# Zambia-led Prevention Initiative

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## ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| CATZ | Community Alcohol Teams in Zambia |
| CBD | Community-based Distributor |
| CHAMP | Comprehensive HIV/AIDS Management Program |
| CMMB | Catholic Medical Mission Board |
| CPO | Community Purchasing Order |
| CSW | Commercial Sex Worker |
| DACA | District AIDS Coordination Advisor |
| DHO | District Health Officer |
| DMO | District Medical Office |
| EE | Economic Empowerment |
| FP | Family Planning |
| GBV | Gender-based Violence |
| GROW | Grass Roots building Our Wealth |
| GRZ | Government of Republic of Zambia |
| HIV | Human Immunodeficiency Virus |
| HTC | HIV Testing and Counseling |
| JRT | Job Readiness Training |
| MARP | Most-at-risk Populations |
| MC | Male Circumcision |
| MCDMCH | Ministry of Community Development, Mother and Child Health |
| MCP | Multiple and Concurrent Partnerships |
| MoH | Ministry of Health |
| MSM | Men who have Sex with Men |
| MTA | Men Taking Action |
| MTCT | Mother-to-Child Transmission |
| NAC | National HIVAIDS /STI/TB Council |
| NGO | Non-governmental Organization |
| OYDC | Olympic Youth and Development Center |
| P3 | Public-Private Partnerships |
| PCI | Project Concern International |
| PEG | Psycho-Education Group |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PLA | Participatory Learning and Action |
| SHARPZ | Serenity Harm Reduction Program Zambia |
| STI | Sexually Transmitted Infections |
| TC | Testing and Counseling |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VCT | Voluntary Counseling and Testing |
| VMMC | Voluntary Male Medical Circumcision |
| ZHECT | Zambia Health Education and Communication Trust |
| ZPI | Zambia-led Prevention Initiative |

# I. Project Background

The United States Agency for International Development (USAID)-funded Zambia-Led Prevention Initiative (ZPI) was implemented in the Republic of Zambia as part of a broader response to the HIV epidemic in Zambia. FHI 360 was the lead partner, in collaboration with Afya Mzuri, Catholic Medical Mission Board, Comprehensive HIV/AIDS Management Program (CHAMP), Grassroot Soccer Zambia, Hodi, Project Concern International (PCI), Population Council, and the Zambia Health Education and Communication Trust (ZHECT). The total budget for this four and a half-year project was US $39,726,852; the total funding obligated was US $29,213,733 which included US $793,920 for the Task 4 option (community-based family planning and reproductive health services) that was exercised by USAID in October 2013.

The purpose of the ZPI project was to increase utilization of community-level interventions through a targeted approach and to provide technical leadership and expertise on comprehensive, effective, community-based prevention efforts aimed at reducing HIV transmission in Zambia. The project had four objectives:

1. To build capacity in communities affected by HIV/AIDS to access more effective, gender-sensitive, higher-quality HIV prevention programs, including testing and counseling (TC), male circumcision (MC), and prevention of mother to child transmission (PMTCT);
2. To strengthen the continuity and coordination of, as well as commitment to, effective, efficient, and sustainable HIV prevention, including TC, MC, and PMTCT;
3. To design efficient, sustainable, and locally owned responses to HIV/AIDS, including increased engagement with the private sector; and
4. To provide community-based family planning and reproductive health services as an adjunct to effective prevention of HIV/AIDS.

### *Provinces and Districts of Project Area*

ZPI operated in all provinces of Zambia, employing a planned three-phase approach to expanding throughout the country. In Year 1, the project was initiated in five provinces - Eastern, Southern, North Western, Lusaka, and Copperbelt - covering four to seven districts in each province, for a total of 28 districts. In Year 2, the project expanded to Luapula and Central provinces. In Year 3, the project initiated activities in the remaining two provinces, Northern and Western. The project was implemented in at least 50 percent of all districts nationwide; it carried out activities in 44 districts in nine provinces as in the figure on the following page. While ZPI did not have a formal provincial office in Muchinga Province, which was created in 2011 after the project had commenced activities, it operated in some districts within the province.

**Figure 1. ZPI Presence within Zambia**

| PROVINCES | DISTRICTS | YEAR OPENED |
|---|---|---|
| Copperbelt | Ndola, Chingola, Kitwe, Luanshya, Kalulushi, Mpongwe and Masaiti | **2011** |
| Eastern | Chipata, Katete, Lundazi, Petauke and Chama | **2011** |
| Lusaka | Luangwa, Chongwe, Kafue and Lusaka | **2011** |
| North Western | Solwezi, Kabompo and Kasempa | **2011** |
| Southern | Mazabuka, Choma, Namwala, Livingstone, Kalomo, Sinazongwe and Monze | **2011** |
| Central | Kabwe, Mkushi, Serenje, Mumbwa and Itezhi-Tezhi | **2012** |
| Luapula | Samfya, Mwense and Kawambwa | **2012** |
| Northern | Mbala, Kasama, Mungwi and Mpulungu | **2013** |
| Western | Mongu, Senanga and Lukulu | **2013** |

## II. ZPI Technical Approach

With an estimated HIV prevalence of 14.3% among men and women age 15-49 years, Zambia is one of the Sub-Saharan African countries most affected by the HIV/AIDS pandemic. Of the 13.1 million people living in Zambia in 2010[1], an estimated 1.1 million people were infected with HIV, and less than 15% knew their status. Key social and behavioral factors contribute to the high prevalence of HIV in Zambia, including gender-based violence (GBV), low levels of male circumcision, multiple and concurrent partnerships (MCP), and low levels of condom use. The purpose of the ZPI project was to increase utilization of community-level interventions through a targeted approach and to provide technical leadership and expertise on comprehensive, effective, community-based prevention efforts aimed at reducing HIV transmission in Zambia.

The ZPI project approach has been to pilot and evaluate effective HIV prevention interventions, including structural interventions and economic development interventions; to facilitate increased coverage, access, and uptake of these interventions; and to strengthen the capacity and engagement of the Government of Zambia (GRZ). In addition, ZPI worked with the private sector as part of a broader response to the HIV epidemic in Zambia.

ZPI's technical approach recognized the multifaceted nature of HIV risk and the need to address key risk factors contributing to HIV transmission in Zambia. The challenge in making a fundamental shift in the way that HIV prevention is conducted in Zambia was ensuring, first, that all activities were gender sensitive and gender responsive. The general HIV prevalence rate for adults age 25-49 is 14.3%; the prevalence for women is 15%, compared to 12% for men.[2] Among women, the prevalence rate peaks at 26% among age 30-34; this is four times the rate of women age 15-19 and more than twice the rate of those age 45-49. For men, the prevalence rate peaks at 24% among men age 40-44, a sharp increase from 4% among men age 15-19, and drops to 19% among men age 45-49.

In addition, the critical factors which contribute to HIV prevention interventions were identified and used as platforms for community engagement. The factors identified were the '*key drivers*' as stipulated by the National AIDS Council (NAC) – the major drivers of HIV infections - and include MCPs, low and inconsistent condom use, low levels of MC, sex work, men who have sex with men (MSM) and mother to child transmission (MTCT). The community mapping conducted in communities at ZPI's inception revealed other key risk and vulnerability factors which were linked to the key drivers identified by NAC, and can also be defined as underlying layers of those key drivers. ZPI used key drivers as a starting point and then peeled the layers to uncover, through the community mapping, core risk and vulnerability factors fuelling the key drivers. Communities identified key factors affecting them, and these included alcohol and drug misuse, GBV and violence against children, economic vulnerability, stigma and discrimination, living with a disability, and mental health issues. These factors, which are known to increase an individual's vulnerability to HIV transmission, were used as the basis for the development of the ZPI risk and vulnerability lens approach described below.

### *Gender sensitive programming*

ZPI interventions and activities were designed to be gender sensitive - exposing the role that gender plays in the risk of becoming infected with HIV, as well as access to treatment, care and support. This was a cross-cutting theme; all ZPI activities addressed the social, cultural and economic factors that put men, women, girls and boys at risk for HIV and explored the power imbalances between men and women that contribute to this.

Two technical strategies were developed to guide ZPI's gender sensitive programming:

1. **Gender Sensitive Programming for HIV Prevention**: This strategy recognized the use of gender as a transformative lens for designing interventions across HIV/AIDS prevention, treatment, and care programs, and as a critical part of the effort to reduce HIV infections for women and men.

1 *Census of Population and Housing Report.* 2010.
2 *Zambia Health Demographic Survey (ZDHS).* Government of the Republic of Zambia. 2007.

2. **Male Involvement Programming for HIV Prevention**: This strategy emphasized the critical role of male involvement in the provision of comprehensive HIV prevention interventions in Zambia. Male involvement was one aspect of ZPI's gender programming approach, designing interventions across HIV/AIDS prevention, treatment, and care programs targeting men, male adolescent youth and boys. Understanding the role that male involvement plays was identified as critical in reducing HIV infections and violence against women.

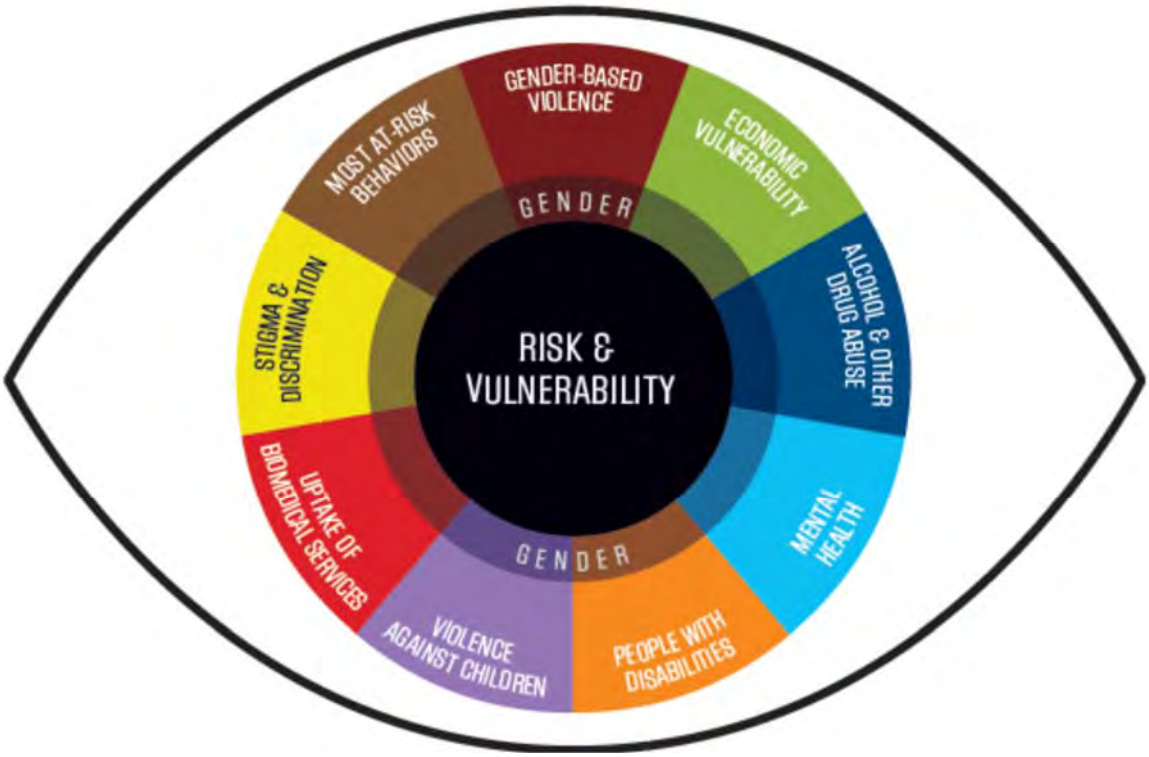
Understanding the structural determinants of how people live in Zambia such as social structures and customs, and traditions; religious beliefs and values; economic structures and access to resources; constructions of masculinity and femininity; and patterns of sexual relationships, including marriage, was a critical dimension in understanding the structural risk factors that put individuals at risk. Key activities addressed the social, cultural and economic factors that put men, women, girls and boys at risk for HIV and explored the power imbalances between men and women that contribute to this. They addressed the cultural understanding of what it is to be a man and woman in Zambia and male norms and behaviors; GBV; and sexual exploitation and violence against children, including early marriage and transactional sexual relationships. Specific interventions were designed for different target groups, such as girls and young women, boys and young men, men, women and couples.

### *ZPI's Risk and Vulnerability Lenses*

Factors which put individuals and communities at risk for HIV and affect HIV prevention interventions are numerous and diverse. Following the community mapping exercise conducted at the beginning of the project, the ZPI technical team determined that if ZPI interventions were to yield results which prevent new HIV infections, a fundamental implementation shift needed to take place. The approach focused on protecting both those who are negative but vulnerable to HIV infection due to their gender, age, economic status or physical or mental disability and other behavioral issues that put them at risk, as well as conducting Positive Health, Dignity, and Prevention (PHDP) interventions with people living with HIV (PLHIV). The ZPI lenses were designed to function both as independent factors and as interconnected variables to deepen understanding of both individual and social vulnerability to HIV infection, and to enhance programming.

Critical to this strategy was the recruitment of a team of Advisors and Specialists with technical expertise in each of the lens areas to lead the design of lens-based interventions, as well as building the capacity of ZPI staff, partners, sub-grantees and communities to conduct activities focused on these lenses.

**Figure 2. ZPI Risk and Vulnerability Lenses**




1. **Gender-Based Violence (GBV)**
   The Zambian Anti Gender-Based Violence Act (2011) defines GBV as "any physical, mental, social or economic abuse against a person because of a person's gender, and includes: a) violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to that person, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life; and b) actual or threatened physical, mental, social or economic abuse that occurs in a domestic relationship." Statistics in Zambia show that women are more at risk for HIV and one of the key risk factors for women is GBV. HIV prevalence data in Zambia show not only the gendered nature of HIV infection that puts women at higher risk than men, but the socio-economic characteristics that put urban, more educated populations, including women, at higher risk than the urban, less educated population.

2. **Economic Vulnerabilities**
   Economic vulnerability refers to economic characteristics (assets, activities and capabilities) that limit an individual, household or community's ability to anticipate, manage, resist or recover from the impact of the threat/hazard, such as HIV/AIDS. Economic vulnerability perpetuates poverty, which shapes the risk environment for HIV in ways that are complex and multidimensional, including limiting educational opportunities, exacerbating gender inequalities and perpetuating social norms that subordinate, putting one at risk of physical and sexual violence, and social fragmentation and the erosion of systems of norms and networks that might foster resilience in communities and support HIV risk reduction. This is especially the case for women and adolescent girls.

3. **Uptake of Biomedical Services for HIV (Evidence-Based HIV Prevention, Integrated Care)**
   PMTCT, voluntary counseling and testing (VCT) and MC are designated as primary evidence-based interventions in the Zambian guidelines for prevention of HIV transmission in the general population. The Zambia National PMTCT program uses a four-prong approach adopted from World Health Organization (WHO) recommendations for a comprehensive PMTCT strategy:
   1. Primary prevention of HIV infection among women of childbearing age.

2. Preventing unintended pregnancies among women living with HIV.
3. Preventing HIV transmission from women living with HIV to their infants.
4. Providing appropriate treatment, care, and support to mothers living with HIV and their children and families.

ZPI's prevention activities were not facility based, so the project focused on Prongs 1 and 2.

