has been proven to work. HTT has been identified as one of the leading organizations in South Africa in terms of providing community-led solutions in the farming community and as such has become a best practice even outside the IOM project.

### 6.2.6 *Sectoral Focus*

The IOM pilot projects focussed on two labour sectors that are characterized by high levels of labour mobility: agriculture and mining. By piloting the model in the same sectors but in different countries and contexts, IOM demonstrated that the model is relevant and effective for these sectors. A sectoral approach allowed the lessons to be learnt from the different sites and synergies to be built across the region. In addition, common challenges and vulnerabilities faced by the sector were identified, thereby building regional knowledge on HIV and migration in each sector.

The projects identified that each sector has several spaces of vulnerability, associated with the migration process. These different spaces need to be linked so as to ensure a consistency in approach. For instance, the responses in the mining sector should try to ensure a link between the mine worker sending communities and the mine itself.

By creating regional networks of communities affected by and organizations working in specific sectors, a more comprehensive HIV, health and development response can be realized.

### 6.2.7 *Partnership Building*

The IOM pilot project has been built on partnerships between IOM, implementing partners and technical partners. The success of the project has been as a result of the deliberate effort of all stakeholders to exchange ideas and learn from experiences. IOM provided all the partners not only with financial resources but also technical expertise that ensured the successfully implementation of the model in the different sites.

The partnership with technical experts in the fields of gender and development communication provided partners with regular support and mentoring and resulted in the pilot projects accessing standardized support that was contextualized for local situations and implemented throughout the different sites. As mentioned above, exchange and learning through visits and interaction between the different implementing partners also supported partnership building as all partners learnt from each other and successful initiatives were shared and replicated where possible.

In addition, at the local level all the implementing partners made strategic alliances with different stakeholders to support implementation of the project and leverage additional resources such as HCT. Partnerships were forged at different levels such as with local and national civil society organizations, donors, private sector and local and national government.

### 6.2.8 *Advocacy*

One of the key roles of the pilot projects within the broader IOM PHAMSA programme was to provide evidence from the ground on the realities faced by migration-affected communities and as such act as an advocacy tool at the local, national and regional level. For instance, at the national level the projects have provided opportunities for partners and IOM to lobby for appropriate interventions for migrants such as the RSSC's partnership with SWABCHA and government.

The pilot projects in the different sites provide local examples of how migration affects the health of many. By sharing this with partners at the local and national level IOM seeks to create "migration health champions" from within SADC member states who in turn can lobby and advocate at the SADC level for migration-health related issues.

### 6.2.9 *Strategic Information*

Often access to migration-affected populations is limited due to several factors such as fear of deportation or discrimination. As such, the pilot project sites provided an opportunity for evidence to be gathered from this marginalized group, through baseline assessments, formal research, focus-group discussions and regular monitoring and reporting. Primarily, this information has been used to ensure the relevance and effectiveness of the implementation of the project but this strategic information should be used at a national and regional level to support awareness raising, advocacy for policy development and resource mobilization.


Communal garden to supplement nutritional supplements for patients in Hoedspruit, South Africa.

# 7. LESSONS LEARNT

## 7.1 Common Lessons Learned

In each of the pilot projects documented there are lessons learnt but this section focuses on those lessons that are over arching and common throughout the six projects. Despite their positive impact, the different projects have brought to the fore critical learning points, which will aid future planning of similar projects targeting migration-affected communities.

The pilot projects worked with different "types" of implementing partners from the private sector (RSSC), regional organizations (TEBA), national NGOs (CHAMP) and local NGOs (HTT). Some common lessons that emerged include:

### *7.1.1 Regional Applicability*

Network of partners: By building a network between implementing partners lessons have been shared. For instance, exchange visits between programmes and project sites have assisted other programmes in implementing the model better; such exchanges should be done regularly.

### *7.1.2 Using a Model (Framework) to Guide Project Development and Implementation*

- The HPSD model has been able to provide implementing partners with practical ideas and activities that were developed through a continuous process of learning from experience.

- The HPSD model built on regional and global lessons and experiences. It took proven or emerging interventions such as "One Man Can", participatory communication and peer education and tailored them to be cognizant of migration and local contexts. The package of components then formed a more comprehensive and inclusive response which thus guided implementation so that the different components of the model did not operate as vertical programmes but rather formed a collective, integrated response.

