



**USAID** | **ZAMBIA**  
FROM THE AMERICAN PEOPLE

# ZAMBIA COMMUNICATIONS SUPPORT FOR HEALTH

**Gender Analysis and Strategy**

**August 2013**



Contract No. GHS-I-007-00004-00; Task Order No. GHS-I-05-07-00004

*This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International Inc. The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.*

## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	4
METHODOLOGY .....	6
GENDER ANALYSIS.....	6
CSH GENDER INTEGRATION REVIEW .....	13
RECOMMENDATIONS FOR GENDER INTEGRATION INTO CSH ACTIVITIES	
INTERMEDIATE RESULT 1: NATIONAL HEALTH COMMUNICATIONS CAMPAIGNS STRENGTHENED .....	19
INTERMEDIATE RESULT 2: GRZ USE OF EVIDENCED-BASED HEALTH COMMUNICATIONS APPROACHES INCREASED.....	21
INTERMEDIATE RESULT 3: LOCAL CAPACITY TO SUPPORT SUSTAINED IMPLEMENTATION OF IEC/BCC ACTIVITIES STRENGTHENED .....	22
INTERMEDIATE RESULT 4: COORDINATION OF IEC/BCC ACTIVITIES BETWEEN USAID PROJECTS INCREASED .....	23
MONITORING AND EVALUATION.....	23
CONCLUSION.....	24
ANNEX 1: MEETINGS WITH STAKEHOLDERS HELD JUNE 2013.....	25
ANNEX 2: WORKS CITED.....	26

# Acronyms

IEC	Information, Education and Communication
IPTp	Intermittent preventive treatment for pregnant women
ITN	Insecticide-treated nets
M&E	Monitoring and Evaluation
MCP	Multiple and concurrent sexual partnerships
MCDMCH	Ministry of Community Development, Mother and Child Health
MDG	Millennium Development Goals
MGCD	Ministry of Gender and Child Development
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child Health
NAC	National HIV/AIDS/STI/TB Council
NMCC	National Malaria Control Center
PMTCT	Preventing Mother to Child Transmission
SADC	South African Development Community
STIs	Sexually Transmitted Infections
TB	Tuberculosis
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
ZDHS	Zambia Demographic and Health Survey
IEC	Information, Education and Communication
IPTp	Intermittent preventive treatment for pregnant women
ITN	Insecticide-treated nets
M&E	Monitoring and Evaluation
MCP	Multiple and concurrent sexual partnerships
MCDMCH	Ministry of Community Development, Mother and Child Health
MDG	Millennium Development Goals
MGCD	Ministry of Gender and Child Development
MOH	Ministry of Health
MNCH	Maternal, Newborn and Child Health
NAC	National HIV/AIDS/STI/TB Council
NMCC	National Malaria Control Center

## EXECUTIVE SUMMARY

Launched in July 2010, the United States Agency for International Development (USAID)-funded Communications Support for Health (CSH) is a four and a half year project that aims to increase the technical capacity of the Government of the Republic of Zambia (GRZ) and civil society organizations (CSOs) to increase national-level awareness of and equitable access to health services in Zambia through targeted activities in information, education, communication/behavioral change communication (IEC/BCC). CSH IEC/BCC activities are focused in the health areas of HIV/AIDS, family planning/reproductive health, maternal newborn and child health (MNCH), malaria, and nutrition.

CSH has four Intermediate Results (IRs):

1. National health communication campaigns strengthened
2. GRZ use of evidence-based health communications approaches increased
3. Local capacity to support sustained implementation of IEC/BCC activities strengthened
4. Coordination of IEC/BCC activities between United States government projects increased

This report is divided into three sections: 1) A gender analysis that identifies gender-based constraints within a Zambian context for each of the CSH target health areas, 2) a review of CSH program findings as they relate to mitigating gender constraints and increasing gender equity in the section titled, “CSH Gender Integration Review”, and 3) a list of recommended illustrative activities to help guide the project’s technical staff to successfully strengthen gender integration throughout all of CSH’s activities in its fourth and final year of performance.

The gender strategy makes a number of recommendations for each of the project IRs. A summary of key highlights is included below.

- *Collaborate with existing GRZ gender programs to increase campaign reach.* Work with the Ministry of Community Development, Mother and Child Health’s (MCDMCH) Department of Community Development to distribute CSH campaign materials targeted to women through their Women’s Empowerment Program.
- *Engage more men in Safe Love clubs.* Safe Love clubs work in communities to educate men, women, and youth on healthy relationships and safe sex practices to prevent the spread of HIV/AIDS. Club membership is dominated by women as men view community health clubs as a predominantly female activity. Also, meetings are often held at times not convenient for men with jobs outside of the home. Facilitators should survey male community members about their reasons for not joining and establish meeting times that work for both men and women’s schedules.

- *Promote women as advocates for voluntary medical male circumcision (VMMC).* The National HIV Communications Strategy includes guidance on promoting women as VMMC advocates; therefore, CSH should ensure VMMC materials target and educate women to the benefits of VMMC in the reduction of HIV infection and human papillomavirus (HPV), which can lead to cervical cancer in women.
- *Dedicate segment of Your Health Matters, Let's Talk television program to gender-based violence (GBV).* Your Health Matters is a 25-minute television series produced by the Ministry of Health (MOH) that airs once a month and addresses a variety of health topics. A GBV segment should encourage women to report incidences of GBV and promote the importance of supportive relationships in adopting healthy behaviors.
- *Co-host quarterly media breakfast with the Ministry of Gender and Child Development (MGCD).* MGCD hosts quarterly breakfast meetings to educate media representatives from TV, print, and radio on gender issues and how to accurately report on them in the media. This presents an opportunity to further promote messaging of the Safe Love campaign and present members of the media with gender-based facts on HIV/AIDS, particularly for the new VMMC component.
- *Integrate gender criterion in procurement review process for Formative Research in Action request for proposals (RFP).* Two provinces will be selected to receive funding to conduct formative research on any CSH health topic of their choosing. CSH will include gender criterion in the review scorecard to ensure research approaches adequately mainstream gender throughout the research process.
- *Add gender integration component to GRZ and CSOs IEC/BCC trainings.* National communication strategies across GRZ partners outline gender-based constraints and provide guidelines to mainstreaming gender in IEC/BCC campaigns, but many staff have not been trained in gender mainstreaming approaches for IEC/BCC initiatives. CSH will integrate a gender mainstreaming training and workshop component into Technical Working Group (TWG) trainings and will conduct trainings with CSO partners and grantees.
- *Review sex-disaggregated data for gender trends and present gender findings in CSH quarterly reports to USAID.* Findings reveal there are gender trends across program activities, i.e. Safe Love clubs have a higher female membership than male membership, that should be reviewed and where inequalities exist, should be addressed if possible. Further, gender trends, success stories, and findings should be included in the quarterly reports to USAID.