**4. Violence Against Children**

In our society, children occupy the least powerful position and are particularly vulnerable to HIV infection through the many faces of GBV (described above), intergenerational sex, cultural beliefs around early marriages, and sexual cleansing. Girls are especially vulnerable and particularly exposed to sexual abuse and other forms of exploitation. The myth that having sex with a child can cure an HIV infected person has increased children's, and particularly girls', vulnerability to HIV infection. Children with disabilities are extremely vulnerable to sexual abuse due to negative cultural beliefs that they bring bad luck and 'a curse' to the family. Many children with disabilities are kept in homes, hidden from neighbours, friends and family.

**5. Different Abilities**

People with disabilities are at risk of HIV infection, but may lack access to HIV prevention and support services, for example, because information is not given to them in a format that they can read. Rates of sexual assault and abuse are high among the disabled population, particularly for people with intellectual impairments and those who are institutionalized. In Zambia, people with disabilities face HIV-related stigma and discrimination in many forms, including stigma linked to sexuality as they are seen as asexual, exclusion from taking part in HIV-related activities such as TC, lack of physical access to health facilities, and sexual exploitation because of the belief that having sex with a person with a disability, such as albinism, can cure AIDS. People with disabilities represent a broad range of disabilities including physical, emotional, intellectual, visual and auditory, yet they do not receive necessary services and are especially vulnerable to HIV and challenges to access to prevention, care and support. Culturally, people with different abilities are stigmatized and invisible in Zambian society. Women and children are particularly vulnerable to sexual abuse.

**6. Mental Health**

The links between HIV and mental health is one of the least recognized areas in HIV prevention, treatment and care. Mental health is a complex interplay of biology, genetics, environmental risks and socio-cultural factors; factors affecting mental health include loneliness, depression, low self-esteem, sexual abuse, GBV, alcohol and drug misuse, and other things that can be risk factors for HIV. HIV prevention interventions need to address the close association between mental health, social and environmental factors and an individual's ability to make and maintain risk-averse behavior changes. As with disability issues, mental health issues are often overlooked because of stigma at the community and individual levels. HIV/AIDS can be a factor in the mental status of PLHIV; for instance, those who have lived with HIV for a long time can experience a range of neurologic and cognitive impairments like memory loss, aggression and agitation.

**7. Most-at-Risk Populations (MARPs)**

At-risk populations are among the most marginalized and most likely to be stigmatized. In addition, resources and national HIV prevention campaigns are not necessarily geared to their specific HIV prevention, treatment and care needs. PEPFAR guidelines on MARPs define target groups as commercial sex workers (CSW), injecting drug users (IDU) and MSM. In Zambia, the definition of MARPs also includes:

- partners of persons who practice casual heterosexual acts
- persons who practice casual heterosexual acts
- persons in stable sexual relationships, including marriages
- babies born to HIV+ mothers

Other groups recognized as being at comparatively high risk include highly mobile populations such as migrant workers, long distance truck drivers, minibus drivers, refugees, prisoners, uniformed personnel (such as the military and police), and fish traders.

8. **Alcohol and other Drug Use/Misuse**

The Zambia HIV/AIDS Strategic Framework 2006-2011 called for a holistic view of the HIV/AIDS situation, and identified drug and alcohol abuse as a major driver of the HIV/AIDS pandemic. Studies show a consistent association between alcohol use and sexual risks for HIV infection. Among people who drink, greater quantities of alcohol consumption predict greater sexual risks than do frequency of drinking. In addition, there are clear gender differences in alcohol use and sexual risks; men are more likely to drink and engage in higher risk behavior whereas women's risks are often associated with their male sex partners' drinking. Factors that are most closely related to alcohol and sexual risks include drinking venues and alcohol serving establishments, sexual coercion, and poverty.[3] People who misuse alcohol and other drugs also place additional strain on their immune systems, which can negatively impact their nutritional status and adherence to ART. The outcomes of HIV therapy improve significantly among alcoholics who stop drinking. In addition, there are inadequacies in information necessary to inform policy formulation and programmatic design in prevention, treatment, care and impact mitigation. Young people, pregnant women and people with preexisting health conditions, including being HIV positive, are more vulnerable to the physical and psychological negative consequences of alcohol misuse.

9. **Reproductive Health**

WHO defines reproductive health services as those that address the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It is now well established that reproductive health services are intertwined with sexual behaviors and prevention of HIV transmission. Reproductive health emphasizes the provision of appropriate counseling and support to men and women regardless of HIV status to enable them to make informed decisions about their future reproductive life, with special attention to preventing unintended pregnancies. Services to virtually eliminate MTCT provide an ideal platform to deliver the entire recommended minimum package of antenatal, maternal, child health and reproductive health services. This ensures that pregnant women are offered HIV screening, and they and their partners are offered services to prevent HIV and other sexually transmitted infections, unwanted pregnancies and sexual violence.

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*"The 'risk and vulnerability lens' approach brought about innovation by integrating components that predispose individuals and communities to HIV infection, constructing a multifaceted platform for change based on the theory of change. 'Lenses' provided a range of entry and implementation points to HIV prevention and options to address other social and health problems. Incorporation of a strong gender element into the programming at all levels of the project, including staff and volunteers, brought about changes in gender norms as reported in the midline survey and found during qualitative interviews. Male involvement catalyzed changes toward gender equity and brought about couples counseling and reductions in alcohol and substance abuse. Involving traditional leaders was a key entry point as they became role models for communities and were partners in implementation, some even volunteered. Economic empowerment (GROW groups) was an on ramp for HIV prevention, with considerable uptake at community level by women and later by men.*

*The project reached underserved areas, improving access to critical information and services where they did not exist, especially in Western and Luapula provinces. ZPI built strong partnerships, especially with provincial, district and community leaders, as well as with other USAID implementing partners. The project engaged in joint planning and implementation activities with all of these groups."*

*-ZPI End-of-Project Evaluation Report*

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[3] Seth C. Kalichman, Leickness C. Simbayi, Michelle Kaufman, Demetria Cain, Sean Jooste: *Alcohol Use and Sexual Risks for HIV/AIDS in Sub-Saharan Africa: Systematic Review of Empirical Findings.* Society of Prevention Research 2007.

### *ZPI Community Mobilization Framework*

ZPI defined communities broadly, to include those based on geographical areas, such as village communities; shared values, such as religious groups; experiences, such as PLHIV, alcohol and drug misuse, GBV, and others; or shared characteristics, such as gender and age. Some communities were already in existence, such as social clubs for business people (for example, Rotary and Lions Clubs or Sports Clubs), while some arose from ZPI's community mobilization interventions, such as communities advocating for particular changes.

ZPI's community mobilization interventions were structured as a process of empowering local communities through awareness creation, self-organization and action. The community engagement process was designed to encourage local ownership of interventions and create incentives for action. ZPI used numerous community mobilization strategies including:

- Community participation: involving community members and organizations in decisions that affect their communities
- Community activities: encouraging communities to participate in interventions conducted in their neighborhoods and communities
- Community consultation: community members working together and addressing needs they identified in their communities and families
- Community development: activities that create strong communities and contribute to addressing wider social goals, such as the reduction of HIV/AIDS

ZPI's community mobilization engaged communities to:

- Address the underlying drivers of HIV transmission in Zambia and understand gender's significant role in determining an individual's vulnerability to HIV infection.
- Understand the structural determinants of how people live in Zambia, such as social structures and customs, and traditions; religious beliefs and values; economic structures and access to resources; constructions of masculinity and femininity; and patterns of sexual relationships (including marriage), and how these can contribute to an individual's risk of HIV.
- Increase ownership and sustainability by taking part in the design and management of HIV/AIDS services and activities, creating a greater sense of community responsibility to maintain services over time with minimal outside support.
- Create demand for and increase community access to HIV/AIDS services as individuals and communities become more aware of HIV risk.

## III. Performance Toward Targets

**Table 1. Progress toward Life-of-Project Targets**

| Indicator Code | Indicator (Years tracked) | LOP Targets | Actual Achieved (Number) | % Achieved Against Target | Achievement of Indicator |
|---|---|---|---|---|---|
| P8.1.D | Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required (Years 1-4) | 572,000 | 625,410 | 109% | Achieved |
| P8.2.D | Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required (Years 1-3) | 174,000 | 143,375 | 82% | Not Achieved: Indicator retired by PEPFAR end of Year 3 |
| KP_PREV | Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (Year 4 only) | 2,000 | 1,009 | 51% | Not Achieved: Change in indicator definition from stand-alone KP_PREV to inclusion in GPY_PREV |
| HTC_TST | Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results. (Years 1-4) | 155,000 | 216,408 | 140% | Achieved |
| P1.1.D | Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) (Years 1-3) | 27,500 | 9,796 | 36% | Not Achieved: Removed from contract. |
| P7.1.D | Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions (Years 1-3) | 17,000 | 20,090 | 118% | Achieved |
| P8.3.D | Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required. (Years 1-3) | 75,000 | 113,374 | 151% | Achieved |
| P12.2.D | Gender Based Violence and Coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS. (Years 1-3) | 92,500 | 96,500 | 104% | Achieved |
| GEND_NORM | Gender Norms within the Context of HIV/AIDS: Number of people completing an intervention pertaining to gender norms, that meets minimum criteria (Year 4 only) | 2,900 | 3,034 | 104% | Achieved |
| C5.7.D | Number of eligible adults and children provided with economic strengthening services (Years 1-3) | 10,500 | 16,021 | 152% | Achieved |
| H2.2.D | Number of community health and para-social workers who successfully completed a pre-service training program (Years 1-3) | 30,000 | 10,171 | 34% | Not Achieved: Indicator retired by PEPFAR in Year 3. |

See **Annex 1** for graphical representations of ZPI's yearly progress in achieving targets.

# IV. Project Implementation Summary

### Task 1: Ensure that communities affected by HIV/AIDS access more effective, gender sensitive, high-quality HIV prevention programs, including TC, MC, and PMTCT

Although HIV incidence in Zambia has stabilized at 1.6% annually and prevalence at 14.3%, the absolute number of new infections is likely to continue increasing without effective prevention strategies. The drivers of the Zambian HIV epidemic include: MCP; low and inconsistent condom use; low levels of MC; mobility and labor migration; vulnerability among MARPs (such as sex workers and MSM); and vertical MTCT.[4] Underlying social factors and behaviors, such as alcohol abuse, gender inequality, beliefs about male dominance and sexuality, GBV and sexual coercion further fuel the epidemic. ZPI's biomedical HIV prevention approaches included scaling up and strengthening PMTCT services, increasing coverage of quality HIV TC (HTC) and promoting uptake of voluntary medical male circumcision (VMMC). ZPI also implemented and promoted biomedical prevention interventions that target PLHIV, including couples counseling and sexually transmitted infection (STI) screening and treatment. PMTCT, MC and HTC are evidence-based interventions that can contribute significantly in identifying PLHIV and providing referral to care services while integrating behavioral interventions for both HIV positive and negative persons for prevention of HIV transmission.

Over the life of the project, ZPI reached 625,410 clients (315,287 males and 310,123 females) with community-led behavioral HIV prevention interventions. This is 109% of the life of project target.

***Gender and Lens-based Work:*** Being able to understand the role that gender plays in an individual's vulnerability to HIV infection is a critical dimension in reducing infections for women and men. Capacity building in gender was an initial priority to ensure that all program activities were gender sensitive, and all staff had had common set of knowledge, skills, and methodologies for gender sensitive programming.

Capacity building of staff, partners, sub-grantees and stakeholders was a key strategy for providing a base for interventions. As foundation training, ZPI teams and sub-grantees were given basic trainings in gender to ensure that all activities were gender sensitive and/or had a gender focus. They were also trained in the basics of Participatory Learning and Action (PLA), to have the skills and tools to conduct discussions that addressed HIV risks, as well as prevention actions at individual and community levels. In addition, each lens had specialized trainings (Economic Empowerment, GBV, PMTCT, Male Involvement). After each training, ZPI teams developed work plans for utilizing the information from the training. Provincial teams also assisted and supervised sub-grantees to plan lens-based interventions and activities. Gender and gender-based training provided the framework for designing these interventions.

As an example, to introduce communities to ZPI's community mobilization methodology, all provinces conducted PLA discussions on what gender means in communities and explored the social construction of gender in Zambia; how we learn to become women and men; the gender norms that structure relations between women and men; and the relationship between gender and power and how this impacts HIV infection. Discussions on the social and cultural structures that underpin gender relations provided a basis for further discussions and actions such as recognizing the importance of male involvement in HIV prevention. In North Western and Luapula provinces, for example, community mobilization activities focused on using men as champions for PMTCT, VMMC, TC and GBV interventions. Men, who were trained in the Men Taking Action (MTA) community mobilization methodology, were used to encourage and ensure the participation of men in all prevention activities as well as to support female partners to access PMTCT services. Training also promoted appropriate coordination and sustainability of the interventions in all priority areas.

[4] *2009 Zambia HIV Prevention Response and Modes of Transmission Analysis.* ZPRMA. 2009.

ZPI activities intentionally ensured that the interconnectedness of HIV risks was explored from each lens. For example, on the Copperbelt, ZPI sub-grantee Mapalo Support Group conducted activities with PLHIV focusing on HIV prevention using small group discussions. Discussion topics included the relationship of alcohol and drug abuse to HIV transmission and the effect on antiretroviral therapy (ART) adherence. Participants' suggestion that more information dissemination was needed on alcohol misuse to individuals on ART led ZPI to conduct further interventions on alcohol. A safe space was created and the importance of correct and consistent condom use, good nutrition, and adherence to ART were all discussed during the sessions, and participants were referred to the nearest Health Center for family planning services. This strategy was important because it enabled ZPI to tailor interventions to the needs of the clients.

ZPI reached the target groups by working with nine international and local consortium partners (see list in **Annex 2**), as well as local subcontractors and 43 sub-grantees (see **Annex 3**). In addition, ZPI gave small grants, Community Purchase Orders (CPOs), to 37 community special interest and hard-to-reach groups, to conduct focused community mobilization activities. **Annex 4** includes a summary of CPO recipients and the activities each conducted. Recipients included the Albino Foundation of Zambia, which conducted small group discussion meetings with traditional leaders on the effects of negative cultural beliefs and stigma and discrimination related to HIV/AIDS on persons with disabilities, especially those with albinism; Network of Zambian People Living with HIV and AIDS (NZP+), which conducted discussions with ART Support Group members to understand the importance of adhering to antiretroviral drugs with an emphasis on how to monitor fellow clients on ART service; and to Muslim men in mosques, to hold discussions on gender, masculinity and GBV.

***Biomedical Services:*** ZPI worked closely with its partners to implement a comprehensive, evidenced-based biomedical HIV prevention package in all nine provinces to ensure communities affected by HIV/AIDS accessed these quality interventions. ZPI specifically scaled up the best of "what works" for biomedical HIV prevention. It engaged the respected community members such as the chief, headmen, traditional birth attendants, MTA champions, anti-GBV committee members and the clergy in sensitizing and mobilizing the community on the importance and benefits of accessing biomedical services; this engagement increased the uptake of biomedical services.

ZPI worked with the Ministry of Health (MoH) at provincial level and Ministry of Community Development Mother and Child Health (MCDMCH) at the local (district) level, as well as at the national level, in planning and conducting biomedical trainings/orientations (PMTCT, HTC, PHDP and VMMC) to health staff and sub-grantees to improve their biomedical HIV prevention capacity in a sustainable manner.

