Project Title	Introducing Comprehensive Sexuality Education and HIV Prevention and Treatment Methods through Pop-Up Clinics to Secondary School Girls in KwaZulu-Natal, South Africa
Funds Requested	$412,819
Project Duration	24 months (January 15, 2025 - December 13, 2026)
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Problem Statement

High rates of HIV/AIDS among young women ages 15-24 years old in Durban, KwaZulu-Natal, South Africa account for over 60% of new infections and are influenced by low socioeconomic status, gender disparities, lack of preventative care resources and education.

Introduction and Needs Assessment

Background Information

Human immunodeficiency virus (HIV) is a retrovirus that attacks the immune system leading to people living with HIV (PLHIV) immunodeficient and more susceptible to other infections or diseases (UNAIDS, 2023b). This can lead to acquired immunodeficiency syndrome (AIDS) within 8-10 years of infection (UNAIDS, 2023b). HIV does not always present symptoms, making it hard for people to identify their HIV status without proper screening. The lack of awareness around a person's status has led HIV to spread worldwide. In addition to the worldwide spread of HIV, there is no cure for the disease, however, antiretroviral therapy (ART) is mainly used for treatment (UNAIDS, 2023b). In response to the HIV outbreak, UNAIDS came up with the 90-90-90 goals and later the 95-95-95 goals in an attempt to promote preventative care towards HIV/AIDS. By 2030, UNAIDS hopes to have 95% of PLHIV know their status, 95% of PLHIV on ART, and 95% of PLHIV achieving a suppressed viral load (WHO, 2023b). While some countries have successfully met these goals, other countries have fallen behind. HIV is still prevalent in sub-Saharan Africa, with most cases found in South Africa.

South Africa has over 7.5 million people who are infected with human immunodeficiency virus (HIV), accounting for 17% of the global burden of HIV infections (UNAIDS, 2023). In 2022, adolescent girls and young women (AGYW) ages 15 to 24 years represented more than 77% of new HIV infections in sub-Saharan Africa (Kim et al., 2021). Of people living with HIV,

80% live within 5 major provinces of South Africa. KwaZulu-Natal has the highest HIV prevalence among these provinces (Ramjee et al., 2019). In addition, there is less than one healthcare facility per one PLHIV in KwaZulu-Natal (Kim et al., 2021). Interventions and access to healthcare with regard to medicines and treatment for HIV/AIDS is sparse due to the long distance between clinics and the lack of adequate transportation. Therefore, more than 80% of the country is more than 30 minutes away from the nearest healthcare facility (Kim et al., 2021). In the KwaZulu-Natal province, 60% of PLHIV are women, with incidence rates of 12 per 100 women in the city of Durban (Allinder & Fleischamn, 2019 & Ramjee et al., 2019). Only 42% of districts in Africa have programs that are dedicated to HIV prevention for adolescent girls and women (UNAIDS, 2023).

Due to the gender disparities in South Africa, young women are more likely to drop out of school and experience learning losses than their male counterparts (Duby, 2023). In addition, education on how and why HIV/AIDS infections spread and knowledge of its symptoms are limited due to the lack of resources and their cultural norms around such a taboo subject (George et al., 2022). Keeping girls in school is one of the most significant preventive measures to reduce HIV/AIDs in adolescent girls and young women as they are often infected at a young age (George et al., 2022). Providing information about sexual education and reproductive health can be an effective method of reducing HIV by decreasing risky sexual behavior (sexual acts without condoms and sexual acts with multiple partners) that put them at risk for getting infected.