## METHODOLOGY

A field office workshop (based on USAID's [Guide to Gender Integration and Analysis](#)) held June 17 and 18, 2013 complemented and informed this strategy. The primary purpose of the workshop was to build staff capacity to mainstream gender equitable programming across project activities, gain buy-in from CSH technical staff to implement these activities, improve the CSH team's ability to articulate the importance of a gender equitable approach to GRZ stakeholders, CSO partners and grantees, and measure the impact of these efforts. Soft and hard copy versions of the workshop and other resources were distributed to the staff so they may continue to use and adapt them as needed. For clarification about any gender terminology in this report, please refer to USAID's *Gender Terminology* available at: [http://transition.usaid.gov/our\\_work/cross-cutting\\_programs/wid/pubs/Gender\\_Terminology\\_2.pdf](http://transition.usaid.gov/our_work/cross-cutting_programs/wid/pubs/Gender_Terminology_2.pdf).

Individual meetings with CSH technical staff, GRZ partners, CSO partners, and grantees were held the week of July 17<sup>th</sup>, 2013 to gain deeper insight into how program operations address gender constraints and how activities serve men and women differently to influence behavior change in each of the CSH health focal areas. A list of stakeholders met with in-country are provided in Annex 1.

## GENDER ANALYSIS

This gender analysis begins by highlighting some of the primary gender constraints within the larger Zambian context followed by an overview of constraints within each of the health focal areas addressed by CSH: HIV/AIDS, family planning/reproductive health, MNCH, malaria, and nutrition.

### *Zambia Gender Analysis*

Zambia has experienced relative political peace during its colonial and post-colonial eras. Economic growth has fluctuated since its independence from Britain in 1964, with more steady economic growth since 2000. Throughout the 1960s and 1970s Zambia's economy thrived on the copper mining industry resulting in an urban population boom. Traditional gender roles were further solidified with men taking up unskilled labor positions in mining and women serving as the primary caretaker for the family.

The decline of the copper mining industry in the 1970s gave way to crippling poverty rates that endured throughout the 1980s and most of the 1990s. Economic policies gradually liberalized in the 1990s; however, macro-economic policies did not adequately support social health services and led to the introduction of medical fees and the de-institutionalization of health care provision towards home-based care, especially for chronic illnesses such as TB and HIV/AIDS. Such policies further impoverished women without access to finance which resulted in the compromise of their health and increased their burden and role as caretaker when family members fell ill.<sup>1</sup> The negative impact on women's health contributed to women's' inability to participate in other aspects of society such as attaining an education and taking up income-

---

<sup>1</sup> Strategic Country Gender Assessment: Zambia, World Bank, 2004.

generating activities. Zambia's participation in poverty reduction strategies in the past decade such as the Millenium Development Goals contributed to its gradual economic recovery; however, Zambian gender assessments (2004 World Bank Zambia Strategic Country Gender Assessment; 2012 World Economic Forum Gender Gap Report; 2012 Southern Africa Development Community (SADC) Gender Barometer: Zambia) confirm gender inequality persists across all aspects of society.

Despite the statutory evolution of gender equality in Zambia similarly mirroring that of the international community, discriminatory customary laws and practices continue to significantly hinder women's equitable participation in Zambian society. In light of these challenges, the government of Zambia recognizes the importance of gender equality to address poverty and ensure developmental growth, and has taken commendable strides to improve societal conditions for women, most notably the establishment of the MGCD and ratification of the SADC Gender Protocol in 2012. Most recently, Gender Focal Point (GFP) persons have been appointed in all the planning departments of line ministries and other major government agencies, and the MGCD is currently conducting a review of the National Gender Policy. Although Zambia has developed many of the necessary gender policies (see box) and national action plans it has yet to fully operationalize, monitor, and report on such plans and is starting to address these implementation needs.

<b>Milestones in Zambia's Path Towards Gender Equality</b>
<b>1985</b> – Ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
<b>1996</b> – Women in Development Division in the National Commission for Development Planning transformed into the Gender in Development Division (GIDD) Cabinet office; GIDD facilitated development of the first national gender policy
<b>2000</b> – First National Gender Policy approved
<b>2004</b> – Strategic National Action Plan (NAP) approved. The NAP operationalized the vision of the national gender policy
<b>2012</b> – Ministry of Gender and Child Development (MGCD) established
<b>2012</b> – Ratification of the Southern Africa Development Community (SADC) Protocol on Gender and Development; provides tools to set realistic, measurable targets, time frames and indicators for achieving gender equality and equity and evaluate progress made by Member States

### ***HIV and AIDS***

Zambia has an HIV prevalence rate of 14.3 percent with women representing 57 percent of infections and men representing 43 percent.<sup>2</sup> In addition to biological factors that increase women and girls' vulnerability to HIV, gender power dynamics contribute to women being more vulnerable to contracting the virus, such as women's lack of negotiation skills for safe sex and financial dependency on men resulting in women taking up multiple concurrent partners (MCP). Women's lack of negotiation skills for safer sex resulting in low condom use (37.4 percent)<sup>3</sup> is compounded by the common cultural practice of men having multiple concurrent partners (MCP) with low condom use rates (27 percent), ultimately compromising a woman's ability to protect herself.<sup>4</sup> Women, especially those in the young and urban demographic, are more likely to take up MCP for a variety reasons such as financial dependency and to increase the likelihood of finding a partner for marriage. Conversely, men are more likely to take up MCP, particularly in

<sup>2</sup> SADC Gender Protocol 2012 Barometer – Zambia, 2012

<sup>3</sup> ZDHS, 2007

<sup>4</sup> ZDHS, 2007

northern and southern regions, due to cultural norms encouraging or rewarding men with increased social status or from engaging in the common cultural practice of polygamy. The HIV rate among men in polygamous unions is 19 percent versus 15.9 for men in non-polygamous unions.<sup>5</sup> Another factor that correlates to MCP is men comprise a majority of the migrant labor population, which disrupts long-term partnerships and increases the likelihood of men engaging in MCP, particularly with sex workers.

Low condom use rates is a key driver of new infections, thus it is important to understand the underlying psychosocial reasons for the lack of condom use among men and women. 31 percent of Zambians reported not being able to ask their husband or partner to use a condom.<sup>6</sup> Women lack negotiation skills for safe sex because traditional customs designate men as the primary decision-maker in the household and this extends to the relationship. Women are often labeled as promiscuous if they carry their own condoms or may be deemed untrustworthy by an established partner if they initiate safe sex discussions and, in some instances, may lead to GBV.<sup>7</sup> Common beliefs shared by both men and women include suspicion of infidelity of a partner who introduces condom use in an established relationship and the belief sex will not be as pleasurable with a condom.

Alcohol and drug abuse significantly impairs decision-making when it comes to fidelity and safe sex practices and is a contributing factor to GBV especially towards women compromising a woman's ability to protect herself against HIV and sexually transmitted infections (STIs) (see box).

10 percent of all HIV infections in Zambia are children under the age of 14 largely as a result of mother-to-child-transmission (MTCT). In addition to expectant mothers not knowing their HIV status, knowledge gaps in how to reduce the risk of MTCT such as the use of antiretroviral drugs (ARV) are a significant contributor to this statistic; the 2007 Zambia Demographic and Health Survey (ZDHS) revealed only 68 percent of women and 56 percent of men are aware that MTCT can be reduced by taking ARVs during pregnancy.<sup>8</sup>

Women are further burdened by Zambia's high HIV rate as they disproportionately serve as the primary caretakers for infected and affected orphans and family members. Zambian women are

**The Effects of Gender-Based Violence (GBV) on Women**

In some regions of Sub-Saharan Africa, women are 1.5 more times likely to contract HIV as a result of GBV and there is "behavioral evidence that men who use violence against their female partners are more likely than non-violent men to have a number of HIV-risk behaviors including MCPs, frequent alcohol use, visiting sex workers, and having an STI, all of which increase the women's risk of HIV" (WHO, 2013)

- 47 percent of Zambian women reported experiencing physical violence since the age of 15.
- Women employed and compensated in cash (54 percent) are more likely to experience violence than unemployed women (40 percent).
- Urban women (50 percent) are more likely to be victims of GBV than rural women (44 percent).
- 85 percent of women and 69 percent of men believe that a husband is justified in beating his wife for at least one reason.