- The approach has sparked renewed passion amongst "HIV fatigued" communities, as it responds to real needs rather than providing "the normal" HIV awareness and prevention interventions (IEC, didactic peer education and so on).

- The HPSD model uses a long-term, social change approach and requires both time and resources to have a full impact. However, the model allows for partners to respond to immediate and/or new emerging needs, for example sex workers in Hoedspruit.

### *7.1.3 Partnerships*

- By working with others locally and nationally, the implementing partners have leveraged additional support including services (such as HCT, radio and so on) and have built the capacity of other stakeholders on issues around migration and health.

- Partnering with government not only at central but provincial and district levels has been the cornerstone of the pilot projects as these partnerships facilitate support to migrants in the areas of gender and ART. HTT in Hoedspruit, South Africa, partnered with the Department of Health; they received support in terms of the provision of ARVs to farm workers and stipends for the CAs.

- Partnerships have facilitated broader support for the project and for the issue of migration health – these now need to be exploited for future advocacy and resource mobilization.

- Lessons learned from mutually beneficial arrangements of private and civil-society partnerships (such as RSSC in Swaziland and CHAMP in Zambia) need to be documented and costed so as to support broader replication.

### *7.1.4 Institutional Commitment and Capacity*

- Senior-level institutional commitment from implementing partners is critical for the implementation and sustainability of interventions.

- Exit strategies for partners need to be developed and should have been included from the commencement of the projects.

- To ensure transfer of skills amongst implementing partners, IOM built capacity within partner organisations. However, a more systematic transfer of these skills within the partner is essential. Otherwise when staff members leave the organisation institutional memory and specific skills can be lost.

- Expectations and priorities of private-sector systems versus development objectives need management. Both RSSC and TEBA have a private-sector outlook where profit is key rather than a developmental approach that is longer term.

- Change agents are pivotal and have redefined the role of peer educators. The approach of using CAs could prove useful for other workplace and community interventions. Acknowledging CAs and provision of some form of reward should be considered by all the partners.

- Technical support from IOM, SGJN and Sibambene was much appreciated and greatly facilitated implementation. This was evident in CHAMP, which received less direct support and whose implementation was thus not as strong as in other sites.

# 8. RECOMMENDATIONS

## 8.1 Advocacy and Policy

- At the national level there is a need for greater advocacy on migrant's health rights. Utilizing the evidence and experience gathered locally, through the implementation of the projects, IOM and partners can lobby and advocate with government and non-government institutions (such as local clinics and municipal health departments, police, home affairs, local business, traditional leader and healers) for the needs and rights of migrants and communities affected by migration.

- SADC countries generally have weak local and district health systems and services and these need to be strengthened so as to enable them to deliver appropriate health services. IOM and partners should advocate for health services that are migration sensitive. Rather than developing specific migration-health services, issues such as migration should be included within the country's health system, creating an inclusive public-health approach to health-service delivery.

- IOM and partners should advocate to regional and national sectoral bodies and governments to establish public–private partnerships to learn from and, where appropriate, replicate the model in strategic geographical and sectoral sites, for example mining, transport, agriculture and construction sectors.

- IOM and partners should develop local and national communication strategies that are specifically aimed towards advocacy and bringing together other stakeholders such as government, organized labour and so on.

- The project sites should consider becoming regional and/or sectoral learning centres that provide lessons and evidence that can be shared with others working in spaces of vulnerability nationally and regionally.

- IOM should develop a regional dissemination and partnership strategy for the HPSD model.

## 8.2 Programmatic

- There is enough success within all the project sites to warrant the scaling up of the model to more sites within the countries and in other countries as well as continued support for the projects.

- IOM should document and disseminate tools that could be used to assist others develop or implement projects in spaces of vulnerability.

- Partners and IOM should build on the success of the SBCC approach that has brought people together to discuss their own vulnerabilities and links HIV and gender to non-traditional HIV interventions such as life skills and food security. This has been well accepted in countries like Lesotho where nutrition and food security have been embraced as part of the project.

- The mainstreaming of gender and migration should be made more explicit in the different components of the model.