ZPI reached 216,408 people (101,452 males and 114,956 females), which is 140% of its life of project target, with TC services. ZPI provided TC services to communities through community outreach activities in partnership with the District Health Offices (DHOs) and ZPI sub-grantees, including ensuring quality of service delivery as indicated in the ZPI minimum standards for TC. ZPI conducted PMTCT services within communities by mainly focusing on TC for couples and pregnant women, ensuring that implementation of these activities adhered to the minimum standards as stipulated in the national guidelines. The MTA methodology was one of the main strategies used to increase male involvement in HIV prevention for the family. Increasing demand for TC is a direct result of ZPI lens-based activities, conducted in partnership with the MCDMCH, which served to mobilize communities to access biomedical interventions, and in particular TC.

For example, ZPI supported health workers to provide TC at community mobilization activities conducted in various communities and workplaces as part of the community mobilization interventions. In addition, ZPI partners and sub-grantees used the door-to-door strategy for reaching individuals, couples and families. In Central Province, communities were mobilized through discussion on the benefits of TC. The Chowa Home-Based Care Community Mobilizers conducted HIV prevention information sharing sessions prior to TC and people who were interested in knowing

their HIV status received HTC services. Pre-test counseling was conducted to ensure that people had adequate and accurate information on the benefits of testing and how to sustain the test results. The TC took place in the comfort of the clients' homes and test results were confidentially provided to the clients after a post-test was done. The people whose results were positive were referred to the health centers of their choice for other HIV management procedures. In Northern Province, mobile TC services were targeted at communities in Chisanga and Nakapampa, Chanda Mukulu, Mungwi/Malole-Chifulo and Mukuka Mfumu. Those who participated in TC all received their results. Mobilization was done by the engagement of community mobilizers, traditional leaders and Reproductive Health Center personnel who disseminated information on the importance of TC to community members. In Eastern Province, community facilitators from sub-grantee Young Happy Healthy and Safe worked with health care providers from Mkanda and Vizenge health centers to conduct door-to-door TC targeting young people, parents, and couples. The exercise was very much appreciated especially by young people, as they reported feeling free and comfortable as they were assured of confidentiality and knew their results just after the HIV test.

### Task 2: Strengthen the continuity and coordination of, as well as commitment to, effective, efficient, and sustainable HIV prevention, including TC, MC, and PMTCT

***Community engagement: Implementation of HIV prevention interventions***

ZPI's implementation strategy was rooted in participatory community behavior change methodologies and gender sensitive activities across all the ZPI lenses (see **Annex 5**). The Senior Technical Advisor led a team of Technical Advisors for Community Mobilization, Economic Empowerment (EE), and Gender, and Technical Specialists for Biomedical Interventions and Public Private Partnerships (P3) who provided technical guidance and capacity building for the ZPI teams and partner organizations. All ZPI partner technical teams were trained to provide direct service delivery and to further train and supervise sub-grantees to conduct targeted community interventions. The PLA community mobilization methodology was used as the foundation of all ZPI activities to address HIV risks and vulnerabilities, and promote shared responsibility between women and men for HIV prevention and sexual and reproductive health. ZPI's method of engaging stakeholders exemplifies the PLA approach of facilitating a process of collective analysis and learning within communities. An example of this is the community mapping, discussed earlier, that ZPI worked closely with key GRZ stakeholders to conduct at the beginning of the project; this enabled ZPI to introduce the project to communities as well as to begin the process of identifying key HIV risks and target groups.

ZPI's success can be attributed to its inclusive community engagement strategy, introduced earlier in the Technical Approach section. The use of PLA methodology for small group discussions ensured that more people, including traditional leaders, actively participated in HIV prevention discussions and understood how issues affected them and their communities. Traditional leaders ensured that the action plans agreed to by the groups/communities were carried out. In addition, sensitive issues, such as challenging and responding to GBV in communities, were better received when the Chiefs took active roles to ensure that HIV prevention activities were integrated into existing structures, such as including HIV prevention in initiation ceremonies for both boys and girls. Traditional leaders became champions and were at the forefront of challenging negative cultural norms, such as early marriage, by prohibiting traditional and church leaders from performing such ceremonies.

In all provinces, the most basic need identified was the use of community engagement methodologies to ensure common standards for conducting activities and ensuring quality reporting and data collection using ZPI minimum standards and reporting procedures. The training of community volunteers as PLA facilitators became a priority, and ZPI worked with an extensive cadre of community volunteers trained in PLA methodology to conduct gender-sensitive, high quality HIV prevention programs. Trained facilitators worked with a total of 1,183 lens-based community groups (see Table 2 below) that are now self-sustaining and will continue their work in communities that they have begun under ZPI. ZPI's key strength has been working closely with communities and enabling them to be part of the process of identifying key risks and developing action plans to mitigate the spread of HIV.

**Table 2. Lens-based Community Groups**

| Type of Lens | Name of Group | Number of Groups | Total Number of People Within Groups |
|---|---|---|---|
| Economic Vulnerabilities | GROW Savings and Loans | 268 | 4,977 (4,180 women, 797 men) |
| Family Planning | Traditional Leaders Men's groups | 6 | 90 |
| Gender Norms | Men's groups | 18 | 450 |
| | Boys for Change | 10 | 250 |
| | GROW Girls | 19 | 339 |
| | Men Taking Action | 18 | 350 |
| Gender-Based Violence | Anti-GBV Committees | 28 | 349 (164 women, 185 men) |
| Alcohol and other Drug Use/Misuse | Community Alcohol Teams in Zambia (CATZ) | 278 | 8,474 (3,983 women, 4,491 men) |
| | Psycho-Education Groups (PEGs) | 538 | |
| | **Total** | **1,183** | **15,579** |

All community mobilization activities were conducted at community level and used one of the ZPI lenses as a starting point. In some lens areas, these community groups established themselves to focus their interventions and provide a platform for further mobilization in their communities. In Eastern Province, for example, the GROW Self Help Groups became effective platforms for other HIV prevention interventions, such as GBV. These groups of 25 people or less held regular discussions following the ZPI minimum package of interventions. Groups met weekly or bi-weekly, and have consolidated into structured groups. This is important for work across lenses and in taking part in national events such as National VCT Day and World AIDS Day.

ZPI's community mobilization strategy also recognized the importance of buy-in and the need to work with Chiefs and use traditional ceremonies as platforms for concerted community-based HIV prevention interventions across all lenses. Over the life of the project, ZPI worked with 31 chiefs in all project areas.

**Table 3. Activities Conducted with Chiefs**

| Province | Chiefs | Key Activities Conducted |
|---|---|---|
| Luapula | Kasoma Bangweulu, Mwewa | Formation of community-level GBV committees and GBV response teams |
| North Western | Mujimanzovu, Kalunga, Kasempa, Sikufele, Kalunga, Chiyengele, Ingwee | Advocating for VMMC, uptake of TC and PMTCT |
| Copperbelt | Machiya, Chieftainess Lesa, Chieftainess Malembeka | Uptake of TC and PMTCT, couples counseling, using MTA champions |
| Central | Chibale | Uptake of TC, MC during Ichibwela Kumushi traditional ceremony |
| Lusaka | Mphukha, Mburuma, Chieftainess Chiawa and Chieftainess Nkomesha | Participation in community PLA discussions, uptake of VCT |
| Southern | Singani, Mungaila, Sinazongwe | Challenging harmful gender norms - sexual cleansing, early marriage, alcohol and drug abuse |
| Eastern | Mbang'ombe, Kawaza, Kathumba | Uptake of TC using traditional ceremonies |
| Western | The Litunga | Male involvement working with Indunas and male groups to address negative male norms and GBV |
| Northern | Chanda Mukulu, Mwamba, Nkole Mfumu, Chieftainess Mukuka Mfumu and subordinate Chiefs Kela, Mutale Mukulu and Chikwanda | Chiefs' representatives are taking the lead in mobilizing communities on links between GBV and HIV |

***Sexual and Gender Norm and GBV Interventions:***
ZPI's community-based GBV prevention activities arose out of the recognition of the need to address both biomedical and behavioral factors in the transmission of HIV. For example, cultural and economic inequalities fuel women's and girls' vulnerability to and risk of HIV and GBV transmission. Overall, the project reached 96,500 (104% of its life of project target) clients with GBV prevention messages and/or services (43,425 males and 53,075 females).

At project start, ZPI teams and sub-grantees were trained on GBV and succeeded in increasing community understanding of what GBV is, exploring the links between GBV and HIV, and exploring ways that communities could mobilize against GBV.

Following initial trainings on gender basics, ZPI teams and sub-grantees used PLA community methodology tools to conduct community-based discussions with different target groups to understand the social construction of gender and the traditional norms that underpin these constructions to challenge negative gender norms, and provide a better understanding of gender and the social construction of masculinity and femininity. Discussions were held in small community groups in single-gender and mixed groups and used tools such as the River of Life to enable participants to explore and understand better their own experiences of gender; values clarification exercises to measure and understand attitudes towards cultural norms held by both men and women; and to explore issues of gender, power, and sexual relations and how they impact HIV transmission. In exploring gender norms and behaviors, and in particular the relationship between gender and power, communities began to understand how these affected exposure to HIV for both women and men and in particular the relationship between gender and power, which often expressed itself as GBV.

During the PLA community assessment processes carried out at the beginning of the project, lack of male involvement in HIV prevention and reproductive health activities was identified as a major challenge. Men's failure to participate in information sharing and community activities related to HIV, gender, and reproductive health was linked to high GBV and the continued vulnerability of women to HIV infection. As a result, ZPI developed a proactive program aimed at involving men in gender, HIV, and reproductive health programs, using the male involvement approach. ZPI designed interventions across HIV/AIDS prevention and treatment to engage men in challenging negative norms, perceptions, values, belief systems and behavior that put men and women at risk of HIV. ZPI trained provincial teams and sub-grantees and supported them in the formation of men's groups to conduct community interventions with men and boys. The gender and masculinity trainings focused on helping men to understand issues around harmful cultural practices, such as how negative masculinity is tolerated by culture and tradition which is learned through the process of socialization. The training also emphasized the role of men in preventing GBV, and working with other stakeholders to increase the response to GBV prevention at all levels. By equipping them with participatory skills and knowledge on gender and GBV, the training made it easy for men to conduct community activities. Apart from the basic training in gender, masculinity and HIV, the men's groups received training focused on men's health using the Men's Health Toolkit, which is the only resource developed in Zambia to encourage men to discuss male reproductive health issues and general issues on gender and HIV.

Through discussions on gender and power, men are starting to understand and recognize how they use their power over women negatively and are challenging themselves to find ways to use power positively to protect women and children against both GBV and HIV. Other issues discussed included the need for increased male involvement in PMTCT and family planning services and understanding the role men can play to support partners during pregnancy. Over the life of the project, ZPI has facilitated the formation of 36 men's groups including in communities that focus on men's roles in preventing HIV and GBV, MTA Groups for PMTCT, coaches of different sports disciplines at the OYDC, the PHDP men's groups managed by the Network of Zambian People Living with HIV and AIDS (NZP+), the Seventh Day Adventist Church Leaders, and the Muslim community in Zambia. In Western province, for example, male involvement activities have become embedded in the Barotse Royal Establishment communication channels. Indunas (Traditional Counselors to the King) trained

in male involvement have formed men's groups to spearhead HIV prevention discussions in the Situngu Traditional Court Sessions which are held weekly. Issues discussed have included addressing and challenging male gender norms that contribute to GBV and HIV transmission, such as transactional sex in the fishing camps and the lack of land ownership for women, which leaves them economically vulnerable and in particular at risk for economic violence. Issues discussed in Situngu Sessions were in turn reported to the Litunga's court where actions could be taken. For example, as a result of reports on the impact of the lack of land ownership for women, the issue is being discussed at the highest level.

ZPI focused on working with young men by using sport as a platform to engage boys and men in prevention of violence against girls by working with Grassroot Soccer and the Olympic Youth Development Centre (OYDC). Male coaches were trained to work with the established sports teams. At OYDC, for example, the coaches themselves formed the *Men Alert* group to spearhead the male involvement activities at the centre and satellite communities to challenge perceptions, attitudes and behaviors among athletes and the wider community. In addition, ZPI designed a special intervention at OYDC, *Boys for Change*, which engaged boys and young men age 15-24 to explore what put them at risk for HIV as well as introduce them to opportunities and interventions that would improve their social skills and health status. A total of 25 peer facilitators were trained to conduct the discussions for the 250 Boys for Change participants, using the Sexuality and Life Skills curriculum, to challenge negative male gender norms and promote and encourage health seeking behavior.

In 2012, ZPI engaged Raising Voices[5], a Uganda-based non-governmental organization (NGO), to provide technical assistance and implement the *SASA!* methodology, building on ZPI's gender and community mobilization strategies. *SASA!* is a primary prevention methodology developed by Raising Voices, designed to help organizations inspire and enable community activism to prevent violence against women and HIV through encouraging critical analysis, dialogue and action about the power imbalance between women and men. Raising Voices trained ZPI staff and partners on the *SASA!* methodology, teaching new perspectives on power, violence against women, and HIV and challenging participants to reflect upon power in their own lives and the systemic power imbalances between men and women within their society. The training helped participants understand that *SASA!* begins in their own lives and in their intent to try to use their power positively.

The training laid the foundation for the *Regional 16 Days of Activism against Violence against Women Campaign 2013* whose campaign theme was "Power! We all have it. How are you using yours?" As is ZPI tradition for the 16 Days, all provincial teams planned extensive community discussions around various aspects of the theme using the *SASA!* toolkit to structure the discussions. For example, in Southern Province, discussions were tailored to the communities and focused on the use of power. In Pemba Clinic, PLHIV discussed the forms of violence they experienced in the community and asked individuals to examine how they used power in relationships. In Chief Mapanza's area, discussions focused on the power of chiefs and traditional rulers, the type of power traditional leaders have in communities, and how leaders use their power positively and negatively. These discussions enabled participants to understand how power plays an important role in all communities and relationships and how an imbalance and misuse of power can lead to many forms of GBV, including psychological, economic and physical abuse.

As a response to the new PEPFAR indicator introduced in 2014, GEND_NORM, ZPI introduced the Stepping Stones community mobilization activity. It is one of the interventions that addresses gender norms that meets all three criteria of the indicator, has been rigorously evaluated and has demonstrated a significant impact on changing gender norms and related HIV risk behaviors.

[5] Raising Voices is a regional leader in the field of violence prevention and has supported the implementation of practical programs to prevent violence against women and children in East, Horn and Southern Africa. The organization specializes in creating practical violence prevention methodologies, documenting them in detailed program tools and providing technical assistance to organizations wishing to use community mobilization to prevent violence against women by addressing power imbalances between women and men.

Stepping Stones is a training package on HIV/AIDS communication and relationship skills, designed to:

- Enable women and men of all ages to explore their social, sexual and psychological needs, to analyze the communication blocks they face, and to practice different ways of behaving in their relationships.
- Challenge people's attitudes and behaviors to themselves and to others.
- Encourage men and women of all ages to share their fears and successes so that they can learn from each other's experiences.
- Enable individuals, their peers and their communities to change their behavior - individually and together - through the 'stepping stones' which the various sessions provide.