- ZDHS, 2007

<sup>5</sup> ZDHS, 2007.

<sup>6</sup> 2011 – 2012 Progress of the World's Women: In Pursuit of Justice, UN Women, 2011

<sup>7</sup> Human Rights Watch, Gender-Based Abuses and Women's HIV Treatment in Zambia, 2007

<sup>8</sup> ZDHS, 2007

also more vulnerable to poverty due to high care and treatment costs compounded by their lack of opportunities to take up income generating activities.

The most vulnerable population to HIV are young women and girls (see box) with girls between the ages of 15 and 24 four times more likely to contract HIV than boys. Findings reveal young Zambians start having sex and engage in other risky behaviors as early as 10 years for girls and 12 years for boys. Girls in rural areas marry as early as 14 years, putting them at higher risk of contracting STIs including HIV. In addition, the common misbelief that having sex with a girl child heals HIV/AIDS has increased the risk of HIV infection among young girls.<sup>9</sup>

#### **Youth, The Most Vulnerable to Health Risks**

- Women between age 23 and 24 have the highest HIV prevalence rate (15 percent); men of the same age have a 10 percent prevalence rate
- Girls between the ages of 15 and 24 are four times more likely to contract HIV than boys of the same age group
- Only 10 percent of sexually active girls aged 15 to 19 use a family planning method
- Child sexual abuse, known as “defilement” in Zambia, increases the likelihood of STI contraction which facilitates HIV transmission

VMMC is linked to a reduction in female-to-male HIV transmission risk by as much as 60 percent and has been identified by the GRZ and the international health community as an effective approach to reducing HIV rates worldwide and in Zambia. In some regions such as Western and Northwestern provinces, male circumcision is considered a right of passage into adulthood or practiced for religious reasons.<sup>10</sup> Barriers to increasing the rate of VMMC procedures include fear of irreparable damage and diminished sexual pleasure. Alternatively, some men believe circumcision prevents all STIs, including HIV, demonstrating a lack of proper knowledge on risk reduction versus risk elimination. Since MC is a procedure for men, women often lack sufficient knowledge of the benefits VMMC have on women such as the reduction in HPV that can lead to cervical cancer, and subsequently do not advocate for the procedure.

#### ***Family Planning/Reproductive Health and Maternal, Newborn and Child Health (MNCH)***

The 2007 ZDHS revealed about 41 percent of births are unwanted at the time of conception. This may be due to power imbalances between couples when it comes to family planning as large families are desirable in Zambian culture and women may succumb to societal pressure to have more children than desired (46 percent of men think the husband alone should make the decision on the number of children to have). The ZDHS reports about 30 percent of Zambian women use any form of contraception and only 25 percent use modern contraceptive methods. Young and unmarried women report challenges accessing contraception because many health clinicians will not provide contraceptives to them as an effort to discourage premarital sex and abortion. While access to and availability of contraceptives can be difficult, cost is rarely an issue due to government and donor-funded supplies being available for free at most public facilities. Contraceptive use is higher among women in urban areas than among women in rural areas (48 and 37 percent, respectively). Rural women face more obstacles to accessing and using contraceptives due to distance to facilities, and misunderstanding of correct contraceptive use or family planning practices from modern medical terms not having a direct local translation.

<sup>9</sup> World Bank, 2005

<sup>10</sup> Zambia VMMC Operational Plan 2012-2015

CSH formative research revealed women overall had high knowledge of the use and benefits of modern contraceptives (birth control pill, injectables, and condoms)<sup>11</sup>, however many women do not use contraceptives out of fear for side effects – both accurate, e.g. weight gain, and false side effects, e.g. cancer. Additional obstacles to contraceptive use for both rural and urban women are long waiting times at clinics and stockouts especially for the pill and injectables.<sup>12</sup>

95 percent of married women, aged 15 to 49, reported their husband knew of their contraceptive use<sup>13</sup>; however, in instances where the husband was against the use of contraceptives, some women used them without the husband's knowledge and prefer the use of injectables for their increased efficacy and concealability.<sup>14</sup> In Zambian culture it is desired, particularly by men, to have large families and thus is a primary reason for not using contraception and not practicing recommended birth spacing.<sup>15</sup>

The maternal mortality rate for Zambia is as high as 630 per 100,000 live births. Roughly eight women die each day due to pregnancy and childbirth related complications.<sup>16</sup> Health services in rural communities are poor, especially emergency obstetric care. According to the 2008 Ministry of Health and National Aids Council Zambia Country Report, 52 percent of births occur at home while 43 percent occur in public facilities. The same report indicates that urban women are more likely to deliver in a health facility (79 percent) than women in rural areas (28 percent). In rural areas, many women live far from the nearest health facility and gaining access to transport is a challenge. The 2007 ZDHS shows that close to half (47 percent) of all deliveries were assisted by a health provider. Women in urban areas are more likely to be assisted by a skilled provider (75 percent), while women in rural areas are likely to be attended to by either a traditional birth attendant (31 percent) or a relative (32 percent).<sup>17</sup> Societal norms that support home deliveries with a traditional birth attendant can deter a woman from delivering in a hospital or clinic with skilled care.<sup>18</sup>

One-fourth of women who have visited antenatal care (ANC) clinics continue to delay the initiation of ANC until after their sixth month of pregnancy, subsequently missing out on potential benefits of early ANC services. Women in rural areas cite distance as the primary reason for not seeking ANC or for not delivering in a facility. Further, many women do not believe early ANC visits are necessary or may not have been aware of their pregnancy or signs of complication. Also, afternoon visits are inconvenient for women who must return home before dark, and transportation costs often hinder women's ability to attend ANC visits.

Men's knowledge and involvement in maternal care continues to be low as maternal health is

---

<sup>11</sup> CSH Safe Motherhood Formative Research Report, 2012

<sup>12</sup> J-PAL, 2012

<sup>13</sup> ZDHS, 2007

<sup>14</sup> J-PAL, 2012

<sup>15</sup> ZDHS, 2007

<sup>16</sup> SADC Gender Protocol Barometer: Zambia, 2012

<sup>17</sup> SADC Gender Protocol Barometer: Zambia, 2012

<sup>18</sup> CSIS, Strengthening U.S. Investments in Womens Global Health, A Trip Report of the CSIS Delegation to Zambia, March 2013

primarily deemed a woman's responsibility. Women often forgo postpartum care as they are unaware of its importance especially in relation to the emphasized importance of ANC and delivery services to the health of the mother and child.