- Identifying and targeting cultural gatekeepers, as was done in Tres de Fevereiro (Mozambique), is key to supporting and promoting social and behavioural change at the community level and should be encouraged in all sites.

- Sustainability is key and IOM and the projects need to focus on developing sustainability plans.

- Partners role in advocacy on issues around gender, migration and HIV needs to be defined and capacity built to enable partners to influence local, national and regional policies and programmes.

- Developing localized and targeted communication such as billboards and murals has the power to unify a community around HIV prevention, as exhibited in Swaziland and South Africa. This is because the community not only identify with the message but also with their colleagues whose images are on the billboards. This has promoted ownership of the projects.

- Institutional and senior management ownership of the approach is critical for partners. IOM should, when establishing partnerships, put in place specific management and institutional capacity building that will assist the project and staff to be better integrated. This is especially evident with private-sector partners.

## 9. CONCLUSION

The success of the IOM pilot projects is remarkable, given that they are long-term developmental interventions that have only been operational for two years and were successfully adapted to suit different contexts in southern Africa. The sites have witnessed social and behavioural change among the migration-affected communities by tailoring a "model" to the specific contexts in the different sites.

A novel finding is that dialogues around gender, migration and HIV appear to be a useful tool for sustainable social and behavioural change, since it is the target group themselves who decide what action to take. The findings suggests that the IOM health promotion and service delivery approach can be used effectively to respond to gender, migration and HIV in southern Africa and that this can be used as a tool to influence programming across the region in other "spaces of vulnerability".