Population Description

Overall, there are about 3.2 million people that live in the urban city of Durban, making it one of the most populated and busiest cities in the country (World Population Review, 2023). According to the World Population Review, about half the residents speak English as well as

Zulu, Afrikaans, Xhosa (World Population Review, 2023). Roughly half of the population is Black African, 25% are Indian or Asian and 15.3% are White (World Population Review, 2023). Additionally, 68% of the city's residents are under the age of 19 with the population expected to grow in the next 10 years, increasing the need to focus on healthcare for the younger population (World Population Review, 2023). Women make up half the population of the city and have a huge impact on the social and economic scene. Due to that, it's important that women are treated equally and are cared for in terms of their health. Men are also a part of the issue as they suffer from high rates of HIV as well. It's essential that they are included in the interventions so the problem can be alleviated from both sides. Unfortunately, this is not the case in most provinces such as KwaZulu-Natal since 60% of PLHIV are women (Allinder & Fleischamn, 2019).

Existing Programs

The Joint United Nations Program on HIV/AIDS (UNAIDS) was adopted in 2014 by the South African government in hopes to achieve 90% of HIV positive people are aware of their status, 90% of those diagnosed should receive sustained antiretroviral therapy, and 90% of those on ART achieve viral load suppression by 2022 (WHO, 2023). The program now aims for HIV testing, treatment, and viral suppression rates to be 95-95-95 by 2030. The program is a part of the United Nations family which includes 11 other UN system agencies that work together to fight AIDS through the use of strategies that analyze HIV/AIDS data to make progress at the local, national, regional, and global levels (UNAIDS, 2024). Thus, shaping policies around HIV through the use of evidence, experience, and political advocacy to build both health and community systems, legal frameworks, and shape the response to HIV (UNAIDS, 2024). Their use of strategy, advocacy, and support has transformed policy, allowing the connection to

governments, private sectors, and communities to deliver the life-saving services in hopes to end the HIV/AIDS epidemic.

Another program is the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program. Announced on World AIDS Day 2014, DREAMS works with the United States President's Emergency Plan for AIDS Relief (PEPFAR) to reduce rates of HIV among adolescent girls and young women and meet the Sustainable Development Goal of ending AIDS by 2030 (USAID, 2023). To do this, DREAMS continues to empower AGYW to increase gender equality among different sectors, mobilizing communities to encourage change, reducing HIV risk of sex partners through referrals, and strengthening families (USAID, 2023). Partnered with the United States Agency for International Development (USAID), the DREAMS program incorporates a comprehensive HIV prevention package that includes screening and testing, counseling, PrEP, condom promotion, improved sexual and reproductive health care, caregiver services, post-violence care, and more (USAID, 2023). The services in the HIV prevention package are designed to meet the urgent needs of AGYW, plus increasing economic growth, education, and government sectors.

Finally, the Universal Test and Treat (UTT) strategy was created in 2015 and recommended by the World Health Organization to be implemented in South Africa in 2016. The policy increased access to ART for all people regardless of clinical stage, allowing people to start ART within 14 days of the initial HIV-positive diagnosis (Nicol et al., 2022). Like the last two goals, UTT was adopted by the South African government in hopes to achieve the UNAIDS 2030 target goals including the 95-95-95 goal by increasing HIV testing and immediate treatment regardless of CD4 (cell) count, in an attempt to reduce the spread of the virus (Nicol et al., 2022). Before the UTT program, only 45% of newly diagnosed HIV positive individuals were linked to

care in the KwaZulu-Natal province of South Africa (Nicol et al., 2022). By utilizing the UTT program, South Africa has made progress towards achieving UNAIDS HIV 95-95-95 goals, however more progress is yet to be made to reach them by 2030.

Despite the current efforts of the UNAIDS program, awareness of HIV status in South Africa still remains lower than the rest of the world due to a lack of information, testing, and access to care. As of 2022, 94% of South Africans are aware of their HIV status (UNAIDS, 2023). In addition, only 46% of young people (ages 15-24) have access to comprehensive knowledge on how to prevent HIV. This is especially significant for young women who are 4 times more likely to be infected. (The Lancet HIV, 2018).