### ***Malaria***

Malaria-related mortality rates continue to be high, accounting for up to 40 percent of all infant deaths and 20 percent of all maternal deaths in Zambia with Northern and Eastern provinces claiming the highest incidences.<sup>19</sup> Pregnant women are the most vulnerable to malaria due to their decreased immunity and higher risk for anemia, stillbirth, premature delivery, and low-birth weight infants; therefore, many intervention and treatment programs target pregnant women. Despite the dramatic increase of free and subsidized mosquito nets and malaria knowledge among Zambians being high, habitual use of insecticide treated nets (ITNs) remains a challenge. The 2007 ZDHS reveals more than half (52 percent) of all pregnant women reported sleeping under a mosquito net. Low net use can be attributed to household members using them for alternative purposes including fishing (mostly men) or window curtains and dressmaking (mostly women).

Intermittent preventive treatment for pregnant women (IPTp) with sulfadoxine-pyrimethamine (SP) is a proven antimalarial drug provided during routine ANC visits from the second trimester. 89 percent of mothers reported taking an antimalarial drug for prevention during their last pregnancy, while 86 percent reported taking IPTp at least once. The WHO-recommended two-treatment dose target was achieved by 70 percent of pregnant women during their last pregnancy. CSH formative research revealed women often leave health facilities without receiving IPTp, arrive too late in their pregnancies to complete the full course of IPTp, or have concerns about the safety of medications during pregnancy.<sup>20</sup> Pregnant women and mothers of children under the age of five years are aware of the importance of nutrition in the prevention and treatment of malaria, but often lack the financial resources to provide a balanced diet for both themselves and their children. Additionally, they often lack the money needed for transportation costs for ANC and postpartum health visits.

### ***Nutrition***

In the 2007 ZDHS, 45 percent of children were stunted, 5 percent were wasted and 15 percent were underweight with higher prevalence of stunting in boys (48 percent) compared to girls (42 percent) and higher rates in rural areas (48 percent) compared to urban areas (39 percent). Undernutrition is highest in adolescent girls compared to all other age groups of females, reflective in part of their lack of decision-making power.<sup>21</sup> This high prevalence of women's malnutrition is related to a number of factors, particularly poverty, women's high burden of productive (e.g., agriculture field work) and reproductive tasks (pregnancy and parenting), lack of decision-making power, and limited access to resources.<sup>22</sup> Constraints to addressing malnutrition and child stunting vary between men and women with the burden being placed more on women due to their traditional role as primary caretaker.

---

<sup>19</sup> ZDHS, 2007

<sup>20</sup> CSH Malaria Formative Research, 2012

<sup>21</sup> Infant and Young Child Nutrition Program, USAID/Zambia: Integrated Nutrition Investment Framework

<sup>22</sup> Milimo et al, 2004

Similar to family planning and maternal health knowledge, women are aware of the majority of healthy diet and hygiene practices, but most commonly lack access to resources to adopt and maintain healthy behaviors. Even when financial resources are available, both men and women are at the mercy of local and seasonal supply of fruits and vegetables that may not be available in their region, or during certain seasons. Women have more limited access to income compared to men, and with families prioritizing already limited funds for living expenses such as housing and education for children, dedicating sufficient funds to the purchase of diverse foods quickly drops down on the priority list and may not be feasible. CSH formative research on nutrition behaviors revealed while men control and bring in family income, women are supported by their husbands in making better food choices and were able to ask their husbands for money to purchase diverse foods.

Although men were supportive of women's food choices they remain mostly passive in diet and hygiene practices, leaving it to the woman to make these decisions for the family. Evidence shows that active engagement by men increases the likelihood that women will make healthier food choices for their children and the household. A significant factor to low birth weight is physical stress and exhaustion due to women's work schedules. Zambian woman generally work twice as long as men: 12-13 hours each day, compared to 6-7 hours by men.<sup>23</sup> While women may know they should avoid working in the fields, carrying heavy loads, and walking long distances when pregnant, they feel obligated to do so because of social pressure and lack of assistance from their husbands and other family members.<sup>24</sup> In CSH research, women stated other responsibilities, both work and personal, took time away from proper food preparation, consistently adopting healthy hygiene practices, and attending the necessary clinic visits. Mothers in urban and rural locations faced similar challenges in dealing with food shortages, but rural mothers seemed to feel a greater impact without access to foods that are more consistently available in urban markets. Rural and urban mothers exhibited similar nutrition behaviors, with the exception of a higher rate of rural mothers supplementing their children's diets with watery porridge, and lower rates of safe drinking water storage.<sup>25</sup>

---

<sup>23</sup> Milimo et al, 2004

<sup>24</sup> Milimo et al, 2004

<sup>25</sup> CSH Formative Research Report: Nutrition Behaviors Amongst Households in Zambia, 2013

## CSH GENDER INTEGRATION REVIEW

To-date CSH has demonstrated a comprehensive understanding of gender constraints to promoting positive health behavior change among men, women, and youth in Zambia and has strategically identified interventions in a majority of its activities that address gender-based barriers. The following section presents activities and key achievements by IR in supporting the GRZ and CSOs with their IEC/BCC strategies as they specifically relate to gender. It should be noted this is not an exhaustive list due to the volume of materials produced by CSH but rather highlights activities that address gender-based constraints and accomplishments with gender parity in program implementation. The VMMC component of the Safe Love campaign and the First 1,000 Most Critical Days nutrition campaign were recently launched so results are not available at the time of this report. Activities under IR 4 have not produced gender impact and therefore no highlights are included in this section, but an opportunity for integration is presented in the recommendations section.

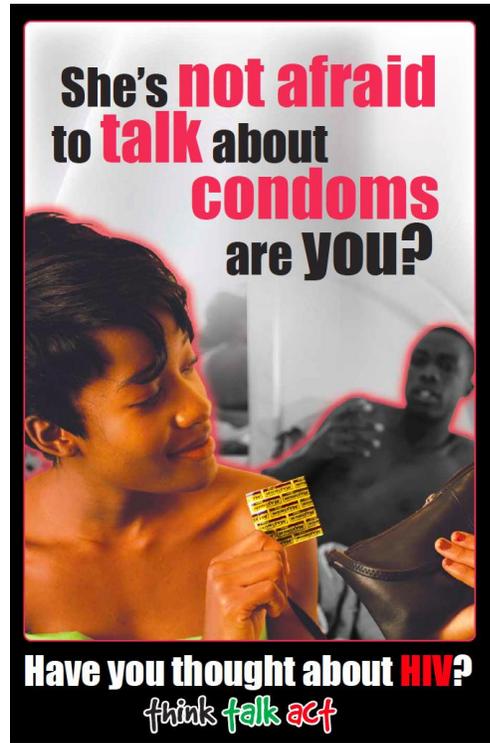
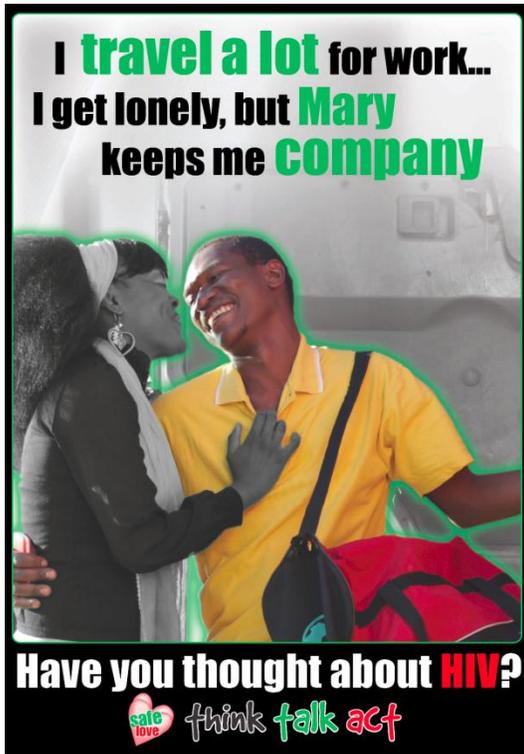
### ***IR 1: National health communication campaigns strengthened.***

CSH supports GRZ partners in the design, implementation, and monitoring of national BCC campaigns in the program health focal areas, and CSH campaign strategies demonstrate strong responsiveness to the key gender-based constraints to promoting healthy behaviors in each of the health topics.