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# 11. APPENDIX

## Key Assessment/Analysis Tool: Scorecard

** This scorecard is measured from a total of 100*

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| **1. EFFECTIVENESS (25 points)** | | | | | | | |
| ***1.1 Project/Programme Design/Structure (10 points)*** | | | | | | | |
| Goal/s is/are clearly articulated and well understood by beneficiaries and implementers. | Interviews/FGDs/Lit. review | | | | | | |
| Project/programme is in line with the appropriate national HIV and AIDS strategic plan and/or the appropriate regional and international instruments on migration? | Lit. review/Interviews | | | | | | |
| Strategies are in place and clearly articulate how the goal can be achieved/supported by clear implementation plan. | Lit. review/Interviews | | | | | | |
| Clear strategies are in place to evaluate impact of the project | Lit. review/Interviews | | | | | | |
| Project/programme has clear results as defined by implementers, beneficiaries and stakeholders and in line with original objectives | Lit. review/Interviews | | | | | | |
| Project's/programme's services/activities are clearly defined. | Lit. review | | | | | | |
| Project/programme has clear systems in place (financial, community outreach, distribution/disbursement, equipment). | Lit. review/Interviews | | | | | | |
| Baseline/assessment ground-work was undertaken prior to project's/programme's commencement. | Lit. review | | | | | | |
| Project/programme has clearly defined targets. | Lit. review | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| Project's/programme's objectives are SMART (specific, measurable, attainable, realistic and timely). | Lit. review | | | | | | |
| Project/programme embraces an integrated approach (vs vertical). | Lit. review/Interviews | | | | | | |
| There is sectoral expertise to manage and implement the project/programme. | Interviews | | | | | | |
| ***1.2 Community Involvement (10 points)*** | | | | | | | |
| Project's/Programme's priorities are based on actual needs of the community – evidence of needs assessment done. | Lit. review/Interviews/FGDs | | | | | | |
| Community knows and understands the objectives of the project/programme. | Interviews/FGDs | | | | | | |
| Community participated in the initiation/conceptualization of the project/programme, setting priorities. | Lit. review/Interviews/FGDs | | | | | | |
| Community participates in the project's/programme's planning, monitoring and evaluation. | Lit. review/Interviews/FGDs | | | | | | |
| Community participates in the project's/programme's implementation, as volunteers or paid staff. | Lit. review/Interviews/FGDs | | | | | | |
| There is a sense of ownership of the project/programme, among communities. Community feels the project and its outcomes belong to them. | Lit. review/Interviews/FGDs/Observations | | | | | | |
| Community contributes in cash or in kind towards project's/ programme's activities. | Lit. review/Interviews/FGDs | | | | | | |
| There is gender sensitivity in community participation (both men and women are involved equally). | Interviews/FGDs/Observations | | | | | | |
| Community is satisfied with the project's/programme's services (both men and women). | Interviews/FGDs/Observations | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| ***1.3 Monitoring and Evaluation (M&E) (5 points)*** | | | | | | | |
| Systematic methods of tracking inputs and outputs are in place. | Lit. review/Interviews | | | | | | |
| Key stakeholders, including the community, participated in the development of the project's/ programme's indicators. | Lit. review/Interviews/FGDs | | | | | | |
| Project's/programme's activities are periodically monitored and evaluated including coverage. | Lit. review/Interviews | | | | | | |
| Quality assurance/quality benchmarks are in place and are being followed. | Lit. review/Interviews | | | | | | |
| Participatory monitoring and evaluation methods are being used that include the community. | Lit. review/Interviews/FGDs | | | | | | |
| M&E (impact, assessments, outputs) data are analysed periodically. | Lit. review/Interviews | | | | | | |
| Results of impact evaluations are used to make meaningful adjustments to the project/ programme. | Interviews | | | | | | |
| **2. ETHICAL SOUNDNESS (10 points)** | | | | | | | |
| Confidentiality, as a principle, is upheld in interactions with project's/programme's service beneficiaries. | Lit. review/Interviews/FGDs | | | | | | |
| The interests of vulnerable groups (young people, women, children living with disability and children living with HIV), are respected and protected. | Interviews/FGDs | | | | | | |
| Project/programme does not directly or indirectly violate human rights. | Interviews/FGDs | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| Project/programme has a value statement for protection of interests of various vulnerable groups. | Lit. review/Interviews/FGDs | | | | | | |
| Project/programme always embraces the concept of informed consent when dealing with human beings as participants. | Lit. review/Interviews/FGDs | | | | | | |
| There is evidence of equitable distribution of project's/ programme's resources (finances, geographic distribution, sex). | Lit. review/Interviews/FGDs | | | | | | |
| The autonomy of beneficiaries is protected and respected during project/programme roll-out. | Lit. review/Interviews/Observations | | | | | | |
| There is an ethical standard ("do no harm" principle) embedded in the project's/programme's policies. | Lit. review | | | | | | |
| There is a minimum service provision package (clearly defined, access irrespective of colour, creed, sex, religion, political affiliation). | Lit. review/Interviews | | | | | | |
| Project/programme is transparent (allows for external and internal programmatic and financial audits). | Lit. review/Interviews | | | | | | |
| **3. COST EFFECTIVENESS (12 points)** | | | | | | | |
| Distribution of project's/ programme's resources is cost effective (administration versus programming) and is proportionate to available resources. | Lit. review/Interviews | | | | | | |
| There is evidence of increased number of children and community members whose quality of life has been improved by the project's/programme's resources and services. | Lit. review/Interviews | | | | | | |
