



STEPS OVC Program Final Report



Sustainability Through Economic
Strengthening, Prevention & Support for
Orphans & Vulnerable Children, Youth
& other Vulnerable Populations



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ACKNOWLEDGEMENTS

This report describes the various interventions and activities undertaken under the Sustainability Through Economic Strengthening, Prevention, and Support for Orphans and Vulnerable Children, Youth, and other Vulnerable Populations (STEPS OVC) program implemented in Zambia from July 2010 to March 31st, 2016. The STEPS OVC project was funded by the U.S. Agency for International Development Zambia Mission and led by World Vision in collaboration with indigenous organizations and more than 300 local community-based organizations and private sector partners.

The successes and lessons learned in this report would not have been possible without the support of the U.S. Agency for International Development. We gratefully acknowledge all consortium partners and their sub-grantees under the grant for their determined efforts to reach out to the most vulnerable in the Zambian communities and drive to improve the wellbeing of Orphans and Vulnerable Children (OVC) and People Living with HIV and AIDS (PLHIV).

Notable mention goes to numerous program staff that contributed to this study; in particular, the Program Management Unit (PMU) team is recognized for their guidance and technical support to the partners and sub-grantee organizations.

The important contributions of consortium partner program staff, too numerous to list, cannot be overstated. The successful implementation of the STEPS OVC grant was truly a collaborative endeavor. Most of all, we are grateful to the program beneficiaries and participants who have shared this STEPS OVC journey with us from the beginning.

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LIST OF ABBREVIATIONS

AB.....	Abstinence, Be Faithful
ART	Antiretroviral Therapy
ADP.....	Area Development Program
BCS	Basic Care and Support
CRS	Catholic Relief Services
CC	Community Caregiver
CHW	Community Health Worker
CHBC	Community Home Based Care Alliance
CoPIS.....	Community-Based Prevention Information System
CT.....	Counseling and Testing
CDC	U.S. Centers for Disease Control
DATF	District AIDS Task Force
DQA.....	Data Quality Assessment
DDCC.....	District Development Coordinating Committees
DHMT.....	District Health Management Team

ECR	Expanded Church Response
GIK	Gifts-in-Kind
GRZ	Government of the Republic of Zambia
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
LLIN	Long-Lasting Insecticidal Net
LOP	Life of Project
M&E	Monitoring & Evaluation
NASF	National AIDS Strategic Framework
OCB	Organizational Capacity Building
MOU	Memorandum of Understanding
MCDMCH	Ministry of Community Development, Mother and Child Health
MoH	Ministry of Health
OVC	Orphans and Vulnerable Children
PCAZ	Palliative Care Association of Zambia
PLHIV	People Living with HIV and AIDS
PMP	Performance Monitoring Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PwP	Prevention with Positives
PMU	Program Management Unit
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development and Support
SILC	Savings and Internal Lending Communities
SUCCESS	Scaling Up Community Care to Enhance Social Safety Nets
STI	Sexually Transmitted Infection
SARF	Stakeholder Activity Reporting Form
SO	Strategic Objective
STEPS OVC	Sustainability Through Economic Strengthening, Prevention and Support to OVC, Youth and Other Vulnerable Populations
TSA	The Salvation Army
USAID	United States Agency for International Development
TST	Technical Sustainability Assessment Tool
TWG	Technical Working Group
WV	World Vision
WVZ	World Vision Zambia
ZPI	Zambian Prevention Initiative

EXECUTIVE SUMMARY

The program was implemented in four phases, with Phase one (2010-2013) implemented throughout the country in a consortium with six international partners: Catholic Relief Services, Care International, The Salvation Army, Africare, Expanded Church Response, and Futures Group as well as over 388 local partners. Phase two (July 2013-September 2014) shifted to just two international partners, World Vision and Futures Group (now Palladium), and was primarily implemented through 13 high-performing local partners as well as reduced to 43 districts in Zambia. Phase three (October 2014-September 2015) reduced implementation to five provinces and worked with eight local partners. The final phase (October 2015-March 2016) of the program was implemented in two provinces with four local Non-Governmental Organizations (NGOs).