One of the goals of the DREAMS program is to empower adolescent girls and young women to reduce the spread of HIV. Unfortunately, the program cannot be successful until efforts are made to reach partners and families (Fleischman, 2021). To empower girls and women and then put them back into their same environment without addressing their partners and families does not create functional and long-lasting impacts. With this program, addressing gender norms of inequality also needs to be talked about more due to women often being seen as less important than their male counterparts in South Africa. This gender disparity is acting as a barrier for adolescent girls and young women to education, including sexual health education (Fleischman, 2021). The low socioeconomic status of women in South Africa reinforces the unequal gender norm which encourages women into relationships that expose them to HIV (Mabaso et al., 2019).

Despite the efforts made with the UTT strategy, many people living in South Africa are yet to be connected with healthcare services due to transportation cost and distance from the clinic. 64.1% of people living with HIV delay returning to or have not returned to healthcare

clinics at all due to the cost of transportation and the long travel times (Nicol et al., 2022). To address this issue along with HIV prevalence, the healthcare system needs to establish a more sustainable strategy to link people to testing services to promote awareness and retention of care.

Program Description

Goals and Objectives

Goal 1: Increase access to HIV prevention/treatment services for young women, ages 15-24 years old in Durban, South Africa.

Objective 1: Establish a partnership with 4 secondary schools or universities in the immediate Durban area within the first year.

Objective 2: Set up one pop up clinic to provide HIV prevention and treatment services within one year.

Objective 3: Increase access to both male and female condoms by 10% every year.

Objective 4: Increase the number of students receiving HIV counseling and testing annually by 10% within the first year.

Goal 2: Provide education about HIV/AIDS to young women.

Objective 1: Introduce Comprehensive Sexuality Education curriculum to one of our secondary partner schools within the first year. Implement CSE to at least two more partner schools by the end of the second year.

Objective 2: Have at least a 20% improvement in understanding risky sexual behaviors (sex without condoms & sex with multiple partners) by the end of the first year.

Objective 3: By the end of the second year, 50% of young women will know how to practice safe sex.

Intervention Strategies

Due to most HIV/AIDS cases occurring among young women ages 15-24 in Durban, KwaZulu-Natal, South Africa, this project aims to increase their access to HIV prevention and treatment services, and improve their knowledge on the matter through education. As a result, this project will contribute to getting South Africa closer to achieving UNAIDS' 95-95-95 goals. In order to achieve these goals, we will establish partnerships with 4 secondary schools by the end of the first of our intended two-year long intervention. With the help of Epione and Life Entabeni Hospital, we plan to set up at least one pop-up clinic by the school in order to provide HIV prevention and treatment services such as performing screenings, and providing antiretroviral therapy (ART) and HIV counseling among other resources. The pop-up clinic will also be promoted through the use of posters throughout the city as well as through word of mouth, specifically from our culturally adapted CSE workshops. In addition to our pop-up clinics, we plan to adapt the United Nations' Comprehensive Sexualily Education (CSE) curriculum around South Africa's cultural and gender norms into at least one of our partner schools in the first year, and two partner schools the following year.

In order to help our first activity run smoothly, we will partner with Epione based in Soweto, who help connect patients to healthcare services through their mobile platform. During this intervention, they will allow us to use their mobile platform to connect people to continuing services should they need it. In addition to their valuable experience, they have also successfully established pop-up clinics at health drives in the Soweto community. In order to have a smoothly operating pop-up clinic, Life Entabeni Hospital will provide a General Practitioner (GP) to provide antiretroviral medication such as PrEP and PEP and any materials needed for testing and treatment. We will also hire and train community health workers to assist and provide general information on HIV such as prevention methods and connect them to further care through Epione

if need be. In addition to the personnel running the pop-up clinic, we will also need administrators to help identify the space and approve the pop-up clinic. These will include our partner school administrators as they will grant us their space or somewhere nearby to establish the pop-up clinic throughout the school day.

In order to implement CSE into Durban-area secondary schools, we will first need the approval of the school board with the help of the KwaZulu-Natal Department of Health and Department of Education. Next, we will hire a workshop facilitator to train the faculty within our partner schools how to properly teach the CSE curriculum. The workshop facilitator will account for up to 15 school teachers to attend the training. Adapting the CSE to be culturally competent will be an equally collaborative effort between the Department of Health, Department of Education, South African National AIDS Council, the school board, the faculty of each partner school, the workshop facilitator, and community leaders families.