| There is evidence to enable calculation of "cost per client" measure (cost known). | Lit. review/Interviews | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| A standard package is provided at a reasonable cost. | Lit. review/Interviews | | | | | | |
| Services are delivered in a timely manner. | Interviews/FGDs | | | | | | |
| There are adequate human resources for programme's activities. | Interviews | | | | | | |
| The strategy used by the project/ programme has resulted in multiplier effects (cost–benefit). | Lit. review/Interviews/FGDs | | | | | | |
| Project/programme has introduced cost-saving/reduction systems. | Interviews/FGDs | | | | | | |
| **4. RELEVANCE (12 points)** | | | | | | | |
| Project/programme is socially and culturally acceptable. | Interviews/FGDs | | | | | | |
| Project/programme takes cognizance of specific contexts (literacy, messaging, lifestyle, economic, political, approach, environmental factors, risk groups and areas). | Interviews/FGDs | | | | | | |
| Project/programme does not conflict with the religious norms of the community and has support from political and traditional leadership. | Interviews/FGDs | | | | | | |
| Beneficiaries perceive the project/programme as relevant and timely in addressing their most urgent needs. | Interviews/FGDs | | | | | | |
| The project/programme is in line with demographic, social, political, and economic trends. | Interviews/FGDs | | | | | | |
| Project/programme addresses gender dynamics. | Interviews/FGDs | | | | | | |
| Project is appreciated by vulnerable groups. | Interviews/FGDs | | | | | | |
| Project/programme is perceived as valuable and credible by the community. | Interviews/FGDs | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| **5. REPLICABILITY (11 points)** | | | | | | | |
| Project/programme can be replicated in similar contexts. | Lit. review/Interviews | | | | | | |
| Project/programme sets an example for similar programmes. | Interviews | | | | | | |
| Project/programme is adaptable in different contexts and levels using local resources. | Interviews/Observations | | | | | | |
| Project/programme is replicable in part or in totality. | Lit. reviews/Interviews | | | | | | |
| Project/programme exhibits evidence of proper documentation in terms of goals, processes, evaluation, cost and resources. | Interviews/Observations | | | | | | |
| Project can be scaled up to reach more beneficiaries. | Interviews/Observations | | | | | | |
| Project can be scaled up to improve quality of service | Interviews/Observations | | | | | | |
| **6. INNOVATIVENESS (10 points)** | | | | | | | |
| Project/programme is unique (different methodology from other organizations). | Interviews/FGDs/Observations | | | | | | |
| Project/programme has a new way of reaching children. | Interviews/FGDs | | | | | | |
| The utilization of available resources is done in a creative manner. | Interviews/FGDs/Observations | | | | | | |
| The strategy of implementation, used by programme implementers, is innovative. | Interviews | | | | | | |
| Project/programme concept is new to the community (as perceived by the community). | Interviews/FGDs | | | | | | |
| Project/programme is contributing to the base of knowledge. | Lit. review/Interviews | | | | | | |
| Project's/programme's approach and systems are scientifically/ economically sound and safe. | Lit. review | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| **7. SUSTAINABILITY (20 points)** | | | | | | | |
| ***7.1 Programme Sustainability (10 points)*** | | | | | | | |
| Project/programme is supported by children, community ownership, contributions in cash and kind. | Lit. review/FGDs/Interviews | | | | | | |
| The community expresses confidence that the programme will continue without donor support. | FGDs | | | | | | |
| Skills transfer takes place in relation to the project/ programme. | Lit.. rev/Interviews | | | | | | |
| Project's/programme's vision is in line with the development patterns of HIV and AIDS and national trends (social, economic and cultural). | Lit. review/Interviews/FGDs | | | | | | |
| Project's/programme's vision is in line with national trends (social, economic and cultural). | Lit. review/Interviews | | | | | | |
| Planning and implementation takes into account the issue of sustainability (sustainability plan). | Lit. review/Interviews | | | | | | |
| ***7.2 Financial Sustainability (7 points)*** | | | | | | | |
| Project/programme implementers are aware of potential donors (local and international). | Interviews | | | | | | |
| There exists a positive attitude and willingness to achieve sustainability. | Interviews/Observations | | | | | | |
| Project/programme has the ability to access diversified resources to contribute to its services/activities. (fundraising plan in place) | Interviews | | | | | | |
| Cost-sharing mechanisms are built into service delivery where appropriate. | Lit. review/Interviews | | | | | | |
| A percentage of financial support comes from the community, organization has had stable funding over time. | Lit. review | | | | | | |

| VARIABLE | DATA SOURCE | N/A | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| *7.3 Marketing and Awareness Building (3 points)* | | | | | | | |
| Project/programme is actively marketed to stakeholders and funders. | Lit. review/Interviews | | | | | | |
| Project/programme actively educates and builds awareness amongst stakeholders about its own services/activities. | Lit. review/Interviews | | | | | | |
| Appropriate language is being used in information, education and implementation programmes. | Lit. review/FGDs | | | | | | |
| **TOTAL** | | | | | | | |

## SCORING SCALE

**4** Excellent
**3** Very good
**2** Good
**1** Just satisfactory
**0** Needs urgent attention
**n/a** Not applicable to the project

Total score above 80 per cent is truly a good practice.

Total score from 65 to 79 per cent is a good practice that needs minor improvements in certain areas.

Total score from 50 to 64 per cent is a good practice because of specific areas but it may not be a total package. It can be documented but it needs major improvements for it to qualify as a best practice.

Total score from 40 to 50 per cent is not yet a good practice but has the potential to become a good practice.

Any score below 40 per cent is not a good practice and should not be documented and acknowledged as such.

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