BACKGROUND

STEPS OVC was a six-year (2010–2016), US\$98 million project funded by the President's Emergency Fund for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). The program's goal was to strengthen the capacity of Zambian communities to provide sustainable and harmonized HIV prevention, care, and support services to priority geographic areas, target populations, and stakeholder communities. STEPS OVC had three strategic objectives (SOs):

- **SO1:** Ensure that individuals and households affected by and vulnerable to HIV and AIDS access holistic, gender-sensitive, and high-quality HIV prevention, care, and support
- **SO2:** Strengthen the continuum of effective, efficient, and sustainable HIV prevention, care, and support
- **SO3:** Improve efficiency, sustainability, and Zambian leadership of HIV and AIDS-related services, including engagement with the private sector

World Vision (WV) was the lead agency for STEPS OVC and brought together the expertise and geographic coverage of international and local non-governmental organizations. STEPS OVC collaborated with the USAID-funded Zambian Prevention Initiative (ZPI) to design prevention initiatives, capacity building, and referral mechanisms. Implementing partners worked directly through sub-grantees to train and support community caregivers (CCs) and volunteers who provided core OVC services as well as linked clients to health and economic-strengthening services.

This report outlines STEPS OVC's activities in core areas as well as capacity building and sustainability activities. It highlights outputs, outcomes, challenges, lessons learned, networking and collaboration, activities implemented, and includes a financial report summary. Success stories from the implementing partners can be found in Section 15.2.

PROJECT SUMMARY

STEPS OVC is a six-year USAID-funded project that brings together the expertise and Zambia-wide coverage of international and local nongovernmental organizations under the leadership of World Vision.

GOAL: To strengthen the capacity of Zambian communities to provide sustainable HIV prevention, care, and support services in a harmonized manner to priority geographic areas, target populations, and stakeholder communities.

DATES: July 2010 to March 31st, 2016

FUNDING: US\$98,304,213 (\$74,998,534 USAID, \$23,305,679 match)

GEOGRAPHIC REACH: STEPS OVC implemented activities countrywide with a focus on communities, community-based organizations (CBOs), and the Zambian government. In addition to the main office in Lusaka, partner offices throughout the country coordinated the roll-out of interventions, supported the transition of activities and organizational capacity building, and gathered information for learning. Coordination and roll-out of interventions is implemented out

of partner offices dotted around the country which also support transition of activities and organizational capacity building, and gather information for learning.

TARGETS: STEPS OVC mitigated the HIV epidemic by strengthening comprehensive support services for over 410,379 orphans and vulnerable children (OVC); improving quality of life for 179,414 adults and children living with HIV (PLHIV); delivering HIV prevention information and behavior change skills to 92,220 beneficiaries and HIV+ persons; providing HIV counseling and testing services to 630,248 people; increasing livelihoods of more than 517,851 beneficiaries and 25,121 OVC households through economic strengthening activities; involving an organized network of over 45,000 trained, equipped caregivers; and building the capacity of 388 Zambian CBOs to respond to communities and households affected by HIV and AIDS.

OVERALL OUTPUTS AND INCOMES

This section highlights overall achievements for STEPS OVC. Appendix I provides detailed achievements for STEPS OVC as per the PMP quantitative and qualitative indicators.

The goal of STEPS OVC was to strengthen the capacity of Zambian communities to provide sustainable HIV and AIDS prevention, care, and support services in a harmonized manner to priority geographic areas, target populations, and stakeholder communities.