In Eastern Province, Stepping Stones was introduced to communities in Lundanzi (Chambauni village), Petauke (Kalindawalo at Kawele village), and Katete districts (Kagoro area at Kholowa village). Some of the key lessons from the methodology was that it helped individuals understand what HIV is and how it affects the body. The process motivated some individuals to undergo counseling and make informed choices about being tested for HIV; most were tested and now know their HIV status. Stepping Stones has also motivated community members to work as a unit and focus on developmental projects, such as bridge constructions and well rehabilitations. The community in Kalindawalo now wants to focus on building a community school to meet their hope of having educated children. They have also embarked on revamping the traditional meetings called *Mphala* (for discussions between older and younger men) and *Mphelo* (for discussions between older and younger women.). Through Stepping Stones, it was observed that men in Kholowa thought it was acceptable to use alcohol, which resulted in aggression in homes, not taking responsibility for their families, and money problems as most men used to steal household items in exchange for beer. As a result, some families hardly had enough money for food, and children, especially girl children, were at risk of practicing transactional sex for survival. Increased violence was also accepted as the men became less in control of their feelings and behaviors, thus likely to physically abuse partners and children when drunk. Following lessons learned through Stepping Stones, the community has observed a reduction in cases of violence, cooperation is gradually growing, and partners are experiencing good communication among themselves. Men have learned to listen to their wives and plan together, a shift from the traditional domineering personality and reliance on cultural norms that disadvantaged women and girls. Gender norms are being challenged and equity is slowly being observed. For example, women are now seen participating in *Masika* agricultural marketing which was not done in the past. Participants explained that the unity experienced during Stepping Stones meetings increased the personal commitment of its members and enhanced community-wide change.

Another key GBV intervention was the dissemination of the Zambian Anti-GBV Act (2011) to all provincial teams and key stakeholders, and the establishment of GBV Committees in Central, Lusaka, North Western, Eastern, Copperbelt, Southern and Luapula provinces. Committees led the dissemination of the full Act and simplified versions to communities and ZPI stakeholders, in English and local languages. The workshops were well received and offered most stakeholders a first chance to review and critically analyze the Act and its implication on individual behavior and cultural and religious norms that condone GBV. The content and scope of the Act was an eye opener to all participants, even those in the justice system, such as magistrates and Police Victim Support Unit Officers who are at the frontline of ensuring justice for victims of GBV.

Participants spoke positively about the workshops:

- "The workshop was very fine. I think I'm now a changed person because I have learned a lot. Thank you ZPI for this workshop."
- "I think this workshop was very good in order to sensitize people working with cases of GBV or coming across them in their private lives. This is important in order to raise awareness and start to implement the Act."
- "The workshop has really opened my eyes on what is involved in GBV. It was an educative session, I learned a lot."

- "I feel that gender-based violence is a challenge in our society. I feel something should be done to reduce these cases of GBV."

After the dissemination workshops, GBV Committees were formed in each province comprising of a wide range of stakeholders including the judiciary, police officers, health workers, NGO workers, and others who are directly and indirectly working on the prevention of GBV and/or are involved in care and mitigation. Members of the GBV Committees further disseminated the Anti-GBV Act to community members using various platforms such as churches and mosques and events such as International Women's Day.

***GROW Girls***

Because of the direct links between female poverty and HIV transmission, special attention was given to addressing the economic needs of young women and adolescent girls. ZPI implemented a special program for girls and young women age 15-25, the Grass Roots building Our Wealth (GROW) Girls intervention, that links HIV prevention to economic empowerment. Girls participated in weekly discussion sessions on HIV prevention using the HIV Alliance Sexuality and Life Skills manual. ZPI then provided financial education using the GROW Self Help Group (SHG) model, in which groups of women, men, young women, and adolescents were trained and given skills in saving and managing money. The GROW SHGs are self-sustaining; all money comes from members' contributions and the interest gained from the loans given to members. GROW SHGs had a significant impact on the lives of participating members; having control over their own money helped reduce young women and girls' vulnerability to HIV due to poverty. All ZPI provincial teams directly or indirectly (through sub-grantees) supervised GROW SHG, and these groups were also used as avenues for other HIV prevention work.

The GROW Girls intervention was first piloted by ZPI partners Grass Roots Soccer, Hodi, and OYDC in Lusaka. In the first year, partners recruited a total of 750 participants and 40 group facilitators/mentors. The group facilitators received training in conducting each of the three intervention curricula that made up the GROW GIRLS model. ZPI conducted baseline and midline evaluations to measure the following outcomes for the girls:

- Improved financial knowledge and assets
- Enhanced social support
- Increased self-efficacy and social capital
- Increased knowledge and use of HIV prevention services

The final evaluation of the intervention concluded that overall, girls who participated in GROW Girls had a positive experience and demonstrated many behavioral changes that reduced their risk for transmission and acquisition of HIV, which was the primary aim of the program. Girls also demonstrated economic and social empowerment that led to risk reduction, including improved self-esteem and social connectedness. Program facilitators also showed improvements in these areas and demonstrated risk reduction.

***Operations Research***

To further assess effective, efficient, and sustainable HIV prevention interventions, ZPI conducted four operations research studies during the course of the project. In addition, ZPI conducted a baseline and mid-line assessment of the project. Studies are summarized below from the ZPI end-of-project evaluation report.[6]

- The baseline and midline evaluations were conducted in Copperbelt, Eastern, Luapula, and Western provinces using a cross-sectional community-based approach. Results showed positive changes in HIV testing, male condom use, income earning among females, and gender equity attitudes in both males and females. The GROW Girls Study was designed to identify approaches

[6] *USAID/Zambia: Zambia-led Prevention Initiative (ZPI) End-of-Project Performance Evaluation.* International Business & Technical Consultants, Inc. 2014.

to improve both their economic and health status and understand the challenges of girls and young women affected by both poverty and HIV. The study sought to assess the link between HIV outcomes and economic empowerment. Results of this study are summarized in the GROW Girls section above.

- The *Caregiver Study* was designed to examine the motivations of people volunteering as STEPS OVC caregivers and to understand how best to recruit and retain volunteer workers for the purpose of informing future programs that required the use of volunteers. The two main findings were that community and religious values were virtually universal in the study population with a majority of the volunteers reporting economic and material interests and needs. The findings showed a high level of commitment to people with HIV; volunteers are motivated by compassion for others and a desire to help the community. Monetary compensation is still helpful.
- The main purpose of the *HIV/AIDS Organizational Network Analysis* study was to measure community participation around HIV prevention in ZPI-supported districts. Study results from four districts showed that network connections among organizations involved in HIV prevention existed, but that they were not 'high functioning' in that there was a low density of active collaboration and a near absence of formal inter-organizational ties.
- *Boys for Change* was an assessment carried out as an outgrowth of the GROW Girl study. The assessment was used to design a 12-week intervention. Results showed that very few boys understood girls' sexual development or alcohol use as a drug. Results were used to develop the Boys for Change intervention.

***Alcohol/Substance Abuse Interventions***

The project identified harmful use of alcohol and other drugs as one of the major issues which affects the lives of many Zambians, and has interconnected risks such as HIV/AIDS transmission and management, sexual and GBV, mental health issues, increased levels of poverty, crime, and homicide.

ZPI engaged the Serenity Harm Reduction Program Zambia (SHARPZ) to train Community Alcohol Teams in Zambia (CATZ) to provide support to community Psycho-Education Groups (PEGs) made up of individuals who had identified alcohol and drug misuse as one of their risks to HIV. The trained PEG facilitators act as Change Agents to facilitate community members in discussing and addressing issues of harmful use of alcohol and other drugs in a safer environment. Subsequently, participants have established links between harmful use of drugs and interconnected risks such as HIV/AIDS, GBV, poverty, mental health, homicide, suicide, and crimes. For example, in Central province, the PEG facilitators under Kawama Christian Youth Concern (KCYC) mobilized young women and men in the community and churches with information aimed at reducing the harm and risks associated with alcohol and drug use. Using the Alcohol and You magazine and picture codes, the PEG facilitators held discussions on long and short term effects of alcohol and drugs as well as other substance abuse. Some of the harmful effects of drug and alcohol abuse on the user acknowledged during sessions included practicing risky sexual behaviors such as not using condoms and drunken behaviors such as fighting which could lead to injury. In-school youth talked about often having problems with their fellow pupils and teachers and at times with their parents. Strategies for reducing the risks and harms associated with drug and alcohol use and for reducing and stopping using alcohol and/or drugs, such as being more involved in sporting activities, were shared during the information sessions. ZPI introduced KCYC to the Salesians of Don Bosco Youth Centre in Kabwe, which has a comprehensive range of sporting and other activities for young people. In Eastern Province, trained traditional leaders used focus group discussion, testimony giving and case studies to facilitate the PEG meetings, targeting GROW group members. Those who have reduced their alcohol consumption and made significant life changes act as Champions in giving practical testimony on the effects of alcohol and drug abuse within the communities.

**Table 4. Total Number of CATZ Facilitators and PEGS**

| Sites | Community Alcohol Team (CATZ) | | | Psycho-Education Groups (PEGs) | | | | CATZ + PEG | Males | Females |
|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Total | # of PEGs | Total No. PEG members | Males | Females | | | |
| Lusaka 1 | 8 | 11 | 19 | 26 | 366 | 181 | 185 | 385 | 189 | 196 |
| Kabwe | 16 | 9 | 25 | 65 | 780 | 576 | 204 | 805 | 592 | 213 |
| Kitwe | 15 | 7 | 22 | 63 | 1129 | 455 | 674 | 1,151 | 470 | 681 |
| Chipata | 9 | 11 | 20 | 42 | 651 | 361 | 290 | 671 | 370 | 301 |
| Kafue (Lusaka 2) | 11 | 8 | 19 | 4 | 60 | 29 | 31 | 79 | 40 | 39 |
| Mazabuka | 6 | 7 | 13 | 27 | 406 | 284 | 122 | 419 | 290 | 129 |
| Monze | 13 | 7 | 20 | 55 | 709 | 394 | 315 | 729 | 407 | 322 |
| Lusaka 3 | 16 | 12 | 28 | 64 | 1,205 | 672 | 533 | 1,233 | 688 | 545 |
| Livingstone | 16 | 7 | 23 | 54 | 774 | 372 | 402 | 797 | 388 | 409 |
| Mongu | 7 | 14 | 21 | 78 | 1,218 | 496 | 738 | 1239 | 503 | 752 |
| Katete | 7 | 12 | 19 | 39 | 574 | 344 | 230 | 593 | 351 | 242 |
| Solwezi | 12 | 13 | 25 | 5 | 77 | 37 | 40 | 102 | 49 | 53 |
| Choma | 13 | 11 | 24 | 16 | 247 | 141 | 106 | 271 | 154 | 117 |
| **Total** | **149** | **129** | **278** | **538** | **8,196** | **4,342** | **3,870** | **8,474** | **4,491** | **3,999** |

ZPI worked with SHARPZ to print the CATZ training for distribution to organizations interested in beginning their own groups, and for government partners such as the MCDMCH which has shown interest in using the CATZ training at district and provincial levels.

***ZPI Participation in National Programming and Policy Development***

Throughout the project, ZPI formed close working alliances with GRZ and national, provincial and district levels. At the national level, ZPI took part in Technical Working Groups for the National AIDS Council and GRZ line ministries.

***Engagement of Key Public Sector Entities:*** From the outset, the project consulted and worked closely with key public sector entities, such as the MCDMCH, MoH and NAC. This engagement was strongest with NAC at all levels (national, provincial and district). Interaction with the MoH was largely restricted to the national level due to the current set-up of the health sector system, where the MoH is responsible for national and provincial-level health care and the MCDMCH is responsible for district and community-level care. It is not surprising that linkages with the MCDMCH were strongest at the district level since the project was focused on a community-led approach to HIV prevention interventions. The engagement with these bodies at these levels promoted modest ownership by them and both technical and managerial partnerships.

In 2013, ZPI was part of the Steering Committee for the Third National HIV and AIDS Prevention Convention, hosted by NAC. ZPI supported NAC with the engagement of a technical consultant for the Convention, participated in all technical discussions related to the Convention, and helped review all submitted abstracts to ensure a balance towards prevention and biomedical presentations, as well as ensuring participation of community groups in the Convention's program.

**Table 5. Partnering with Government of Zambia**

| Government Entity | ZPI Participation in National Technical Work Groups and Task Forces |
|---|---|
| National HIV and AIDS/STI/TB Council (NAC) | ▪ Technical and financial support to the Third National HIV and AIDS Prevention Convention (2013)<br>▪ Prevention Technical Working Group<br>▪ PMTCT Technical Working Group<br>▪ Key Populations Technical Working Group |
| Ministry of Community Development and Maternal and Child Health (MCDMCH) | ▪ Safe Motherhood Technical Working Group<br>▪ GBV Technical Working Group<br>▪ Family Planning Technical Working Group (FP TWG)<br>▪ Community-Based Family Planning Task Force<br>▪ Community-Based Distributors (CBD) Task Force |
| Other | ▪ Prisons AIDS Advisory Committee (PAAC)<br>▪ Zambia Network against the Harmful Use of Alcohol (ZNAHUA)<br>▪ Men Engage in Country Network |

### Task 3: Design efficient, sustainable, and locally-owned responses to HIV and AIDS, including increased engagement with the private sector

ZPI reached 16,021 adults and children with economic strengthening services (152% of the life-of-project target of 10,500). ZPI's main economic empowerment activities included conducting a rapid appraisal of existing EE models in project geographical areas to determine models that could be tested and shared as best practices; promoting PCI's self-help GROW methodology to build client and community assets by empowering Zambian women and men economically and socially for prevention; developing a mentorship and job readiness training (JRT) program to build the employment skills of at-risk young people and link them to entry-level jobs in career and vocational track occupations; and implementing a university internship and practicum program. At project start, ZPI developed an Economic Vulnerability Assessment Tool (EVAT) for mapping and determining household vulnerabilities based on community perceptions, as part of the initial mapping exercise. The EVAT tool categorizes households into different economic vulnerability strata and uses PLA mapping tools like Social Map and Wealth Ranking. This ensures that economic vulnerability is contextualized and varies from one community to the other. After categorizing the household, it could easily be linked to the appropriate intervention. Community members themselves, for example, could elect to join ZPI's GROW savings and loans groups.

***GROW Groups***

As introduced earlier, the GROW methodology focuses on building client and community assets, and empowering Zambian women and men economically and socially for HIV prevention. The model relies on the formation of self-directed groups that pool their money and lend to each other. A GROW group is an informal association of poor persons or weaker sections in a community with the common objective of working together for their economic, social, and personal development. GROW groups typically consist of 15 to 20 self-selected members, generally homogeneous and related by income level, geographic location, gender, and/or language and meet weekly. These members borrow individually from the internally pooled savings at agreed interest rates.

Before rolling out the GROW model in all provinces, ZPI developed the following manuals:

- The **ZPI GROW Facilitator Manual** (adapted from the PCI self-help GROW methodology), a field guide for mobilizing and mentoring GROW groups
- **ZPI GROW Training Manual** for training GROW facilitators
- **HIV/AIDS Information Manual** for training GROW groups to integrate basic HIV/AIDS information in their group meetings
- **Basic Entrepreneurship Skills for Micro Entrepreneurs** for personal entrepreneurial competencies, business idea identification, basic marketing skills, financial literacy and simple book-keeping

ZPI trained ZPI staff, partners and GROW groups in the GROW model and Basic Entrepreneurship Skills. At first, many group members were skeptical about how they would save money, seeing themselves as poor and needing to be helped with project money for income generating activities; however, after the GROW training they were surprised at how they could build assets even in an environment classified as poor. This model appealed to women in particular as it provided a much needed avenue for saving and having control over money. These groups were also avenues for HIV prevention information.