The initial plan is to have all eight modules of the curriculum taught to all secondary students. Despite some modules being geared towards a younger age group, many students have not received any sexual education in primary school and will need to build the foundational knowledge in order to achieve the CSE's and our program's goals and objectives. However, the school board and the Departments of Health and Education have the authority to make appropriate decisions if they deem some topics unacceptable due to their prevailing cultural norms. Community leaders and families will also have the opportunity to voice their opinions before the start of the intervention in the form of a community meeting. Based on the epidemiological context, Module 8: Sexual and Reproductive Health will be heavily recommended as it directly relates to the rate of HIV/AIDS in South Africa. Our adaptation of CSE will be a 2-year long curriculum in order to fit within our timeline and to allow for learners

to master its three domains of learning - knowledge, attitudinal, and skills-building. The 2-year timeline also reflects the fact that learning is nonlinear and allows learners multiple opportunities to learn, revisit, and reinforce key ideas. Families will also be expected to help reinforce these ideas in the home setting as long as they are comfortable. These will be in the form of a resource sheet on how to support CSE from home. The timeline will also allow for multiple points of evaluation to monitor the program's progress and adjust the curriculum as needed. However, the exact timing of when each module will be taught will be at the discretion of the faculty since they are best suited to monitoring student engagement and understanding.

The personnel that will be responsible include a Program Manager to oversee both interventions, a liaison for each intervention, four community health workers to operate the pop-up clinic and provide health education to patients, and one workshop facilitator to help implement CSE within the schools. Life Entabeni Hospital will supply and pay for one general practitioner to lead the pop-up clinic. Our partner schools will have the faculty required to teach the CSE and will be engaged with our workshop facilitator.

Logic Model (Chart)

Inputs (What we invest)	**Outputs (What we do and what we get from doing them)**		**Inputs and Outcomes**		
	Activities	***Output***	***Short-term (6 months)***	***Intermediate (1 year)***	***Long-term outcomes (2 years)***
HIV/AIDS prevention supplies	Operate pop-up clinics	Increase access to prevention resources		Decreased HIV/AIDS incidence by 15%	Decreased rates of HIV/AIDS prevalence by 10%
Funding, Partnerships, and Personnel	Promotion of pop-up clinics for those not in school	1 pop-up clinic operation in year 1			
	Referral program to healthcare services	Distribute HIV resources via pop-up clinic			
	Health education + workshops	1 school implements CSE curriculum	Gain knowledge on CSE (skills assessment)	Increase in proportion of young people that use condoms at last sexual encounter by 15%	
	Advertisement for pop-up clinics in schools			Students know how to prevent HIV/AIDS and find resources	
Existing curriculum (CSE)		Students and teachers complete CSE and workshops	Increase awareness around HIV/AIDS prevention	Teachers know how to teach culturally sensitive CSE	

Assumptions	External Factors
Funding Successful partnerships established Ongoing/continued interest in using project resources Clinics are adequately staffed Adequate local support for project	Disease outbreak Civil unrest (riots) Change in governmental administration Loss of funding in the school

Timeline (see Appendix C)

To make the most out of the 2 year timeline, we started by doing the majority of the business/administrative portion of our project within Fall of 2023 to the end of 2024. During this time we got an understanding of the different HIV/AIDS statistics in the city of Durban, located in the Kwazulu-Natal Province in South Africa and also researched current initiatives and interventions being done to create a plan. We also started applying for funding/grants as well as registering for the Broad-Based Black Economic Empowerment (B-BBEE) Certificate, creating connections with potential partners, establishing our partnership with our secondary schools, hiring our staff, signing contracts with Epione and the Life Entabeni Hospital, settling on a place for our clinic, and introducing the Comprehensive Sexuality Education curriculum into one our partner schools.