STEPS OVC has achieved its goal in many respects. To illustrate, STEPS OVC sub-granted to over 403 indigenous, community-based, Zambia-led organizations, of which 388 have received significant capacity building (see Appendix 2). Additionally, STEPS OVC built capacity for 122,689 Community Caregivers (CC) and social workers (Males 49,165 and Females 73,524) to provide services in prevention, care, and support. While the program trained this very large overall number, the trainings were targeted specifically at 44,419 CCs with whom it worked on a regular basis. Training these workers provided the necessary human resource base to ensure a continuum of care between the facility and the community. Notably, 40,886 CCs were linked with health facilities. The linkages with health facilities enabled them to conduct referrals and receive information on emerging health practices among others. The linkage and training also contributed to sustainable programming beyond the period of performance of STEPS OVC. Furthermore, 25% [10,651] of the STEPS OVC CCs were also registered as community health workers [CHW] – a cadre within the Ministry of Health [MoH] staffing structure.

STEPS OVC built sustainable partnerships with the private sector to expand and sustain service provision in communities such as the agreement with Silva Catering Limited to train communities in vegetable production and market linkages. STEPS OVC also endeavored to ensure that local organizations built partnerships with the private sector, yielding mutual benefits and ensuring a continuum of care. For example, the partnership between Pharmanova and World Vision resulted in the successful implementation of the Client kit study, which assessed the LifeStraw Family's acceptability as a purification tool in Zambian households.

Additionally, STEPS OVC has increased the engagement of the GRZ and private sector providers in strengthening and improving the continuum of effective, efficient, and sustainable HIV prevention, care, and support activities. As part of the project's public private partnerships [P3] strategy, STEPS OVC and ZPI worked to replicate and scale up new models, emerging lessons, and practices in the delivery of HIV and AIDS care, treatment and prevention, support, and capacity building for target populations.

STEPS OVC supported the National AIDS Strategic Framework. The project supported GRZ structures such as the District AIDS Task Force (DATF), Provincial AIDS Task Forces (PATF) and District Health Management Team (DHMT) through the District Development Coordinating Committees (DDCCs). It additionally submitted district plans to the District Planning Officers (DPO). Thus far, STEPS OVC has submitted 241 plans to the DPOs. Furthermore, STEPS OVC has contributed to national-level policy documents, including the national M&E Plan, the joint action program review [JAPR], and the OVC standards as a way of ensuring support for government-led efforts in the fight against HIV.

BOX 1: SUMMARY OF ACHIEVEMENTS TOWARD PROJECT GOAL

COMMUNITY CAREGIVERS (CCS)

- 44,419 CCs are registered with STEPS OVC; 59 % are female
- 165 % received pre-service training.
- 92% of CCs are registered with a government health facility, and 25% are trained community health workers

OVC AND THEIR FAMILIES

- 589,793 OVC and their families received at least one care service; this represents 105.3% of the LOP target of 559,872. Of this achievement, OVC represent 117% achievement of the 410,379 of 350, 000 target while PLHIV represent 179,419 achieved against target of 120,000 translating to 149% of target.
- 290,616 (65%) of 449,450 of OVC were enrolled in school

HIV PREVENTION

- STEPS OVC reached 989,229 individuals (270% of the 332,934 target) through small group discussions about stigma, alcohol, and community change.
- 92,081 individuals were reached (105% of the 86,409 target) with “prevention with positives” (PwP) interventions
- 630,248 individuals (248% of the 442,590 target) were counseled and tested for HIV, and collected their test results

ECONOMIC STRENGTHENING (ES)

34,341 households comprised of 517, 851 individuals were reached with ES activities

I.1 SOI: Ensure that individuals and households affected by and vulnerable to HIV and AIDS access holistic, gender-sensitive, high-quality HIV prevention, care and support

1.1.1 Result 1.1: Access ensured for OVC, at-risk Youth, and Vulnerable Adults to Sustainable Prevention, Care, and Support Services

During the life of the grant, STEPS OVC provided services to 589,793 OVC and their families. Of these, 410,379 were OVC while the remaining 179,414 were PLHIV. Of the OVC beneficiaries, 23,744 were HIV positive and were provided with HIV and AIDS related services.