<b>Campaign Title</b>	<b>Health Focal Area</b>
Safe Love	HIV/AIDS
STOP Malaria	Malaria, ANC, Nutrition
Mothers Alive	Maternal Health and Family Planning
First 1,000 Most Critical Days	Nutrition

***Safe Love Campaign.*** The Safe Love campaign addresses the four key drivers of HIV in Zambia - MCP, condom use, low VMMC rates, and prevention of MTCT- through multimedia including television, radio, print, routine activities such as health awareness fairs, and merchandise (t-shirts, stickers, campaign branded condoms). Campaign messages directly address psychosocial causes of risky sexual behavior as they relate to men and women differently.

*Think Talk Act* print posters and flyers address behaviors that lead to the spread of HIV with a series of character pictures depicting different risky behaviors commonly practiced by men and women. Each print piece urges readers to self-reflect on the question, “Have you thought about HIV?” One poster (below left) features a migrant man taking up a sexual partner away from home - a common behavior among men who travel but may not think about the risk factor of taking up MCP. Another poster (below right) challenges the harmful belief that women should not initiate discussions of safe sex by portraying a confident woman presenting her partner with a condom.



A successful initiative of the Safe Love Campaign is *Love Games*, a 24-episode edutainment television series that shares the journey of characters navigating life with and amidst HIV. Through diverse character plotlines, *Love Games* demonstrates the detrimental consequences of risky sexual behaviors and challenges gender norms in an effort to model healthy decisions and relationships. For example, Womba and Chilufya are a discordant couple whose relationship embodies the message of “support for loved ones with HIV.” The show follows Womba, a woman recently diagnosed with HIV, and her male partner, Chilufya who is HIV negative, from couple testing to family planning that addresses how to limit MTCT. Through every obstacle, Chilufya is understanding and supportive of Womba and serves as a positive male model partner, attending doctor visits with his wife and engaging in supportive dialogue ultimately modeling how a man can be supportive of his partner and how a discordant couple can lead a happy and fulfilling life. At the end of each *Love Games* episode viewers are encouraged to call the 990 Talkline to speak one-on-one and anonymously with a trained counselor. The 990 Talkline is managed by CSH grantee, CHAMP. Gender-based results for CHAMP are highlighted under IR 3.

In its first season, *Love Games* generated significant online buzz with its Facebook page, engaging both men and women near equal with “likes” (2,638 women; 2,327 men) and online dialogue via Facebook posts. CSH regularly posts discussion topics inviting *Love Games* fans to answer questions that relate to key messages of each episode such as, “Do you know your status?” This data suggests *Love Games* has characters and messaging that captures the attention of both men and women among the campaign’s target demographic (25-34 year old demographic for both male and female).

***HIV/AIDS Civil Society Organizations (CSO).*** Under the Safe Love campaign CSH works with five CSOs to build the capacity of their community outreach efforts to address HIV and AIDS. The CSOs developed Safe Love Clubs where community facilitators lead routine discussion groups on topics related to HIV and AIDS. A facilitator training curriculum and activities guide were designed to address critical gender issues for both men and women, with specific chapters and activities devoted to GBV, communication in relationships, alcohol and sex, VMMC, and the importance of male involvement in HIV prevention.

CSH encouraged CSOs to strive for gender parity in the recruitment of both facilitators and club members. Gender parity among facilitators is important for gender equality for two primary reasons: 1) community members see women serving as community leaders, transforming the norm that only men can be or should be leaders and 2) community members see men as health advocates and leaders. This challenges the norm that men are not interested in health issues, especially those concerning women. Gender parity among facilitators has nearly been achieved with 92 men and 83 women; however, club membership continues to be dominated by women across all five HIV CSOs (1,330 male members compared to 1,700 female members). In discussion groups with two CSOs held during the gender assignment, community facilitators noted women comprise the majority of membership and routinely attend the meetings more often than men for several reasons: the word “club” connotes a female-oriented event and men typically do not want to attend female-based social events; men are viewed as community leaders and often do not feel they need to be educated on health matters that are deemed a woman’s responsibility; meetings are typically held in the morning or in the early afternoon which precludes men from attending who work outside the home during meeting hours. To foster open and candid discussions, facilitators were trained to experiment with facilitating women-only and men-only discussion groups within a meeting followed by mixed discussion groups.

***STOP Malaria campaign.*** The STOP Malaria campaign works with five CSOs to promote preventive behaviors, particularly ITN use, and treatment for pregnant women and children under the age of five. In addition, the promotion of ANC and feeding malaria-infected children are integrated into program objectives. Through ANC visits women have the opportunity to receive information on the benefits of IPTp, ITNs and treatment for malaria. CSH supported CSOs in recruiting and training an equal number of male and female Community Malaria Agents (CMAs) to conduct food preparation demonstrations, household ITN visits, and lead discussion groups, and nearly achieved parity with 57 percent male and 43 percent female CMAs. Radio dramas and public service announcements (PSA) are currently being translated into local languages to better reach the rural communities.

**Prioritizing the most vulnerable in malaria prevention**

The *All About Malaria* community question and answer booklet guides families to prioritize the needs of pregnant women and children under the age of five when mosquito nets are not available for everyone in a household:

***Q: If families lack sufficient nets to cover every sleeping space, what should they do?***

***A: Pregnant women and children under 5 years of age should be given the first opportunity to sleep under an ITN, since they become more severely ill from malaria than other persons. It is recommended that you also obtain additional ITNs if your family does not have enough. The more ITNs in the house, the safer everyone who sleeps there will be. Free nets are sometimes available at antenatal visits in health campaigns.***

**Mothers Alive campaign.** Change Champions are traditional leaders (chiefs and chieftanesses) that mobilize communities to adopt and promote healthy maternal practices such as attending ANC visits through community meetings and Safe Motherhood Action Groups (SMAGs). Champions are predominantly male chiefs and while gender parity among champions is ideal, having male champions serve as advocates for women's health issues promotes the behavior change of men engaging and supporting women in maternal and child health, and models the ideal that leaders are empowered by knowledge. Regarding key messaging addressing gender-based constraints to maternal care, the *Keeping Mothers Alive* documentary features a male health worker sharing his observation to the increase in men accompanying women to ANC visits in his community. Male support plays an instrumental role in women's maternal health and the increase in men supporting pregnant partners can lead to more women regularly attending ANC visits, whether it is from men contributing finances for transportation costs for ANC visits or physically accompanying their partner to the facility to ensure safety.