The number of GROW Groups formed over the life of the project is clear testimony to the effectiveness of this EE model. Such was the demand for the formation of new groups that, at the end of the project, ZPI conducted additional hands-on skills-based GROW Record Keeping training for Book Writers in Southern, North Western, Northern and Lusaka Provinces. The training covered poverty and HIV/AIDS; salient features of GROW methodology; why ZPI adopted GROW methodology; formation of GROW groups, monitoring and performance of GROW groups; theory and practical/group exercises on how to fill in record books (such as the admission book, minute book, monthly monitoring book, members' passbook, ledger, and cashbook including reviewing the contents of the cashbox); and liquidation of GROW groups including how to use the facilitators' GROW manual when rolling out activities. Since GROW groups are self-sustaining, they represent the best example of an intervention that is destined to keep growing, even after the close of the ZPI project. ZPI has worked to link GROW groups to formal microfinance services, and individual groups can now follow up on those linkages.

In Eastern province for example, Katete District Women's Association (KDWA) used the GROW model as a community mobilization strategy to reach mostly women; over the life of project, KDWA established 94 GROW groups and contributed to the highest portfolio of all provinces (see table below). These groups were then used as platforms for other lens-based activities and discussions, such as GBV, general prevention and encouraging members to go for TC and PMTCT. The fact that group members met weekly for the GROW activities made this grouping a very effective vehicle for conducting broad-based HIV prevention activities.

**Table 6. Performance Status of GROW Groups as of June 30, 2014**

| Province | No. of GROW Groups | Membership | | | Total Portfolio (KR) |
|---|---|---|---|---|---|
| | | Female | Male | **Total** | |
| Copperbelt | 15 | 256 | 45 | 301 | 47,176.15 |
| North Western | 11 | 124 | 40 | 164 | 52,486.00 |
| Eastern | 98 | 1,963 | 62 | 2,025 | 101,140.00 |
| Southern | 22 | 427 | 4 | 431 | 20,298 |
| Lusaka | 16 | 304 | 26 | 330 | 137,751.03 |
| Luapula | 10 | 75 | 66 | 141 | 15,126 |
| Western | 47 | 466 | 239 | 205 | 12,800 |
| Northern | 44 | 552 | 253 | 808 | 132,398 |
| Central | 5 | 28 | 67 | 95 | 13,312 |
| **Total** | **268** | **4,195** | **802** | **4,977** | **532,487.18** |

The GROW model enabled ZPI to reach more women and hard-to-reach communities, such as Muslim women of Lusaka's Chibolya and Matero compounds, with HIV prevention interventions. For example, out of the total membership of 4,997 GROW members, 4,195 (84%) of members were women. The use of the same volunteers across a range of lenses (GBV, biomedical services, alcohol and economic vulnerability) also made it easier to link EE to HIV prevention, because these volunteers, given their wide knowledge, could easily integrate a number of issues from the ZPI lenses during the GROW weekly meetings. Future programs can utilize this resource of experienced community mobilizers.

***Addressing HIV related vulnerabilities of girls and young women***
ZPI's EE interventions provided critical assistance to vulnerable populations, especially women and adolescent girls, by enabling them to generate income, increase bargaining power, transform that power into desired actions and outcomes, and build a savings base for emergencies; these activities ultimately enhanced their ability to mitigate the impact of HIV/AIDS and be less vulnerable to HIV infection.

***Job Readiness Training (JRT)***
As part of the economic vulnerability lens, ZPI developed mentorship and JRT programs to build the employment skills of at-risk young people and link them to entry-level jobs in career and vocational track occupations. Career fairs targeted vulnerable people (orphans, physically and mentally challenged) and grades 11 and 12 high school pupils, giving them an opportunity to associate and speak with practicing professionals and training providers in their area of interest. This opportunity to interact with different professionals provided the pupils with a better understanding of the requirements, expectations, challenges, and benefits of the sector or profession each young person was considering, assisting with their career selection. Nine career fairs were held in different districts as shown in the table below.

**Table 7. ZPI Career Fairs**

| District | Number of Pupils Reached |
|---|---|
| Kitwe | 814 |
| Chipata | 286 |
| Mkushi | 225 |
| Kafue | 920 |
| Mumbwa | 99 |
| Mwense | 300 |
| **Total** | **2,644** |

Pupils who attended the career fairs had positive experiences:

- "The presentations were really inspirational and we were motivated to work hard to achieve our goals and in return we motivate others."
- "As pupils we have been enlightened on how we can make decisions to choose a career in life."
- "We hope to have more of the careers fair and we implore our sponsors to continue sponsoring the Careers Fairs."

ZPI conducted JRT for 767 tertiary students drawn from five institutions: Mulungushi University, Kabwe Institute of Technology, Nkhumbi International College, Kitwe Trades School, and National Vocational Rehabilitation College. The trainings equipped soon-to-graduate tertiary students with job seeking and retention skills, such as preparing for job search, developing a curriculum vitae, how to conduct oneself during a job interview, and how to conduct oneself in the workplace.

***Life Skills Training***
The Life Skills trainings for young people was initially piloted in Copperbelt, Luapula, and Lusaka provinces with a total of 105 youth (35 in Copperbelt, 40 in Luapula, and 30 in Lusaka) and their mentors. Participants were equipped with skills in self-confidence, self-esteem, assertiveness, life purpose, personal leadership, and personal change. Recognizing that these skills are necessary for addressing almost all the ZPI HIV prevention lenses, especially among youth, the training material was later integrated in other youth-oriented trainings provided by ZPI.

***Link to university internship and practicum programs***
The ZPI Internship Program helped new graduates gain practical experience as professionals in supervised work settings and allowed interns to practice their skills and have an opportunity for personal development. ZPI engaged the Global Leadership Program (GLP) to develop a framework for the internship program and identify and place interns in host organizations in Copperbelt and

Lusaka. To maximize the program benefit for interns and host organizations, mentorship activities conducted by ZPI and GLP included orientations to the internship program and host organization, two trainings in Soft Skills Development and HIV Risk Awareness, completion of progress reports and exit interviews by interns and the host organizations, and an intern graduation officiated by the ZPI Chief of Party.

Through a competitive application process, ten interns were selected and placed in host organizations for three months (mid-April to mid-July, 2014).

**Table 8. Interns Selected and Placed by ZPI**

| Gender | Province | Placement Organization | Focus of internship |
|---|---|---|---|
| Male | Lusaka | Lusaka Water and Sewerage | Engineering |
| Male | Lusaka | Lusaka Water and Sewerage | Engineering |
| Female | Copperbelt | Copperbelt Energy Corporation | Human Resources |
| Male | Copperbelt | Copperbelt Energy Corporation | Engineering |
| Male | Lusaka | Catholic Relief Services | Information Communication Technology |
| Female | Lusaka | Catholic Relief Services | Information Communication Technology |
| Male | Lusaka | Class Econ Roofing | Information Communication, Technology/ Sales and Marketing |
| Male | Lusaka | Class Econ Roofing | Electrical Engineering |
| Female | Lusaka | ZAM | Policy and Membership Services |
| Female | Lusaka | Specialized Systems | Sales and Marketing |

Host organizations were identified through the different Chambers of Commerce, Zambia Association of Chambers of Commerce and Industry, Lusaka Chamber of Commerce, and the American Chamber of Commerce, to mobilize private and civil sector organization for the program.

***Private Public Partnerships***

ZPI provided technical assistance in workplace HIV/wellness policy development, peer educator sensitizations/trainings and supportive supervisions; in addition, ZPI motivated workplace management to appreciate the need for an effective and sustainable HIV/wellness program. Over the life of the project, ZPI worked with 42 private and public sector entities to conduct TC, general prevention, and PMTCT. These private sector companies included Lubambe Mines in North Western Province; China Geo Corporation (CGC) and Crescent Holding in Lusaka Province; Sun International and Protea Hotels in Southern Province; and Shoprite Stores in Eastern Province. ZPI also worked with the private farms and farming community in in Southern Province and security companies in Eastern province. Public sector companies included Eastern Water and Sewerage Company and Chipata Municipal Council in Eastern Province; Southern Water and Sewerage Company and Lusaka City Council. In each organization, volunteers were trained in ZPI community mobilization methodologies to address issues identified in work places such condom use, VCT, GBV and alcohol.

One example of these partnerships is the working relationship ZPI developed with CGC, the company constructing the Luangwa-Feira road in Luangwa district. ZPI is the only HIV prevention project that has approached and worked with the company. The company itself had been concerned about both the risk behaviors of their mostly male labor force and absenteeism due to excessive alcohol intake and unspecified illnesses, which was costing the company money in lost labor hours. The process of engagement included holding meetings with management to introduce ZPI and to conduct a mapping of key HIV risks in the workforce. Key risks identified were low and inconsistent condom use which the workers attributed to not having access to condoms in the area and alcohol consumption leading to multiple casual sexual partners as the men were away from wives and had spare cash to spend. A total of 73 PLA facilitators were trained by ZPI in PLA methodology and in male involvement using the Men's Health Toolkit, a men's sexual and reproductive health resource. The PLA facilitators were tasked by the company to conduct weekly small group sessions for workers to gain new knowledge

and find practical solutions. ZPI periodically engaged and supported the District AIDS Coordinating Agency (DACA) and the District Medical Office (DMO) to mobilize health care providers to provide TC services. Referrals for ART were made to the local health centers such as Katondwe Mission Hospital. Through this collaboration, CGC developed a good working relationship with both the DACA and the DMO. CGC will continue to engage them to provide TC and other health services, such as VMMC, to their workers. PLA facilitators also distributed condoms both at work and in locations identified as 'hot spots' in the mapping exercise, such as bars and lodges.

With assistance from ZPI, CGC developed a Workplace Health Policy with particular emphasis on HIV prevention. Topics discussed in the development of the policy included the negative effects of stigma and discrimination in the workplace and availability of HIV/AIDS services. Training cadres of PLA facilitators to conduct regular HIV prevention discussions tailored to the risks and vulnerabilities of the targeted workforce provided a sustainable strategy that can be incorporated in the company's corporate social responsibility agenda and supports sustainability of activities started by ZPI.

ZPI's workplace interventions also recognized the need to reach the wider community that the workers came from and the communities in which the company is located. Sometimes, as with farming areas, a community develops near the farm to cater for the workforce in providing food and other services. ZPI community mobilization activities involved communities for special events such as Family Days and special dates such as World AIDS Day, Women's Day. Working with the DMOs, TC was conducted and male and female condoms distributed. ZPI conducted community activities through small group discussions using PLA tools like the problem tree and cause and effect tool; discussions addressed issues including multiple concurrent partnerships, GBV, and alcohol and drug use, with a focus on the links with HIV transmission.

### Task 4: Community-based family planning and reproductive health services

ZPI's community-based family planning activities began in the final year of the project in three districts: Serenje in Central Province and Samfya and Milenge in Luapula Province. ZPI's activities strengthened Family Planning (FP) services in the communities through exiting HIV prevention and other reproductive health services. ZPI ensured that all FP activities supported activities in the MCDMCH and were integrated as part of the national level FP activities. ZPI built the capacity of senior health care providers to mentor and supervise trained Community Based Distributors (CBDs) of family planning commodities, and trained the CBDs themselves.

**Table 9. Community Based Distributors**

| District | Health Center | Number of CBDs | | Total |
|---|---|---|---|---|
| | | Female | Male | |
| ***Luapula Province*** | | | | |
| Milenge | Chibende | 4 | 6 | 10 |
| | Lwela | 4 | 5 | 9 |
| | Kapalala | 4 | 13 | 17 |
| | Mushili | 3 | 5 | 8 |
| | Miponda | 2 | 7 | 9 |
| | Shikamshile | 2 | 7 | 9 |
| | Sonkontwe | 5 | 8 | 13 |
| Samfya | Fwaka | 2 | 3 | 5 |
| | Kasanka | 3 | 7 | 10 |
| | Katanshya | 3 | 5 | 8 |
| Milenge and Samfya | Combined women only training | 20 | - | - |
| **Total for Luapula Province** | | **52** | **66** | **98** |
| ***Central Province*** | | | | |
| Serenje | Chibale | 3 | 2 | 5 |
| | Kabundi | 4 | 1 | 5 |
| | Mailo | 4 | 5 | 9 |
| | Mulilima | 5 | 11 | 16 |
| | Nchimishi | 4 | 5 | 9 |
| **Total for Central Province** | | **20** | **24** | **44** |
| **Total CBDs Trained** | | **72** | **90** | **162** |

At the start of the intervention, ZPI conducted community assessments and held stakeholder meetings at national, provincial and district levels to identify key constraints to accessing FP services. All three districts highlighted high levels of illiteracy, low levels of reproductive health knowledge; myths and misconceptions about what FP entails; little male involvement in FP matters and low community identification of FP as an issue as factors that contributed to low motivation of community members to access FP services. These assessments and meetings were followed by workshops for 29 health facility managers and supervisors in Milenge, Serenje and Samfya districts to orient them to their responsibilities in providing mentorship for the CBDs in their community mobilization and information giving, and also monitoring the supply chain of commodities to avoid stock outages.

A total of 162 CBDs were trained and all equipped with a bicycle, waterproof coat and bag to carry FP commodities. CBDs conducted community mobilization activities around increasing access to family planning products. A key innovation added to the FP program by ZPI was the strategic involvement of men as a response to the expressed need in all three districts that there was inadequate male involvement arising from myths, misconceptions and traditional norms, and in recognition of the vital role traditional leadership plays in mobilizing members of their communities. As a result, 47 headmen and 5 head women were trained in PLA methodology and issues of gender, masculinity and power. Training allowed them to understand how the power of men can be used positively and influence FP uptake for both women and men, and aimed to increase community involvement, especially that of men. The training proved to be very successful and led to the formation of community-based men's groups to conduct FP mobilization activities that challenged negative norms preventing women and men from accessing FP commodities. In the time that FP activities were conducted, it was demonstrated that in the implementation of a community-based FP intervention, local ownership and participation is critical to its success. FP as a whole was received well in the communities, and male condoms were the most popular in all communities. More women chose injectable FP methods because they are easier to manage than the pill.

At the national level, ZPI was a member of the MCDMCH Family Planning Technical Working Group and contributed to the process of developing a CBD National Strategy. The capacity building

of GRZ health officials; the skills and resources that the CBDs have received and the involvement of traditional leaders support the sustainability of ZPI's FP activities. All data generated by the FP activities are part of the Ministry of Health's reporting procedures and captured in national FP statistics.

## V. Key Project Achievements

- **Developing a risk and vulnerability lens-based framework** of critical factors which contribute to HIV prevention interventions to guide all programming. Having this multifaceted approach to addressing the lenses enabled the project to effectively tackle HIV prevention from several angles in a manner that addressed many community social and health problems. This approach was highlighted in the ZPI end-of-project evaluation; the evaluation report indicated that "the '*risk and vulnerability lens*' approach brought about innovation by integrating components that predispose individuals and communities to HIV infection, constructing a multifaceted platform for change based on the theory of change … The consortium partners afforded a solid theoretical and experiential base, understood the social and cultural context, and had technical expertise to transfer new skills to communities."