Specifically, STEPS OVC provided the following services for adults and children:

TABLE I | Care and Support to Adults and OVC

SERVICE	CHILDREN [under 18]	ADULTS [18 and older]	TOTAL
Number of eligible clients who received food and/or other nutrition services	430,580	197,979	628,559
Number of eligible children provided with education and/or vocational training	390,011	130,833	520,844
Number of eligible adults and children provided with protection and legal aid services	353,835	160,247	514,082
Number of eligible adults and children provided with psychological, social, or spiritual support	451,987	209,140	661,127
Number of eligible adults and children provided with household economic strengthening services	343,123	174,745	517,868

STEPS OVC developed and rolled out program strategies in late 2010. STEPS OVC was required to transition approximately 200,000 OVC from previous PEPFAR-funded projects including RAPIDS. Therefore, in the first year, the project reviewed their eligibility in light of the PEPFAR guidance at the time. This process included having CCs visit OVC households and re-register them under STEPS OVC if appropriate. One impediment to rapid start-up was the gap between the previous and current projects because most staff from previous projects had found gainful employment elsewhere. This staffing shortage meant that it took time to get a full staff to implement the program.

During start-up, the Program Management Unit [PMU] developed the program delivery strategy for all intervention areas as a way of ensuring that care and support services were standardised and in line with PEPFAR and the GRZ's guidance. Against this background, the STEPS OVC indicators went beyond the required PEPFAR New Generation Indicators [NGI] to also include the National AIDS Council Activity Reporting Form indicators.

To support CCs in case management, STEPS OVC rolled out the Child Status Index (CSI) as a job aid. The CSI reminds CCs of the comprehensive needs of OVC and enables them to assess children holistically and make appropriate needs-based care decisions. CCs and their Care Group Leaders¹ discussed CSI scores to ensure that home visit interventions met the needs of the OVC and that appropriate referrals were made. To this end, STEPS OVC conducted CSI training for 9,802 individuals, including 8,910 CCs. To date, CCs have applied the CSI to 430,580 individual OVCs.

While STEPS OVC's life of project [LoP] prevention target was 332,934, in total evidence-based prevention interventions reached 989,229 [297% of the target] (see figure 1). STEPS OVC reached 426,816 individuals [188,181 males, 238,635 females] with HIV prevention education and/or information to adults, OVC, and other household members during the household visits. STEPS OVC implemented the following HIV prevention interventions:

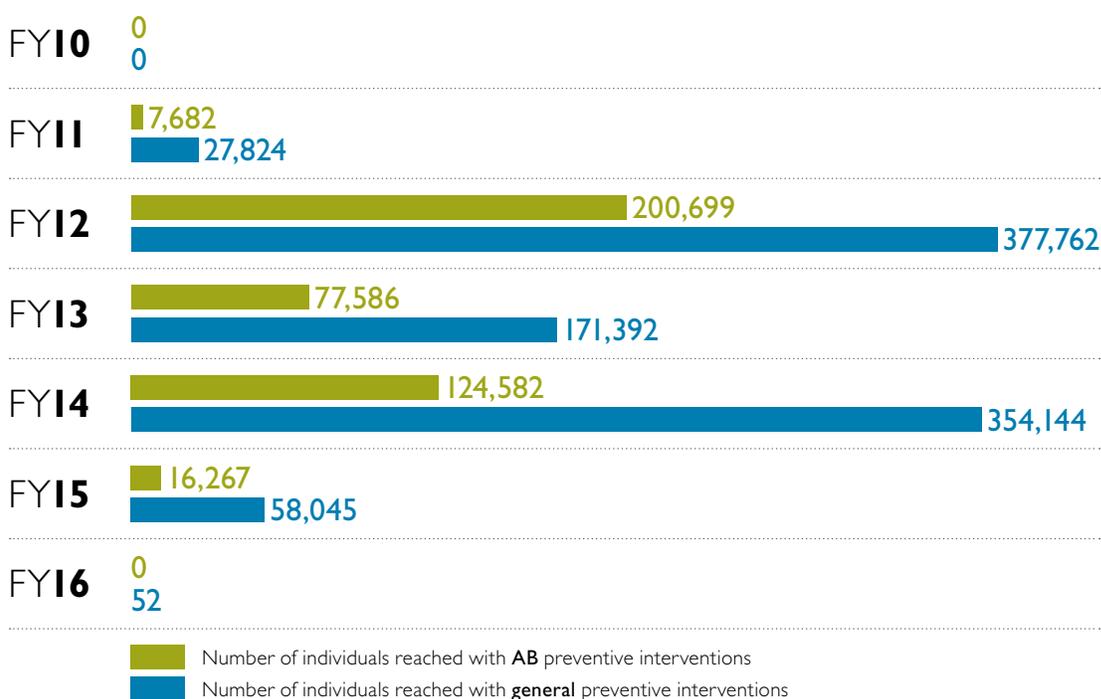
- **Community Change:** STEPS OVC trained 5,822 individuals to provide this small-group level intervention targeting the general community to address sociocultural practices and traditions.
- **Stigma Interventions [Channels of Hope and the AIDS Alliance Stigma Toolkit]:** 5,248 caregivers, staff, and other individuals were trained in small-group interventions that targeted community and religious leaders to identify and address stigma in their localities.
- **Household Dialogues:** STEPS OVC trained 6,307 CCs to conduct an individual-level intervention on HIV prevention with their clients. Household dialogues were targeted at Basic Care & Support (BCS) clients, but were also made available to other vulnerable populations.
- **Alcohol and Drug Abuse Intervention:** STEPS OVC trained 988 CCs in this small-group intervention targeting youth aged 15-24 and other vulnerable populations to reduce HIV sexual transmission by educating them about the dangers of alcohol and drug abuse.

STEPS OVC had Abstinence and *Be faithful* (AB) target of 160,448 people. However, STEPS OVC reached 345,767 people or 215% of the target with packages focused on AB. STEPS OVC used three evidence-based prevention interventions focused on AB, detailed below.

¹Community Care Groups are the established Volunteers groupings to which the CCs are affiliated and are supervised

- **Safe from Harm:** STEPS OVC trained 2,601 CCs to provide this small-group intervention aimed at reducing HIV sexual transmission in youth aged 14-19 years and building parent-child communication skills about sexuality among parents/guardians. STEPS OVC reached 45,254 people with this intervention.
- **Life Skills:** STEPS OVC trained 3,047 CCs to provide this small-group intervention targeting youth aged 10-24 years. The aim of this intervention was to develop knowledge, attitudes, and skills needed to take positive actions on social and health issues. STEPS OVC adapted the RAPIDS Life Skills Manual, and partners were encouraged to run refresher courses. STEPS OVC reached 164,787 youth aged 15-24 years with life skills-training messages.
- **Faithful House:** STEPS OVC trained 438 couples' facilitators in this small-group intervention targeting married and engaged couples. The intervention encouraged discussion on HIV prevention, faithfulness, HIV infection within a marriage, and the general challenges of HIV that families face.

FIGURE I | Number of individuals reached by prevention interventions by year since project inception