***IR 2: GRZ use of evidence-based health communications approaches increased***

Under IR 2, CSH supports the GRZ to conduct formative research in the project health areas and works to build the capacity of key government counterparts to use formative research in designing health communication campaigns and activities.

**Formative Research.** CSH conducted primary and secondary research to inform CSH's campaign strategies for Safe Love, STOP Malaria, Mothers Alive, and First 1,000 Most Critical Days. Where primary research was conducted, methodologies were based on social research best practices, and where campaign target audiences are both male and female, mixed sample groups were drawn for focus groups, in-depth interviews, and trials of improved practices (for the First 1,000 Most Critical Days research only). Sample sizes included more women than men for the Mothers Alive and First 1,000 Most Critical Days formative research due to women being the target audience for behavior change objectives for both campaigns; however, a small portion of men were included to gain insight into male health behaviors and decision-making roles. Research findings present gender-based constraints and observations by age and geographic demographics, and provide recommendations to mitigate constraints in the development of CSH's campaign strategies.

***IR 3: Local capacity to support sustained implementation of IEC/BCC activities strengthened***

CSH supports local capacity to implement sustained IEC/BCC activities with GRZ counterparts through the development of national IEC/BCC strategies and facilitation of technical working groups, and the provision of grants to CHAMP and Afya Mzuri to upgrade systems and expand health services.

**National communication strategies.** CSH supports GRZ partners in developing national communication strategies to strengthen IEC/BCC initiatives in the key health components identified by USAID and CSH. The National AIDS Council (NAC) with the support of CSH, developed the National HIV & AIDS Communication and Advocacy Strategy 2011 – 2015. The communication strategy outlines approaches in behavior analysis, developing IEC/BCC materials, and BCC channels and tools for the public and government counterparts in social

service delivery. Under the behavior analysis section, GBV is identified as one of the key problem behaviors in the treatment, care and support of HIV and highlights target audiences for GBV messaging as it relates to HIV; however, non-infected but vulnerable populations including women and youth are not identified as target audiences. Half of the key messages outlined in the strategy speak directly to empowering women to disclose their status and negotiate for safe sex decreasing their vulnerability to contracting HIV. The communication strategy does promote messaging of support for loved ones living with and seeking treatment for HIV and indirectly addresses issues related to GBV as men more likely to adopt positive behavior will automatically reduce the likelihood of a men resorting to violence. Additionally, the NAC communication strategy includes a section on Gender and Human Rights under Response Management that specifically lays out the objective for 50 percent of GRZ sectors to mainstream HIV and AIDS, gender and human rights in sectoral policies, budgets, and operational plans increased by 2013 and 100 percent by 2015. Overall, the strategy is considerate of gender-based constraints with minor areas for further gender integration.

Like the National HIV and AIDS Communication Strategy, the National Malaria Communication Strategy highlights gender considerations as one of its guiding principles specifically in the selection of malaria committees and production of communication materials for topics such as IPTp in pregnancy. The strategy also highlights the key message that everyone should sleep under an ITN, but those with growing or weakened immune systems should be prioritized, such as young children (under five), pregnant women, and the chronically ill (those with HIV/AIDS, TB, etc.).

While both of these communication strategies do well in identifying gender-based behaviors in the respective health topics covered by CSH, the IEC/BCC strategies do not provide guidance on the best communication channels for audience, and specifically men and women. Men, women, and youth are exposed to and drawn to different communication channels; therefore, media type is a key component to any BCC strategy when optimizing outreach to targeted audiences. For example, women do not speak or understand English as much as men and due to TV broadcasting in English and newspapers printing in English, daily radio use is higher among women than men (63 percent for women; 48 percent for men) with broadcasts more likely to be translated to local languages.<sup>26</sup>

***CHAMP 990 Talkline.*** One of CSH's grantees, CHAMP, has experienced significant success with the scale-up of the 990 Talkline; a free informational telephone information service for individuals to speak anonymously with a trained counselor about various health topics. Several of CSH campaign activities drive the audience to call the 990 Talkline. CHAMP increased the number of trained counselors to provide support on a number of health issues including HIV and AIDS, family planning and reproductive health, maternal health, nutrition, malaria, and the recently added GBV component. Since August 2011, the talkline has received an overwhelming response from men (21,215 calls) compared to women (7,461) with most callers falling within the 20-24 age demographic. The gender-skewed response may be due to men having greater access to mobile phones than women and preference to the anonymity that comes with the

---

<sup>26</sup> AudienceScapes National Media Survey Zambia, 2010

talkline. CHAMP program management noted callers rarely have a preference for male or female counselors and trust the information they are being provided is accurate.

***Afya Mzuri Dziwani Knowledge Center for Health.*** Based in Lusaka, the Dziwani Knowledge Center is a comprehensive health communications resource center for the public to access health information through print and online materials and group seminars. CSH supports the expansion of the center's information technology infrastructure, offering of informational materials and classes, and increased staff to serve visitors. From June 2011 to September 2012, 45 percent of HCRC visitors were females (2,791) compared to 55 percent male visitors (6,136). Currently, the center has gender neutral services and does not target men or women more or differently. Afya Mzuri Resource Center Officer, Peter Nyirenda, speculates the higher number of male visitors may be due to the greater mobility of young men in the urban area of Lusaka where the center is located. During a group discussion with youth between the ages of 15 and 25, many noted their primary purpose for visiting HCRC is because it offers a quiet space to work on school assignments. Since the center is open to the public it is challenging to accurately survey why more men than women visit the center.

## RECOMMENDATIONS FOR GENDER INTEGRATION INTO CSH ACTIVITIES

Below are recommendations for possible interventions, activities, and training courses that could be implemented by CSH based on constraints identified in the background section of the gender analysis of this document. The recommendations are organized by intermediate result (IR).

The following recommendations are based on research of best practices regarding gender and the sectors in which CSH is working and suggestions gathered during meetings with component leaders, CSOs and grantee management and beneficiaries, i.e. Safe Love Club community facilitators and Dwizani Health Communication Resource Center youth visitors, and relevant stakeholders (see Annex 2). CSH project and partners' staff and stakeholder recommendations are significant as they represent activities and interventions that are most likely to receive the commitment from all parties and reflect Zambian needs and priorities.

While several findings reveal a skewed balance of reach and level of engagement by male and female participants depending on media type, some of the recommended activities address the imbalance where feasible. It should be noted, initiatives to address gender imbalance may be outside the scope of CSH (i.e. women may have more limited access to mobile phones than men and thus men are more likely to access the 990 Talkline); however, CSH's ability to offer a mix of media that reach men and women equally overall should not be discounted.

Recommendations outlined below are a "menu" of illustrative activities and interventions for each IR. It is understood some of these recommendations may not be implemented due to timing or cost limitations going into the final year of the project; instead, CSH and USAID are encouraged to prioritize activities based on the project's intended impact, time frame, and budget. The recommendations are intentionally broad with the understanding that CSH and USAID will decide on specific interventions based upon feasibility, sustainability, and commitment from the stakeholders during the final year work planning session.