- **Incorporation of a strong gender element into programming**. Gender was a common theme that cut across all lenses in the program design. It was operationalized through the training of staff involved in the project at the national, provincial, and district levels. The project utilized and referred extensively to Zambia's Anti-GBV law. Initially there was no Male Involvement Officer on the project; this position was later created in order to strengthen the gender component. The project also integrated gender into the training of community leaders and volunteers. Once sensitized to gender issues, traditional leaders became gender 'champions' and role models.

- **Male involvement.** In some interventions (those involving gender norms, couple counseling, and alcohol and substance abuse), male involvement was highly prioritized. Engaging a Male Involvement Officer in 2012 showed great commitment to the project's emphasis on male involvement to challenge harmful gender norms and encourage positive cultural norms. By the end of the project, ZPI had a total of 42 men's and boys' groups, ranging from MTA to headmen's groups involved in family planning activities. All the men's groups were involved in the gender norm transformation in communities and program implementation as volunteers. Most importantly, the chiefs and headmen were champions of male involvement in the ZPI project activities. They acted as role models and leaders of community initiatives which encouraged more men to be involved in community-led HIV preventions efforts.

- **Involving traditional leaders.** Traditional leaders were involved in various aspects of the program. First, in communities where ZPI was implemented, ZPI approached and informed them about the project and what it intended to do around specific lenses, and then engaged them as champions. This ensured the acceptability of the planned behavioral and structural HIV prevention interventions. Second, the community leaders were used as role models on various lenses, such as GBV and alcohol and substance abuse, thereby promoting the adoption of messages and appropriate behaviors by community members. Last, in some cases the local traditional leadership, mainly headmen, also served as volunteers for the ZPI project activities. This provided greater access to volunteers by the community and contributed to more people being reached.

- **Utilizing economic strengthening** (i.e., GROW Groups) as an entry point for other HIV interventions. GROW Groups were initially set up as community micro-savings and micro-lending groups. Due to the multifaceted approaches used in the ZPI project lenses, GROW Groups became channels for disseminating HIV prevention messages, encouraging community dialogue and addressing social and cultural norms. This approach required little support beyond the initial training, a safe place to keep their money, and monthly supervision from a facilitator. The GROW Groups are self-governing and relatively independent, a key factor for sustainability and ensuring that HIV prevention messages and peer support on behavior change is ensured.

- **Reaching out to underserved areas and 'hard to reach' communities.** The ZPI project worked to reach all provinces in Zambia and to reach 'hard to reach' communities. Through local NGOs,

ZPI reached 16 fishing camps and organized 16 groups of MTAs with 275 members. In consultation with the MCDMCH, ZPI also selected sites for family planning interventions in areas that were identified as some of the most underserved (Chama, Milenge, Samfya and Serenje districts), having no partners working in family planning. ZPI successfully worked with 'hard to reach' communities, such as the Muslim community in Lusaka. ZPI established an excellent working relationship with Muslim women, in particular, in the gender and GBV lenses.

- **Building strong partnerships** was at the heart of the ZPI approach. This is reflected in the number of national and provincial level partners, small grants recipients, and CPO beneficiaries. At district and provincial levels, ZPI worked with GRZ ministries, such as the MoH through the DACAs and PACAs in delivering prevention interventions and linking communities to health services. These partnerships laid the foundation for communities to sustain the links as well as be part of the district and provincial HIV prevention structures in the MoH and MCDMCH. At the national level, ZPI has been a member of key technical working groups in the MoH, MCDMCH and NAC. ZPI has also collaborated with other USAID implementing partners, such as Economic Strengthening, Prevention and Support to Orphans and Vulnerable Children (STEPS OVC) by conducting the Caregiver Volunteer study; with Zambia Prevention Care and Treatment (ZPCTII) in developing a Gender Country Strategy; and Communications Support for Health (CSH) in accessing social and behaviour change communications materials. ZPI also built partnerships with the main community key stakeholders and gatekeepers (28 Chiefs and Headmen). These partnerships allowed the project to foster acceptability and ownership of the community-led behavioral and structural HIV prevention interventions across different levels of HIV prevention implementation in Zambia. The partnership allowed these organizations to work more closely, not only with ZPI, but also with one another, and in some cases, encouraged collaboration outside and beyond the ZPI project.

**Annex 6** features success stories from the ZPI project.

# VI. Lessons Learned and Challenges

### *Lessons Learned*

- Having technical expertise in all lenses, and especially in gender, ensured the delivery of a comprehensive, gender sensitive prevention program. The end-of-project evaluation recognized this, noting that the gender component "brought about changes in gender norms as reported in the midline survey and found during qualitative interviews. Male involvement catalyzed changes toward gender equity and brought about couple counseling and reductions in alcohol and substance abuse."[6]

- Having a dedicated team of Technical Advisors and Specialists ensured continuous training and mentoring was conducted through the life of the project. This strategy is important in any project design and ensures both knowledge and skills building are integral in HIV prevention interventions to ensure that correct knowledge forms the basis of behavioral changes and actions to mitigate HIV.

- Although each lens was used as an entry point for targeted HIV prevention, the technical team encouraged cross-lens work to enable individuals to address interconnected HIV risks, such as GBV and alcohol and drug misuse as well as using lens-based groups. This strategy was particularly strong in the use of GROW Self Help Groups as platforms for address other risk issues such as alcohol and access to biomedical interventions, especially TC.

- Having a comprehensive participatory community mobilization methodology ensures uniform delivery of interventions by all provinces, partners, sub-grantees and communities and helps individuals, families and communities evaluate HIV risks, plan and carry out activities to improve their capacity to prevent HIV and access care and treatment. Such learning ensures positive behaviour change at individual level that is rooted in knowledge and skills learned and build community resilience to HIV. ZPI's emphasis on community engagement was noted in the end-of-project evaluation: "There is a high level of ownership at the national, provincial and district levels, with the strongest buy-in at the provincial and district levels. Community involvement at every stage of the project created ownership and led to collective actions to create change. The economic empowerment approach (e.g. GROW Groups) provided an important opportunity for communities to build savings. Communities, however, recognized that they need to develop capacity and be linked to other structures to enhance the growth of their assets through loans and other means."[6]

- Involving community leaders, such as headmen and chiefs, in all HIV prevention work in their communities and areas of influence has proved to be a winning strategy for ZPI. Community leaders provide access to communities as well as act as Champions for the various lens interventions such as male involvement, PMTCT, FP and GBV. This also ensures that interventions started in communities are likely to be sustained beyond the life of the project.

### *Major Challenges and Constraints*

- Reduced obligations from USAID and uncertainty around funding in the final year impacted the project planning and implementation of interventions as some activities were left out of the project. This also created insecurity among staff, resulting in the loss of numerous staff, especially in the Southern provincial office which was closed early, in the beginning of the fourth year of the project.

- Late rollout to some provinces and late initiation of some activities was a challenge to implementation. The project employed a planned phased scale-up of activities throughout the country, launching activities in five provinces in Year 1 (2011), two in Year 2 (2012), and two in Year 3 (2013). Starting activities in these provinces at the later stage of the project was not ideal,

offering little time to make real gains in their interventions nor leave adequate time for the community to own and sustain the prevention efforts. This is especially true given the fact that many of the activities were directly related to behavior change and required substantial time for consolidation and assessment of real progress.

- Private sector engagement on HIV programs, cost sharing, and sustainability are challenging. Private sector engagement and monetary contributions to HIV prevention programs remains a challenge, though a lot of progress has been made in the project. More work is needed to establish more sustainable corporate social responsibility programs in the private sector. The ZPI project has been meeting with the P3 unit at the Ministry of Finance to amend the P3 Act in this regard.

- Realignment of the MCDMCH and MoH came during the course of project implementation, and has proved to be a challenge in some ways. For instance, the FP focal person was at the MoH under the Department of Public Health, but when the MCDMCH was established, this role was shifted to the MCDMCH without a specified focal point person for FP. The mental health lens was also affected; the MoH became responsible for higher-level psychiatric service delivery and the MCDMCH for community-based mental health programing, which negatively affected the mental health activities of the project.

- Changes in PEPFAR indicators and reporting templates were one of the biggest challenges during the course of the project. During the implementation period, PEPFAR changed from Next Generation Indicators to Rapid-Monitoring of AIDS Referral System indicators. Of the 10 major PEPFAR indicators that were tracked during the project period, five were retired (P7.1.D, P8.2.D, P12.2.D, C5.7.D and H2.2.D) and one was dropped (P1.1.D; a health facility level indicator). Only three indicators were tracked during the project's four year implementation period (P8.1.D, P8.3.D and P11.1.D), and one was only tracked in the final year (gender norms).

# ZPI Final Project Report
# Annexes

## Annex 1: ZPI Indicator Achievement Charts

**Figure 1. Number of targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required (P8.1.D)**

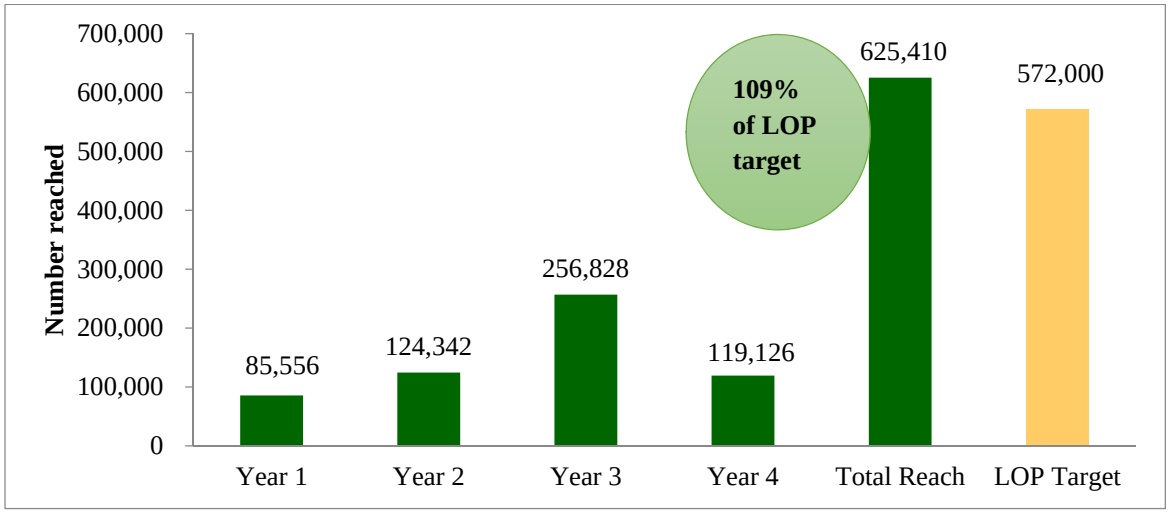



**Figure 2. Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required (P8.2.D)**

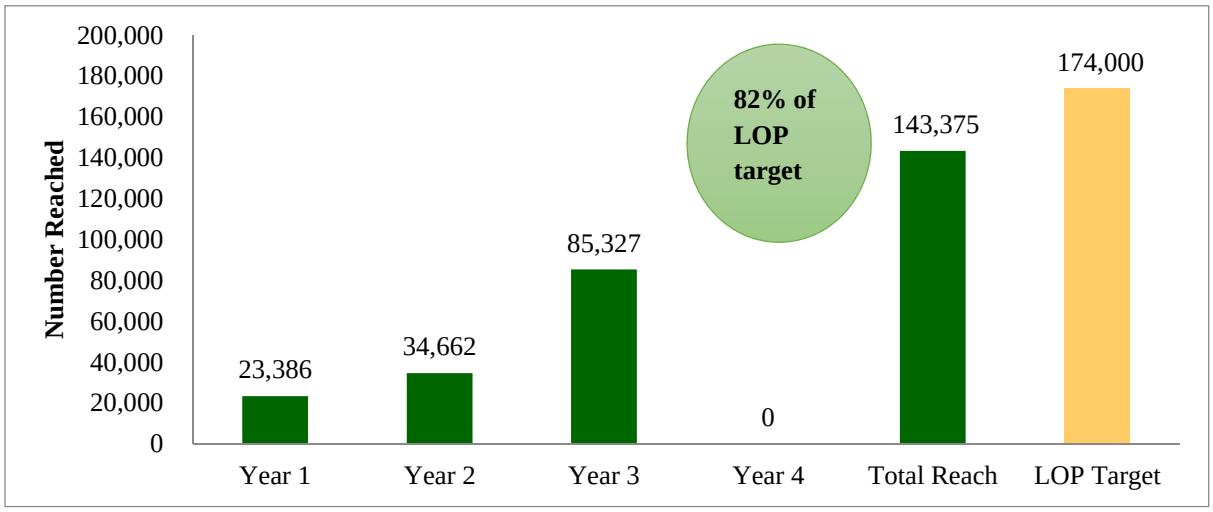


**Figure 3. Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results. (HTC_TST)**

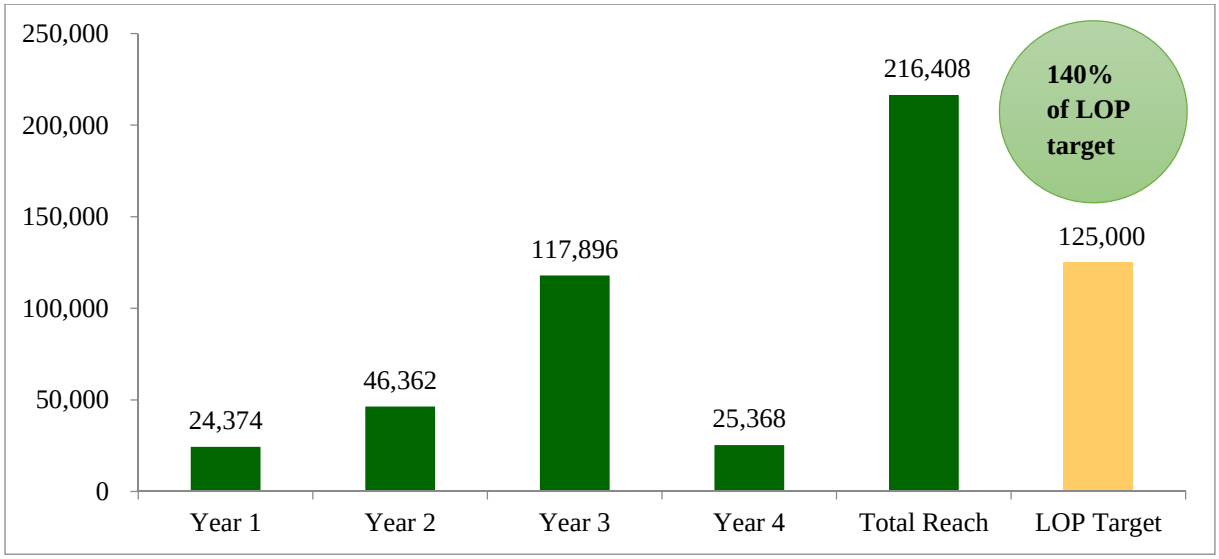



**Figure 4. Number of people reached by an individual, small group or community-level intervention or service that specifically addressed GBV and coercion related to HIV/AIDS (P12.2.D)**