At the start of 2025, we will begin setting up our pop-up clinic and then promoting our clinic. During this time, teachers from our 4 secondary schools will complete the CSE curriculum workshop with the workshop facilitator at the beginning of each school term (every 3 months). After this, at the beginning of every term, a pre-test will be issued to the students to gauge their level of knowledge before the CSE curriculum is implemented. Students will then complete a CSE curriculum workshop taught by the teachers. Followed by a post-test starting in March 2025 and administered by the end of every term. We will also evaluate our clinic's progress every 3 months. By February we hope to start treating our clinic patients and by March we will receive our first progress report. However, we will not report our findings until June to allow for enough data to be evaluated. By December, both our clinic and our CSE curriculum will be in operation for close to a year, allowing us to evaluate the current statistics, and reflect on the success of our interventions. Based on this success, we will start introducing the CSE

curriculum to two more of our partner schools in the second year and finally end our project with our final report.

Stakeholder Engagement Plan (see Appendix B)

Our program implementers will be directly involved with the implementation of CSE within secondary schools as well as our pop-up clinic. Our Program Managers and South African government agencies will be involved with the implementation of both interventions. The KwaZulu-Natal Department of Health will be involved with the implementation of our pop-up clinic along with our organizational partners Epione and Life Entabeni Hospital. Life Entabeni Hospital will also provide to us a General Practitioner (GP) to make on the ground decisions. The KwaZulu-Natal Department of Education will work alongside our Program Managers and our partner schools' board in order to implement CSE within those schools.

Our program decision makers will be responsible for making decisions about each program. Our Program Managers will work directly with the South African National AIDS Council and Durban's religious and community leaders in order to make sure both of our programs are appropriate for the area's cultural norms. The KwaZulu-Natal Department of Health will also make decisions along with Epione and Life Entabeni Hospital on anything related to our pop-up clinic. The KwaZulu-Natal Department of Education will work alongside the school boards in regards to the CSE.

Our program participants will include the faculty who are tasked with teaching CSE and their students and students' families. The faculty will receive yearly CSE workshops to be culturally competent with our workshop facilitator. In addition to these annual workshops, each school teacher will take a pre- and post-test to help with evaluation and identify any weaknesses in the curriculum. As a result, the students will be taught CSE in a culturally appropriate way

with their families reinforcing what is taught in the home setting. Anyone who utilizes our pop-up clinic are also considered program participants. As a result, the staff in our pop-up clinic will be trained annually to smoothly operate the clinic.

Our program partners will have a significant influence on the program through their support. These will include the KwaZulu-Natal Departments of Health and Education, the AIDS Foundation of South Africa, our partner schools, Epione, Life Entabeni Hospital, and the South African National AIDS Council.

Evaluation Plan

Definition of Program Success

Our target population are young women aged 15-24 in Durban, South Africa. There are about 61,970 schoolgirls total, in those186 secondary schools, in Durban (Frith, 2011). That comes out to about 333 girls per school on average that we hope to reach.

In our first year, we hope to have the pop-up clinic established. This will come along with hopefully seeing a 20% improvement in knowledge around risky behaviors (which will be determined in surveys). In terms of the schools, we have confidence that CSE will be implemented in at least one school along with establishing those partnerships with the 4 schools. With those interventions, we want to increase access to male and female condoms (both male and female) by 10% from the existing 47%.

In the second year, we are striving for more ambitious outcomes. That entails the hope that 50% of young women in the CSE program will know how to practice safe sex. We will continue our implementation of CSE based on our evaluation of each term. Lastly, increasing access to condoms is about 10% more.

Key Evaluation Questions

Our first process evaluation question is, by the end of the first year, are the pop-up clinics operating properly to supply adequate HIV/AIDS prevention resources? As well as, has CSE been implemented in at least one school by the end of that year?

Our summative evaluation question is, are participants changing daily behaviors and forming long-lasting habits to reduce the risk of HIV/AIDS?