As a result of the gender review, one recommendation has already been implemented with the appointment of CSH Capacity Building Director, Florence Mulenga, as CSH Gender Focal Person (GFP). As GFP, Ms. Mulenga will monitor the implementation of the below recommendations, and support technical staff in identifying further opportunities for gender integration to maximize CSH's impact on gender equity in its final year.

### **IR 1: National Health Communications Campaigns Strengthened**

**Communication Channels.** CSH utilizes a media mix consisting of traditional (e.g., TV and print) and new (e.g., social media such as Facebook and YouTube) communication channels to disseminate campaign messages on a national scale that do not necessarily target men and women differently, however, communication channels exist for CSH to leverage reach and target campaign messaging to specifically men and women especially for campaigns where women are the primary audience.

- CSH's primary governmental partner, MCDMCH, manages the Women's Empowerment Program through its Department of Community Development, a program that supports women's groups in taking up income generating activities at the district level. CSH should work with the ministry to distribute campaign materials targeted to women, especially for the Mother's Alive and First 1,000 Most Critical Days nutrition campaigns. The mission of the women's program presents the opportunity to encourage women to invest income in health services and healthy behaviors for themselves and their families.
- The MGCD hosts quarterly Media Breakfasts to discuss topical gender issues with media representatives from TV, print, and radio. This presents an opportunity to further promote messaging for CSH campaigns and allows CSH to equip the media with accurate facts and dispel myths about a specific component area. CSH should also advertise campaign events at these meetings and distribute program materials.

***Safe Love campaign.*** Although Safe Love Club membership is dominated by women, it is critical to engage men equally at the community level to increase interpersonal dialogue especially as CSH ramps up VMMC activities targeted to men. During discussions with club facilitators, it was revealed meetings do not always occur at convenient times for men and the health topics themselves are not particularly topics that interest men as much as women.

- Club facilitators and peer educators should be encouraged to engage more men in meetings. It would be beneficial for facilitators to survey men in the community for convenient meeting times and if an all male group (called Insaka) would encourage attendance. Currently, club facilitators are collecting mobile information from club members for the VMMC mobile campaign. This presents an opportunity to informally survey men about meeting times and topics of interest while collecting mobile information.
- Explore facilitating discussions around a sporting activity/event or *Love Games* viewing event to increase male attendance and participation.
- Create a one-pager for facilitators on the importance of male engagement so they understand why male participation in club meetings is key to addressing HIV/AIDS prevention. Include instructional tips on how to adapt meetings and develop discussion topics that engage men.
- Update the *Community Facilitator's Training Curriculum* with a chapter on Gender and GBV to mirror messaging from the Gender and GBV chapter in the *Community Facilitator's Activities Guide*. Educational and instructional content can be taken from the 990 Talkline counselor guide chapter on GBV to ensure accuracy of facts and consistency of messaging.

- The *National HIV & AIDS Communication and Advocacy Strategy* includes guidance on promoting women as VMMC advocates, therefore materials should educate women on the benefits of VMMC (e.g., prevention of HPV) and promote them as advocates for the procedure.

***First 1,000 Most Critical Days nutrition campaign.***

- Materials should promote interpersonal dialogue between men and women regarding where each partner can contribute to better nutrition behaviors, e.g. use existing gender roles to promote interpersonal dialogue - women often have the knowledge of what foods to buy but may not possess the funds. Encourage women to educate their partners on components of a balanced diet and encourage men to financially support a healthy diet as the “protector.”
- In communities where it is cultural practice to give the man more nutrient-rich foods before the woman, ensure messaging directly addresses the importance for men and women to equally consume nutrient-rich foods with special consideration given to pregnant and lactating women, and children under 2 years of age – it is the man’s duty as “protector.” This is an approach used by one of CSH’s partner CSOs, SAfAIDs, with their Safe Love men clubs called “Men as Protectors.” Testing this messaging for the nutrition campaign may generate greater engagement of men.

***Your Health Matters, Let’s Talk.*** The 25-minute television program produced by MOH airs monthly and features community testimonials centered on CSH-related health topics supported by a question and answer session with a panel of health experts.

- CSH addresses GBV in several guides and national BCC strategies yet GBV materials have not been developed that directly target the public. In collaboration with the MOH, CSH will create a segment dedicated to GBV promoting the empowerment of women to report incidences of GBV and encourage men to support partners in decision-making.
- Expounding on messaging across CSH campaigns, one segment of *Your Health Matters* will be dedicated to male involvement promoting the importance of male support and engagement in women’s and children’s health issues. Key messages will include the importance of male involvement in family planning, ANC visits, and childcare.

**IR 2: GRZ Use of Evidenced-based Health Communications Approaches Increased**

***Formative Research.*** CSH recently completed formative research training for provincial advisors and will release a Formative Research in Action RFP where two provinces will receive

funding to conduct formative research on any CSH health topic they choose. The procurement review team will ensure the procurement process includes criterion for equitable gender inclusion with gender considerations to be incorporated into the review scorecard.

### **IR 3: Local Capacity to Support Sustained Implementation of IEC/BCC Activities Strengthened**

***MCDMCH Community Health Communication: Guidance for District level planning and implementation (working title)***. Gender-based constraints identified in CSH formative research across focal areas should be included in the national communication strategy along with evidenced-based approaches to improving equitable outcomes for men and women. While MCDMCH focuses on mother and child health it is important for the national strategy to incorporate male involvement as a key objective in promoting women's and children's health. The strategy should also include a section on how communication plans and campaigns can address gender-based constraints while seeking to minimize unintended consequences, e.g. messaging that is only targeted to women or overwhelmingly encourages women to take control of health decisions, may unintentionally neglect or deter men from participating in health planning and decision-making – a balance in messaging is key to addressing the unique constraints faced by men and women.

***IEC/BCC Gender Mainstreaming Training for GRZ and CSO partners***. Current national communication strategies for GRZ partners do include some gender integration and mainstreaming guidelines as noted in the CSH Gender Integration Review section of this report; however, the downsizing or restructuring of staff may not allow for a dedicated gender specialist trained in gender integration and mainstreaming best practices and techniques. For example, NAC restructured last year and removed its gender specialist position resulting in a human resources member serving as the GFP for the organization. Dedicated gender mainstreaming training will equip GRZ and CSO staff with the skills to identify gender-based constraints and opportunities, plan and design activities to address constraints, and monitor M&E for gender-based trends to adapt and improve its IEC/BCC initiatives.

- NAC, NCDMCH, and MOH each have an IEC/BCC Technical Working Group (TWG) where CSH staff routinely meet to support IEC/BCC activities. A gender mainstreaming training focused on IEC/BCC can be integrated into planned training schedules. The trainings can be co-facilitated with the MGCD who has expressed great interest in partnering with CSH and its GRZ partners. It should be noted gender training should be tailored to the capacity and knowledge of ministry staff, and where applicable, complement previous gender trainings received by select ministries and departments. For example, MCDMCH Senior Planner and Ministry GFP, Ms. Weka Banda, noted MCDMCH has already started to integrate gender into their program components including gender budgeting (allocating funds to gender programs in the annual budget).

For NMCC, an orientation of the TWG in Q4 2013 on the Materials Review Guidelines is scheduled to occur and presents an opportunity to integrate a gender mainstreaming workshop component while reviewing malaria campaign materials.