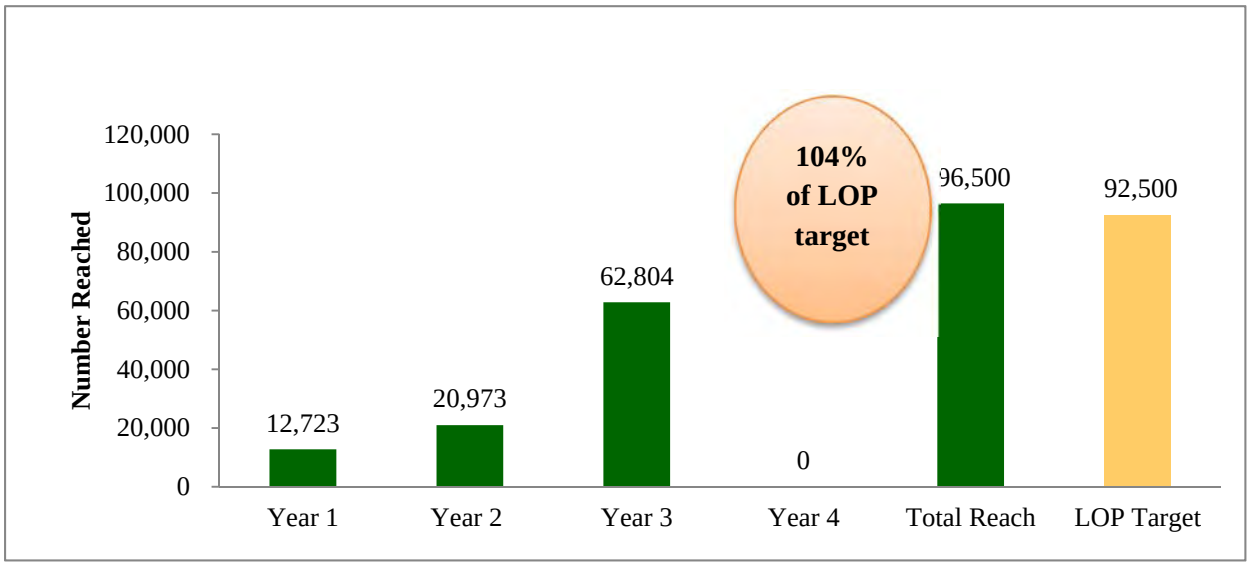


**Figure 5. Number of people completing an intervention pertaining to gender norms that meets minimum criteria (GEND_NORM)**

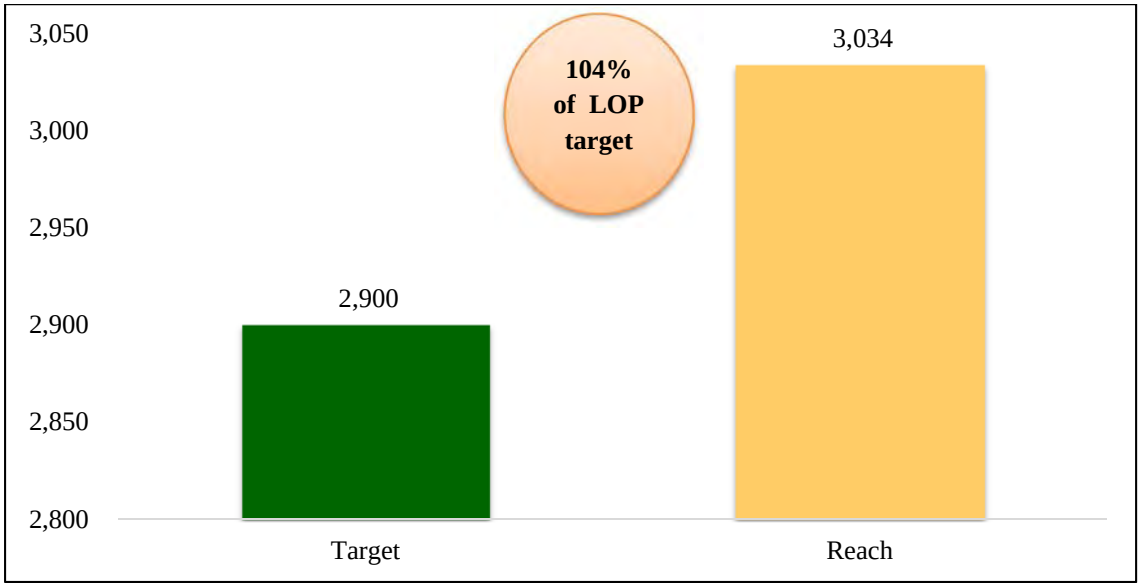



**Figure 6. Number of eligible adults and children provided with economic strengthening services (C5.7.D)**

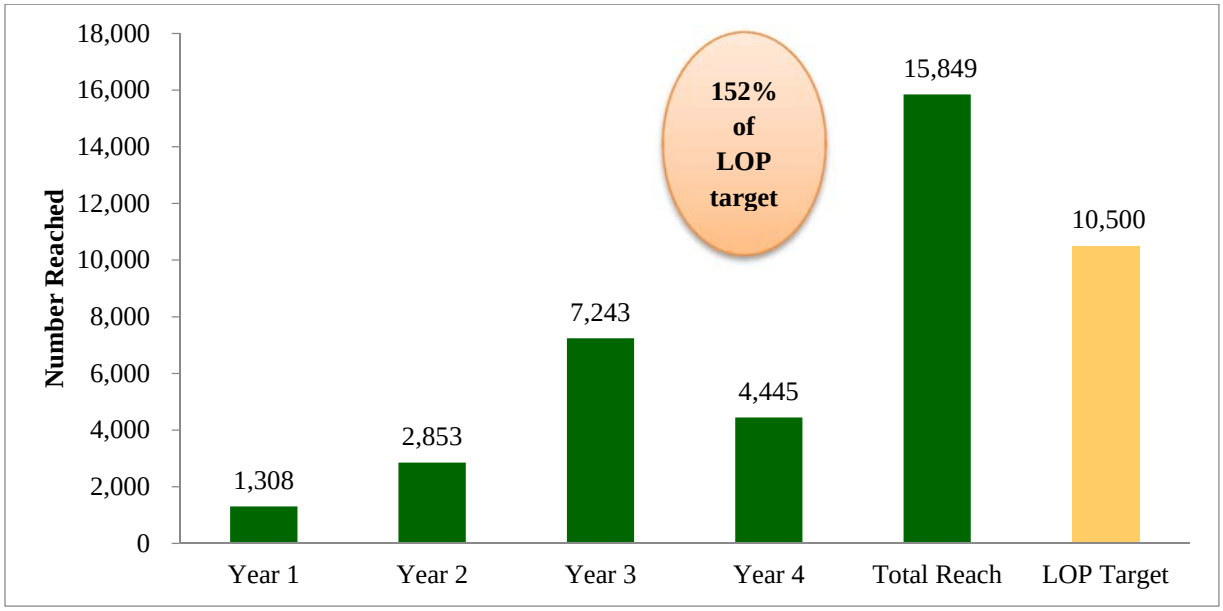
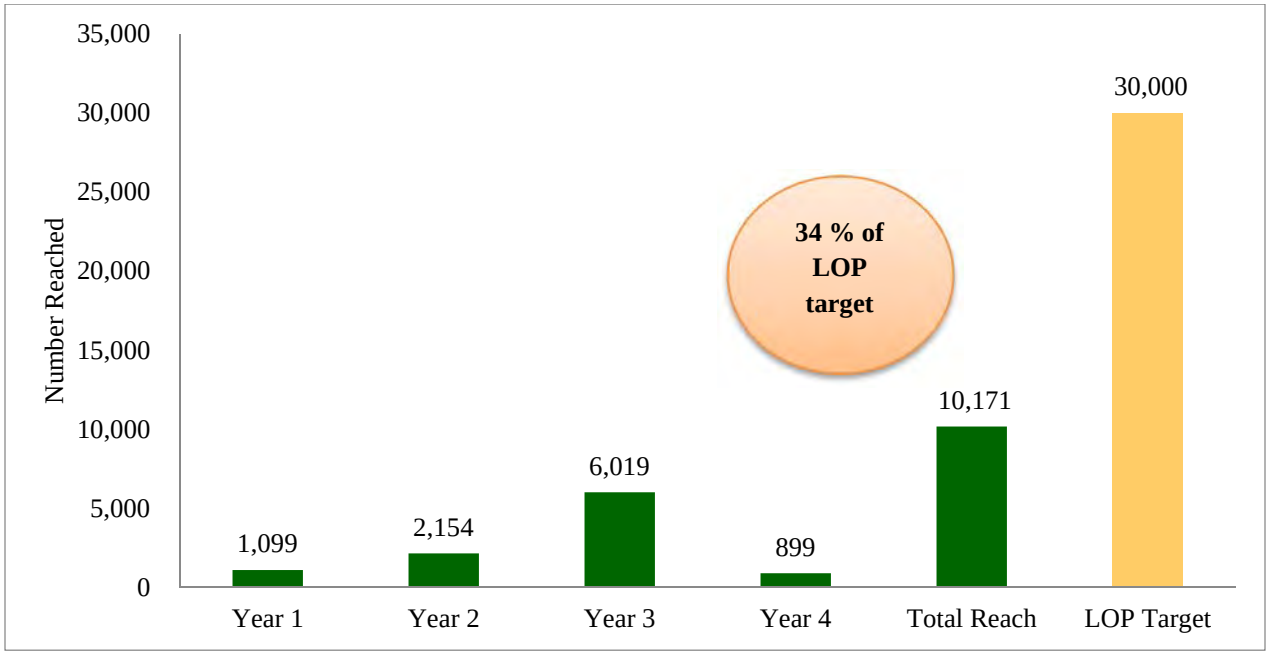


**Figure 7: Number of community health and para-social workers who successfully completed a pre-service training program (H2.2.D)**



## Annex 2: ZPI Consortium Partner Role

| Partner | Summary of Role |
|---|---|
| FHI 360 | ▪ Overall leadership, management and technical oversight<br>▪ Implement HIV interventions in Central, Eastern, Lusaka, Southern, Northern and Western Provinces<br>▪ Oversight for all activities and materials plus M&E and community mobilization |
| Afya Mzuri | ▪ Support behavior change communication, knowledge management and information dissemination<br>▪ Implement HIV interventions in Copperbelt Province<br>▪ Contribute to advocacy and mobilization<br>▪ Second Knowledge Management Specialist to ZPI |
| Catholic Mission Medical Board | ▪ Technical lead for biomedical services (PMTCT; HTC; MC; PHDP)<br>▪ Implement HIV interventions in North Western and Luapula provinces<br>▪ Support male involvement<br>▪ Second Biomedical Specialist and Program Manager to ZPI and provide TA through the CMMB Country Director |
| Comprehensive HIV AIDS Management Program (CHAMP) | ▪ Economic strengthening and link to private sector<br>▪ HIV testing and counseling |
| Grassroot Soccer Zambia | ▪ HIV prevention for youth and girls<br>▪ Mobilizing youth and girls for HTC |
| Hodi | ▪ Community mobilization<br>▪ Increase awareness of GBV<br>▪ Formation of community structures |
| Project Concern International (PCI) | ▪ Economic Strengthening |
| Population Council | ▪ Operations research<br>▪ Measure impact of program (including baseline and midline)<br>▪ Gender and behavior change communication<br>▪ Addressing structural risk factors in the community<br>▪ Develop tool for screening households for sexual abuse<br>▪ Coordinate activities with Olympic Youth and Development Center (OYDC)<br>▪ Second Senior Gender & Behavior Change and Communication (BCC) Advisor, Male Involvement Officer and Evaluation Officer |
| Zambia Health Education Communication Trust (ZHECT) | ▪ Engage the private sector<br>▪ HIV interventions, including TC |

## Annex 3: ZPI Sub-grantees

| Sub-grantee | District | Start Date | End Date |
|---|---|---|---|
| *Central Province* | | | |
| Chichetekelo Outreach Partners (COP) | Kabwe | 01/11/2012 | 31/05/2014 |
| Kawama Community Youth Concern (KCYC) | Kabwe | 12/11/2012 | 31/05/2014 |
| Dackana Community Home-based Care (Dackana) | Kabwe | 12/11/2012 | 31/10/2014 |
| *Copperbelt Province* | | | |
| Community Health Restoration Program (CHReP) | Luanshya | 15/07/2011 | 30/06/2014 |
| Mapalo Support Group | Ndola | 15/07/2011 | 31/10/2013 |
| Asayi - Anti STDs/AIDS Youth International (Z) | Kitwe | 15/07/2011 | 30/09/2012 |
| Pro-Life Advancement and Education Partners (PLAEP) | Kitwe | 15/07/2011 | 30/06/2014 |
| Hosanna Mapalo Orphans and Widows Care | Ndola | 15/07/2011 | 31/08/2013 |
| *Eastern Province* | | | |
| Thandizani Community Based HIV/AIDS Care and Prevention | Lundazi | 15/06/2011 | 30/06/2013 |
| Katete District Women's Association (KDWA) | Katete | 15/06/2011 | 31/07/2014 |
| Young Health Happy Safe (YHHS) | Chipata | 15/06/2011 | 31/07/2014 |
| Kachere Development Program (KDP) | Chipata | 01/10/2012 | 30/11/2013 |
| Chisomo Community Program (CCP) | Chipata | 01/05/2013 | 30/04/2014 |
| *Luapula Province* | | | |
| Youth Development Association (YDA) | Kawambwa | 01/11/2012 | 31/12/2013 |
| Action Africa Help (AAH) | Kawambwa | 01/11/2012 | 31/12/2013 |
| NZP+ Mwense Chapter | Mwense | 01/11/2012 | 31/12/2013 |
| Luapula Families in Distress (LFAID) | Mansa | 01/11/2012 | 31/12/2013 |
| NZP+ Samfwa Chapter | Samfya | 01/11/2012 | 31/12/2013 |
| Caritas Zambia | Mansa | 01/11/2012 | 31/10/2013 |
| *Lusaka Province* | | | |
| Anti-AIDS Teachers Association of Zambia (AATAZ) | Lusaka | 15/06/2011 | 31/08/2014 |
| Kafue Gospel Singers Community Project (KGSP) | Kafue | 15/06/2011 | 30/06/2012 |
| Chilanga Youth Awake (CYA) | Chilanga | 15/06/2011 | 30/06/2012 |
| NZP+ Lusaka Chapter | Lusaka | 15/06/2011 | 30/06/2012 |
| *North Western Province* | | | |
| Kabalusa | Kasempa | 08/06/2011 | 31/12/2013 |
| Kabompo AIDS Program (KAP) | Kabompo | 08/06/2011 | 31/03/2012 |
| NZP+ Solwezi Chapter | Solwezi | 08/06/2011 | 31/12/2013 |
| Maveve Orphans and Home Based Care | Kabompo | 01/09/2012 | 31/12/2013 |
| Loloma Integrated Health Program | Kabompo | 01/09/2012 | 31/12/2013 |
| Treatment Advocacy and Literacy Campaign (TALC), Solwezi | Solwezi | 08/06/2011 | 31/12/2013 |
| Sengenu Charity and Home Based Care (SCHBC) | Kabompo | 01/09/2012 | 31/12/2013 |
| Moment Of Hope | Solwezi | 01/09/2012 | 31/12/2013 |

| Sub-grantee | District | Start Date | End Date |
|---|---|---|---|
| Solwezi Youth Alive | Solwezi | 27/06/2011 | 31/12/2013 |
| *Northern Province* | | | |
| Reformed Church In Zambia Integrated Project | Mbala | 01/09/2013 | 31/08/2014 |
| Community Based Care Foundation (CBCF) | Mungwi | 01/09/2013 | 31/08/2014 |
| Young Women Christian Association, Kasama | Kasama | 01/09/2013 | 31/08/2014 |
| *Southern Province* | | | |
| Kalomo Interdenominational Youth Christian Fellowship (KICYF) | Kalomo | 15/06/2011 | 31/07/2014 |
| Brethren in Christ Church (BICC) | Choma | 15/06/2011 | 31/07/2014 |
| Kwenuha Women's Association (KWA) | Livingstone | 15/06/2011 | 30/06/2012 |
| Youth Development Organization (YDO) | Choma | 15/06/2011 | 30/06/2012 |
| HIV AIDS Technical Support Foundation(HATSFO) | Sinazongwe | 01/10/2012 | 31/12/2013 |
| *Western Province* | | | |
| Young Women Christian Association, Mongu | Mongu | 15/09/2013 | 14/09/2014 |
| Adolescent Reproductive Health Advocates (ARHA) | Lukulu | 15/09/2013 | 14/09/2014 |
| Treatment Advocacy and Literacy Campaign (TALC), Mongu | Mongu | 15/09/2013 | 14/09/2014 |