Evaluation Methods

The qualitative pre-test is given to students, in schools, before CSE is implemented to fully understand the knowledge they have already. The qualitative post-test is given after the first year of implementation of CSE and in the second year as well to evaluate its effectiveness in the schools. The indicator targets would be met if we hit the statistical objectives, stated in our progress success statements. The same will also be done for the school teachers during their annual workshops to help identify any weaknesses within the program.

Data collection will be conducted in 4 ways. The qualitative data which is the human behaviors to CSE. This includes, risky sexual behaviors, ability to obtain treatment/testing, condom usage, knowledge on safe sex. The quantitative data is based on statistics in the clinic. This would be rates of HIV/AIDS diagnoses that come into the clinic. How we obtain rates of HIV/AIDS in the area we are treating, and rates of people treated. The primary data collection (schools, clinic) which is the surveys (in schools), interviews (with patients in clinics), focus groups and community discussions in schools. The public data will be available to the school board (teachers, administrators, etc.) and local government stakeholders (for geographic census data regarding HIV/AIDS).

Evaluation Considerations

The timing is based mostly on establishing milestones by the end of the first year, seeing what was successful, continuing that and evaluating aspects that are lacking. After those evaluations are addressed, we move forward continuing and improving our interventions. With that, at the end of the second year we hope to see the increase in the statistics discussed above. It's important that not only we see success in our intervention but also that we maintain our integrity and consider ethical considerations. This means things like HIPPA South Africa Laws (Personal Protection Information Act), reporting correctly and accurately, as well as the safety in the facility regarding hazardous materials. It's important to both students and patients that we have confidentiality. We hope to protect students and any medical information that is recorded so schools only have access to certain things.

Dissemination Plan

All our stakeholders will have access to our goals and objectives. Our program implementers will also know how our programs are maintaining cultural competence as well as monthly updates of the program's progress until the end of the first term. After the first term, our program implementers will receive a program update after every term. Program decision makers and program partners will receive progress reports each term for evaluation and an annual financial report. Our program participants will also receive cultural competency training either yearly (clinic staff) or before each term (CSE teachers).

Budget Justification (see Appendix A)

Grant Funding Mechanism

Our grant funding mechanism is from the AIDS Foundation of South Africa (AFSA). This organization seemed the best because this grant is focused on the young people and those in school which aligns with our project. This grant focuses on the combination of prevention and

treatment by using strategies that address social and structural factors of HIV through broader sexual and reproductive health frameworks. Our target population are 15-24 year old girls and young women, which fall into their target population of 10-24 year old girls and women. According to their 2021-2022 annual report, they spent 455,135,742 ZAR on project allocations. Divided by their 44 grant sub-recipients, each sub-recipient received on average $551,972 per year which is more than enough to fund our budget (AFSA, 2022).

In order to align ourselves more with the AFSA grant requirements, we would have to register for the B-BBEE certificate. In order to receive this certificate, we will have to prioritize Black empowerment within our organization and focus on hiring within the local area. We will also need to qualify for the SARS tax clearance, which has been addressed in our timeline to manage taxes within the intervention.

Senior Personnel

Our senior personnel will include one Program Manager and a liaison officer for each of our interventions. Our program manager will be required to oversee all of the major interventions and act as a point-of-contact for our partner liaisons. Since we have two major interventions (implementing CSE and a pop-up clinic), this will be a full-time job. The average salary of a program manager in South Africa is reflected in the budget. One liaison will collaborate with our partners involved in implementing our pop-up clinic (Epione and Life Entabeni Hospital) and will report progress updates to the program manager. This will be a full-time position in the first year since they will be heavily involved in the implementation process, and will scale down to part-time in the second year as they will primarily be helping out with evaluation methods. They will also be serving as a point-of-contact for the head General Practitioner (GP), which will be provided by Life Entabeni Hospital. We will also have a liaison for our CSE partners which will

include the school boards and the schools themselves. This will be a part-time position in the first year since they will only be dealing with one partner school, and will scale to full-time during the second year in order to work with more school partners. They will be a point-of-contact for our workshop facilitator and will also report to the program manager. Their salaries are equivalent to the average salary of a liaison in South Africa.