Due to CSH's primary collaboration with MCDMCH, which was created from MOH staff, a specific gender training with MOH is not necessary, but can be accommodated should the MOH identify this as a priority.

- CSH CSOs work specifically with the HIV and malaria/nutrition focal areas. CSOs will undergo refresher trainings in year four, and can also be trained in IEC/BCC and gender integration as it relates to their specific scope. The HIV CSOs should be specifically trained on GBV prevention as this is identified as a contributing factor to the spread of HIV/AIDS significantly impacting women. GBV was recently added as a chapter in the facilitator activities guide and will be added to the facilitator training curriculum, and has already been integrated into the CHAMP 990 Talkline Counselor Manual. Now that GBV guidelines have been incorporated into content, it is important for staff and club facilitators to be properly trained in the guidelines and facts. Already trained CHAMP counselors could serve as co-facilitators with the CSH Capacity Building Director in providing GBV curriculum training to Safe Love club facilitators.

#### **IR 4: Coordination of IEC/BCC Activities between USAID Projects Increased**

*Share gender strategies and collaborate on opportunities for further integration.* All USAID projects should have gender strategies in place for their programs. USAID gender strategies and program results can be strengthened by CSH and USAID health partners sharing their strategy in the next quarterly IEC/BCC coordination meeting for USG partner projects. This will allow projects to share opportunities for further integration, address gender trends, and share solutions to gender constraints.

#### **M&E and Reporting**

CSH's PMEP has recently been updated and does include sex-disaggregated indicators but does not currently include gender sensitive indicators. Due to the limited time remaining on the project's period of performance it is not advised to incorporate gender sensitive indicators at this point particularly in absence of baseline data to accurately measure gender impact.

- Where sex-disaggregated data is collected at both the campaign and IR level, technical leads will review data on a quarterly basis for gender-related trends and identify solutions to address inequities or imbalances and report on positive gender impact.
- Technical leads should include gender-based positive outcomes and challenges in their quarterly summary provided to the Communications Specialist to be

highlighted in the quarterly report (note: qualitative data can also be included such as Facebook discussions that generate online engagement).

## **CONCLUSION**

The recommendations within this gender integration strategy address gender constraints and provide illustrative activities which could be integrated throughout project activities. Project technical staff is urged to engage in in-depth discussions with USAID and relevant stakeholders; conduct mini-assessments; and review gender assessments and research to determine the feasibility and sustainability of activities and refine them as needed. Much of the feasibility of these recommendations relies on the stability and commitment of GRZ and CSO partners. Project staff should take a culturally-sensitive approach to gender, emphasizing it not as a western concept, but as a development approach to be tailored to the Zambian context to improve Zambian health on a national scale.

Gender activities should be integrated into planned activities to the greatest extent possible so that they are cost effective and not perceived to be one-off activities that are being imposed because of US regulations. The desired result is that these gender-focused interventions increase gender equity, specifically increasing men and women's awareness to healthy behaviors and motivating Zambians to invest in their health.

Because of the additional information that will be gained during the work planning and implementation process, this strategy should be reviewed and modified according to the needs of USAID and CSH GRZ and CSO partners. CSH staff is responsible for reviewing, modifying, and updating this document as needed, as well as elaborating on the project's gender strategy based on findings gleaned from additional research and meetings with stakeholders.

## ANNEX 1: STAKEHOLDER MEETINGS IN ZAMBIA, JUNE 17 – 28, 2013

DATE	INSTITUTION	REPRESENTATIVE
June 17	CSH	David Dube, BCC Advisor to NAC
June 19	MCDMCH	Weka Banda, Senior Planner and GFP
June 19	CSH	Kevin Chilemu, Director of Research, Monitoring and Evaluation
June 19	CSH	Christina Wakefield, Technical Director
June 19	CSH	Lillian Byers, CSO Advisor
June 20	CSH	Todd Jennings, Director of PPP
June 20	CHAMP	Christina Mutale, Learning Center Manager and Noria Silumesii, Operations Manager
June 20	SAfAIDS	Chrispin Chomba, Zambia Country Representative
June 21	PRIDE-Kafue	Sophie Kamwata, Program Manager and Choolwe Chimunda, Finance & Administration Manager Discussion group with Safe Love club community facilitators
June 24	MOH	Dr. Tasila Peters, Deputy Director, Technical and Support Services Pauline Mbangweta, Public Relations Officer
June 24	CSH	Linda Nonde, Chief of Party
June 25	MGCD	Christine Kalamwina, Director of Social and Legal Governance
June 25	Latkings	Ben Miti, Executive Director Discussion group with Safe Love club community facilitators
June 25	Afya Mzuri	Peter Nyirenda, Dziwani Resource Center Officer Discussion group with youth visitors
June 26	CSH	Anock Kapira, Civil Society Specialist
June 26	CSH	Victor Peleka, Monitoring and Evaluation Specialist
June 26	USAID	Joy Manengu, Population, Health and Nutrition (PHN) GFP and Emma Sitambuli, Zambia Country GFP
June 26	CSH	Michelle Hunsberger, Communications Specialist
June 26	CSH	Kapasa Sikazwe, BCC Advisor to NMCC
June 27	CSH	Answell Chipukuma, BCC Advisor
June 27	Panos Institute – Southern Africa	Mamoletsane Khati, Regional Programme Manager, Health and Development
June 27	CSH	Prudence Katongo, Media and Campaign Manager
June 28	NAC	Nachilima Musukuma, HR/Administration Manager
June 28	CSH	Florence Mulenga, Director of Capacity Building

## ANNEX 2: WORKS CITED

Ashraf, Nava, Erica Field and Jean Lee. *Household Bargaining and Excess Fertility: An Experimental Study in Zambia*, J-PAL, 2012.

AudienceScapes National Media Survey: Zambia, 2010.

Center for Strategic & International Studies (CSIS), *Strengthening U.S. Investments in Womens Global Health: A Trip Report of the CSIS Delegation to Zambia*, 2013.

Human Rights Watch, *Gender-Based Abuses and Women's HIV Treatment in Zambia*, Vol. 19, No. 18(a), 2007

Machila, Margaret. *SADC Gender Protocol 2012 Barometer: Zambia*, 2012

Milimo et al. *Zambia Strategic Country Gender Assessment*, World Bank, 2004.

Progress of the World's Women 2011-2012: In Pursuit of Justice, UN Women, 2011

*Scaling up Youth-Focused Interventions in the Multi-Country HIV/AIDS Programs (MAP) and Building Capacity of Civil Society Organizations (CSOs), Case from Zambia*, The National AIDS Council (NAC) and World Bank, 2005.

*National Voluntary Medical Male Circumcision Communication and Advocacy Strategy 2012-2015*, MOH.

*National Malaria Communication Strategy 2011-2014*, MOH.

*National HIV & AIDS Communication and Advocacy Strategy 2011-2015*, MOH.

*USAID/Zambia: Integrated Nutrition Investment Framework Overview*, The Global Health Technical Assistance Project, 2011.

*USAID/Zambia Gender-Based Violence Programming Evaluation*, DevTech System, Inc., 2010.

USAID Zambia CSH Malaria Formative Research Report, 2012.

USAID CSH Safe Motherhood Formative Research Report, 2012.

Zambia Demographic and Health Survey (ZDHS), 2007.