## Annex 4: ZPI Community Purchase Orders (CPO)

| Recipient | Province | Activity |
|---|---|---|
| *2011* | | |
| Chilanga Youth Awake | Lusaka | Carry out community mobilization prevention interventions on gender, GBV and HIV/AIDS |
| *2012* | | |
| YWCA | Southern | Conduct HIV sensitization and outreach through small group or individual level prevention in markets |
| Village Sustainable Project | Eastern | Conduct awareness sessions on effects of GBV at household level and community in Maguya community in Chipata District. Engage zonal clinic staff in providing information on PHDP to PLHIV in the Chiparamba community. |
| Jesus Cares Ministries | Eastern | Conduct a day TC, PMTCT, and AB day in two communities in Katete District. |
| NZP+ Choma | Southern | Conduct ART /clinical messages by sensitizing Support Group members on ART to understand the importance of adhering to antiretroviral drugs and fully benefit from its result. Enhance knowledge on ART literacy and adherence with emphasis on how to monitor fellow clients on ART service. |
| National Cultural Peace Workers Team | Eastern | Conduct 3 Community mobilization meetings for 100 CSWs on HIV/AIDS prevention education |
| SHADE Zambia | Lusaka | Male involvement in TC, PMTCT and MC services |
| Friends of Rainka | Lusaka | Conduct GBV, alcohol and other drug use/misuse assessment. Conduct risk reduction counseling focusing on promoting safe sex and reduction of partners. Provide HIV testing and give results for each couple at household level. Provide HIV positive individuals with effective referral system for treatment care and support. Distribute both male and female condoms including appropriate lubricants. |
| God our Help | Lusaka | Sensitize expectant women and spouses (if available) on the importance of TC during pregnancy. Sensitize the expectant women on the importance of antenatal counseling (ANC). Provide HIV counseling and testing for women and their spouses at the household. Refer expected women for ANC and PMTCT. Support HIV-positive individuals with effective referral system. Conduct risk reduction counseling focusing on promoting safe sex and reduction of partners. |
| YMCA Choma | Southern | Conduct HIV sensitization and outreach through small group or individual level prevention in markets |
| HIV/AIDS Advocacy and Care | Eastern | Reach out to pupils in other secondary schools with VCT services |
| HATSFO | Southern | Conduct AB interventions in schools |
| Kafue Gospel Singers | Lusaka | Conduct focus group discussions (FGD) on gender, GBV and HIV/AIDS |

| Recipient | Province | Activity |
|---|---|---|
| Ndekeleni Development Foundation | Southern | Conduct household door-to-door TC in Changachanga, Chibuyu, Ndeke, Show grounds and Kaleya Station communities. |
| *2013* | | |
| Dette Resource Foundation | Lusaka | World Aids Day commemoration activities |
| NZP+ Lusaka Chapter | Lusaka | PHDP interventions |
| Kafue Gospel and Community Development | Lusaka | Conduct FGDs on gender, GBV, and HIV/AIDS |
| Rainka Zambia Limited | Lusaka | Facilitate a community dialogue on GBV focusing on defilement, marital rape, and sex work. |
| The Grand Mufti of Zambia | Lusaka | Providing GBV interventions and HTC |
| The Grand Mufti of Zambia | Lusaka | Providing GBV interventions and HTC |
| Chowa Railway CHBC | Central | Provide HTC services |
| HIV/AIDS Advocacy and Care | Eastern | TC and general prevention in schools in Chipata District |
| Albino Foundation of Zambia | Eastern | TC and general prevention with people with disabilities |
| Ndekeleni Development Organization | Southern | Alcohol and drug use and HTC interventions |
| ART Drama Group | Southern | Alcohol and drug use and HTC interventions |
| Siachitema Central Community Development Organization | Southern | TC interventions |
| Lundazi NZP | Eastern | PHDP in Lundazi |
| PPACSN | Lusaka | Implementation of HIV sessions in Gardern, Kanyama and Chawama compound in Lusaka |
| *2014* | | |
| Lusaka Muslim Women Organization | Lusaka | Conduct sessions raising awareness about power and its relationship with prevention of violence or how it may coerce people to commit violence against women which includes sexual and physical violence |
| Kulima Tower Bus Station HIV Programme | Lusaka | GBV by Kulima Tower Bus Station |
| The Grand Mufti of Zambia | Lusaka | Small group level intervention focused on GBV and HIV/AIDS |
| Grand Mufti of Lusaka | Lusaka | GBV interventions |
| Chifundo Community | Eastern | Undertake community interventions on harmful effects of |

| Recipient | Province | Activity |
|---|---|---|
| Based Sustainable Development Project | | alcohol and drug misuse in relation to HIV and AIDS |
| OYDC | Lusaka | Create awareness on HIV prevention and to win their support towards the youths activities. This will also facilitate for the provision of a more holistic approach to health and wellness. |
| OYDC Boys for Change | Lusaka | Boy's for change aims at reaching 1,500 athletes from alcohol abuse, power imbalance between young boys and young girls by targeting boys for economic empowerment programs to reduce the vulnerability risk among them |
| Chowa Home Based Care | Central | Provision of HIV prevention information and HTC services in Katondo |
| Albino Foundation of Zambia | Eastern | Conduct small group discussion meetings with traditional leaders on the effects of negative cultural beliefs and stigma & discrimination related to HIV/AIDS on persons with disabilities, especially albinos, targeting 700 people. Conduct training in stigma and discrimination on persons living with disabilities, targeting traditional leaders. |

## Annex 5: Key Participatory Learning Action (PLA) Toolkits

1. **HIV/AIDS Alliance PLA Toolkits:**
   - **All Together Now!**[1] Community mobilization for HIV/AIDS provides a guide through the process of mobilizing communities to address HIV prevention, care, support, impact mitigation and treatment for those affected by HIV/AIDS.
   - **Tools Together Now!**[2] 100 participatory tools to mobilize communities for HIV/AIDS is a set of participatory exercises designed to help put All Together Now! into practice. Tools Together Now! and All Together Now! Toolkits utilize PLA as the community mobilization methodology. The philosophy of the two resources is that organizations and communities have to work closely together if they are to address HIV/AIDS successfully. Using the two resources, communities and organizations can:
     - start to address HIV/AIDS together
     - plan together
     - act together to implement the plan
     - monitor and evaluate activities together
     - scale up action on HIV/AIDS together.

   - Sexuality and Life Skills Toolkit[3] developed by the International HIV/AIDS Alliance in 2008, is a result of teamwork between sexual and reproductive health practitioners working with young people in Zambia, Malawi, Zimbabwe and Uganda, is written for anyone who wants to facilitate participatory learning activities with young people to equip them with the knowledge, positive attitudes and skills to grow up and enjoy sexual and reproductive health and well-being. It aims to assist facilitators to provide accurate and complete factual information for young people, plan appropriate educational activities for groups of young people in order to analyse their own situations, resources and needs, to apply their knowledge to their own lives, to increase awareness of their own values and attitudes, to develop their self-esteem and confidence and to develop life skills, for example communication and assertiveness, problem-solving and decision-making. The toolkit contains 65 topic sessions with aims, key facts and a number of different interactive and participatory activities such as role-play, stories, theatre, drawings, etc. to facilitate participatory learning activities with young people to equip them with the knowledge, positive attitudes and skills to grow up and enjoy sexual and reproductive health and well-being.

2. ***SASA!***[4] **Toolkit** for mobilizing communities to prevent violence against women and HIV is an approach uniquely designed to address a core driver of violence against women and HIV which is, the imbalance of power between women and men, girls and boys. Documented in a comprehensive and easy-to-use Activist Kit, *SASA!* inspires and enables communities to rethink and reshape social norms.
   - *SASA!* is about power: *SASA!* is unique in its focus on unpacking power, both its positive and negative uses, shifting away from the traditional focus on "gender" towards the heart of the problem.
   - *SASA!* walks communities through a process of behavior change: *SASA!* evolves step-by-step, avoiding the chronic cycle of awareness-raising.
   - *SASA!* involves everyone! *SASA!* engages a critical mass of people across all levels of society in order to create social norm change.

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[1] http://www.aidsalliance.org/assets/000/000/369/228-All-together-now_original.pdf?1405520021
[2] http://www.aidsalliance.org/assets/000/000/370/229-Tools-together-now_original.pdf?1405520036
[3] http://www.ibe.unesco.org/fileadmin/user_upload/HIV_and_AIDS/publications/Alliance_Sexuality_lifeskills.pdf
[4] http://raisingvoices.org/sasa/

- *SASA!* is personal: It is more than just a program or a job. It is a part of us. *SASA!* helps staff and community members to reflect on their own lives and relationships before trying to influence others.

3. **Men's Health Toolkit** is a resource for working with men on sexual and reproductive health issues. This well-illustrated counseling tool for providers integrates a broad range of men's health (and relevant women's and family health) issues, while maintaining a focus on male sexual and reproductive health and men's participation in family health. Some of the topics covered include male circumcision, family planning, multiple and concurrent partnerships, alcohol abuse, domestic violence, malaria and maternal and child health. The counseling kit is comprised of two parts - a reference manual and a flip chart. Although the reference manual was designed to be used primarily by the health provider when he/she is in need of further information, it has been used in ZPIs male involvement activities to provide a focus for HIV prevention and men's health.

4. **Stepping Stones Stepping Stones**[5] is a training package on HIV/AIDS communication and relationship skills. The Stepping Stones package is designed to:
   - Enable women and men of all ages to explore their social, sexual and psychological needs, to analyze the communication blocks they face, and to practice different ways of behaving in their relationships.
   - Challenge people's attitudes and behaviors to themselves and to others.
   - Encourage men and women of all ages to share their fears and successes so that they can learn from each other's experiences.
   - Enable individuals, their peers and their communities to change their behavior - individually and together - through the 'stepping stones' which the various sessions provide.

5. **Understanding and Challenging HIV Stigma: Toolkit for Action**[6] is a collection of participatory educational exercises for use in raising awareness and promoting action to challenge HIV stigma. The aim is to facilitate open discussion on HIV-related stigma and what we can do to promote a change in attitude and practice. The toolkit was developed to provide people working in the HIV field with a set of flexible educational materials to raise their own understanding and help them facilitate awareness-raising with community groups. The aim is to help people at all levels understand stigma – what it means, why it is an important issue, what its root causes are – and develop strategies to challenge stigma and discrimination. The idea behind the toolkit is to create a safe space where HIV workers and community members can: talk about their own fears and concerns about AIDS; look at the roots of stigma and how it affects us, our families, children and communities; examine their own attitudes and judgmental habits; and develop strategies and skills to confront stigma and discrimination in different settings.

6. **Men Taking Action (MTA)** is a community based intervention developed by the Catholic Medical Missionary Board (CMMB), one of the ZPI partner organizations, to increase male involvement in PMTC in Zambia. The challenge is to reach all pregnant women and their partners to increase the uptake of PMTC. The Men Taking Action (MTA) program approach addresses challenges of involving men in PMTC by working within traditional and community structures. The program engages traditional leaders and community members to educate men about HIV/AIDS and the importance of antenatal attendance and family-centered testing and care. Working with community and traditional leaders, MTA creates male health champions who encourage their families to uptake PMTCT/ VCT services. MTA is grounded in using gender empowering and transformative lens.

[5] http://www.salamandertrust.net/index.php/Projects/Stepping_Stones_training_programme/
[6] http://www.icrw.org/publications/understanding-and-challenging-hiv-stigma-toolkit-action

Steps in Implementing MTA initiative include the following:

1. Orientation of key stake holders such as PATFs, DATFs, CATFs, traditional leaders, community and church leaders.
2. Identifying influential community leaders to be trained as champions of PMTCT and VCT. Champions can be selected from among traditional leaders (chiefs, village headmen/women, herbalists), TBAs, clergy, civic leaders, teachers, etc.
3. Collaboration with DHMTs to affiliate champions with Health Facilities providing PMTCT and ART services.
4. Train the champions in PLA skills to mobilize communities, including a targeting men and couples to meaningfully engage t in PMTCT and VCT services within the general community and in ANC settings.
5. Provide key messages to address: lack of knowledge around PMTCT, ARVs and HIV transmission, addressing myths and misconceptions that perpetuate pregnancy as the only means of transmitting HIV; association of PMTCT and ARVs with an open declaration of one's status and that ARVs may be harmful to mother and baby; patriarchal structure of men that exert a controlling influence over the health decisions within their family; and emphasizing the importance of integrated packages for PMTCT, reproductive health, family centered care, social protection, couple testing and promotion of condom use in pregnancy; family planning with HIV testing before pregnancy; retesting during pregnancy if indicated, early infant diagnosis, infant feeding options and adherence to efficacious drug regiments (ARVs) for HIV positive mothers, children and fathers.

7. **Grassroots building Our Wealth (GROW)** is an innovative and cost effective economic empowerment model that helps very poor people especially women to sustainably build their own social and economic capital through the formation of self-managed groups that save, lend and conduct business together. The model was originally developed by PCI in response to the negative impact of AIDS on children and women in Africa. However, the ZPI GROW model is a combination of ad the PCI's GROW SHG Model and the Christian Aid's Savings and Loan Association (SLA) Model. The GROW model is a community development approach that aims to empower the poor socially, economically, and politically. The approach works by organizing the poor into groups, and helping them realize and explore their assets through continual technical support. The whole process unleashes human potential and empowers the impoverished to become active in their development.

   A GROW groups typically consist of 15 to 20 self-selected members, generally homogeneous and related by income level, geographic location, gender, and/or language and meet weekly. These members borrow individually from the internally pooled savings at agreed interest rates. ZPI's vision of the GROW model is that, apart from improving members' economic well-being through savings and credits facilities (including IGAs), GROW groups weekly meetings will also provide a platform for raising members' awareness on reproductive health and HIV prevention. Its hoped that this integrative approach will lead to three categories of empowerment thus: *power within* (self-confidence, financial confidence, challenging of negative gender norms); *power to* (autonomy in decision making, perceived contribution to household i.e. by partner/others in household, partnership relationship i.e. degree of independence/respect); *power with* (social group membership, and collective action) which are critical in reduction of HIV vulnerability.