Other Personnel

We will be hiring four part-time community health workers to help operate the pop-up clinics. Community health workers have notoriously high burn-out rate, so we will be hiring on a part-time basis to avoid this. Hiring four part-time community health workers will allow us to have two community health workers per shift, with two shifts occurring each day. The average salary of a community health worker in South Africa is reflected in the budget and will report to the onsite GP. We will also be hiring a workshop facilitator to help lead the teacher trainings on how to properly execute CSE within the classroom. They will be part-time in the first year, and full-time in the second year to reflect the increased partnership schools in the second year. The average salary for a workshop facilitator in South Africa is reflected in the budget.

Fringe Benefits

The average fringe-benefits rate is 27.4% of salaries and wages, and has been calculated and is reflected in the budget. Fringe-benefits will include disability and life insurance, retirement plans, tuition assistance and childcare reimbursement.

Equipment

We will need two laptops in order to operate the pop-up clinic in order to record and send test results to Life Entabeni Hospital. These will also help us with our evaluation plan to see if we are making progress towards our goals. The current price of an HP laptop (typically used for

hospital and clinical settings) is reflected in the budget. We will also be giving out free HIV/AIDS testing kits so people are able to test at home as well. Each school in Durban has an average of 333 girls and everyone is recommended to get tested at least once per year. Having 700 testing kits will allow everyone to get tested multiple times if they need to. The cost is reflective of the average cost for a testing kit. The same thought process goes towards lube. Since condoms come in packs of 24, we request to purchase 300 units equaling 7,200 condoms with this cost reflected in the budget. This amount of condoms will allow each student to grab as much or as little as they choose, with each student able to take ten condoms per year on average. We also require 2 canopy tents in order to protect the pop-up clinic from the elements. 12 total foldable chairs and two foldable tables will also be needed to provide space for our community health workers and GP to work and provide prevention and testing services. They will need to be foldable in order to ease the setting up and taking down process. We will also require paper and pens so our students are able to take pre- and post-tests for our CSE evaluation. These tests are four pages long, with each pre-test taking place at the beginning of each term, and a post-test at the end of each term. With there being four terms in a school year, each student will require eight tests. If all 700 students take these tests, we will require fifteen 1,500 paper stacks. This number will triple as we implement CSE within two additional schools. We will also provide free pens to students with our logo on them for each test. These cost $0.58 each, so we will purchase a unit of 6,000 pens. This will also be tripled in the second year.

Travel

We will need to rent a mid-sized van each year. In the first year, we will need the van to move all of the materials needed for the pop-up clinic and will aid in setting up. The van will be

needed in the second year for the deconstruction of the pop-up clinic. It currently costs $81 per day to rent a mid-sized van.

Other Direct Costs

We will be holding one half-day orientation at the beginning of each year for our community health workers to teach them how to operate the pop-up clinic and provide cultural competency training. Since they will be from the local area, we will not be providing any transportation to the clinic (site of orientation). Rather, we will be providing 2 meals (breakfast and lunch) for each of the community health workers (4), as well as the GP and workshop facilitator who will both be leading the training. Each meal will cost $20. Our project requires us to have a contract with all of our partners. Our first year will require consulting services for our three partners (Epione, Life Entabeni Hospital, and the first partner school) and our second year will require two contracts with each of our additional partner schools. This will cost $108 each. Having 500 posters to advertise the pop-up clinic will allow us to put up 5 posters per square mile of the city of Durban which cover 87 square miles. This also allows us to have some extra so we can put more around our partner school since they are our target population. The posters will also be needed for the second year in order to replace the damaged posters.

Total Cost Requested

After adding up all of the costs, the cost of Year 1 is R3,811,090.25, or $203,198 and the cost of Year 2 is R3,931,575.90 or $209,622. Over the course of two years, the total cost of the program is R7,742,647.40 or $412,819, which is well within AFSA's grant allocation of $551,972.

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