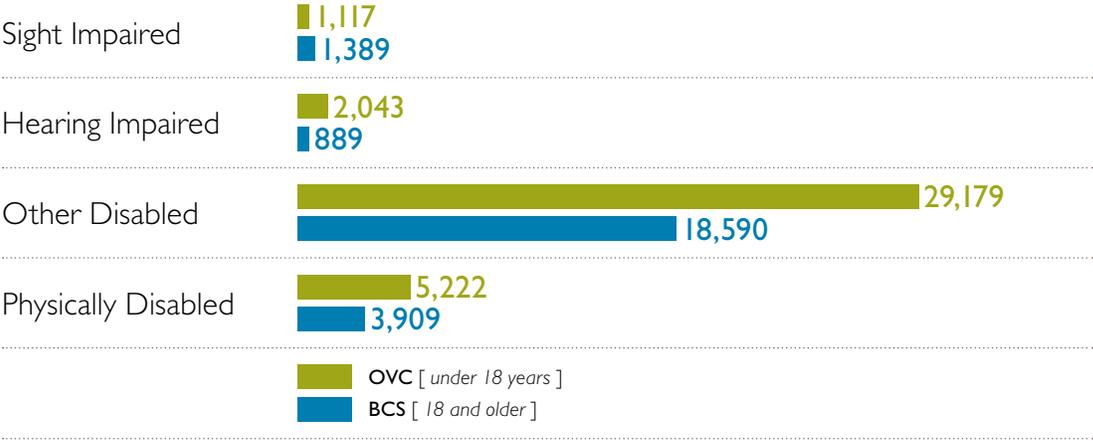


As illustrated in Figure I, achievement in FY13 dropped largely because the program was slated to close at the end of that financial year. A cost-extension was granted and numbers improved in FY14. FY15 has very low numbers because the grant drastically scaled down operations to prepare for close out. Additionally, the USAID grant was no longer funding community prevention interventions

STEPS OVC received and distributed gifts-in-kind [GIK] to sub-grantees and then to beneficiaries (see Appendix 3). Overall, STEPS OVC distributed 19,204 CC kits; 103,002 assorted toys from Hasbro; 155,741 pairs of shoes from private donors through World Vision; and 944,003 assorted t-shirts, blouses, Trousers, jeans, girls' tops, and dresses.

STEPS OVC is cognizant of the relationship between HIV and AIDS and disability. 47,769 (29,179) of the OVC beneficiaries and 18,590 of the BCS clients registered under STEPS OVC had a disability (see Figure 2). Two STEPS OVC sub-grantees specifically supported program beneficiaries with disabilities within their geographical areas.

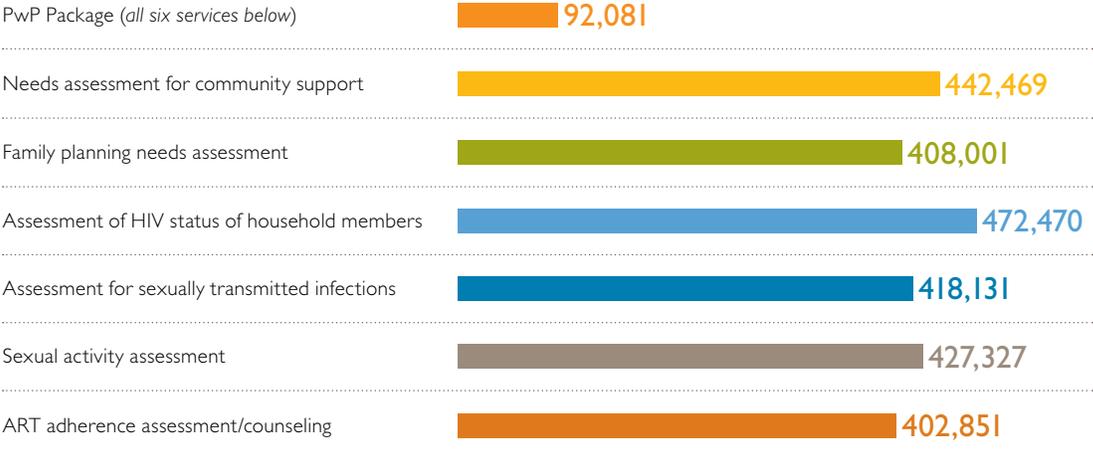
FIGURE 2 | Number of beneficiaries with disabilities, by type of disability



1.1.2 Result 1.2: Access ensured for PLWHIV, from infants to elders and at all stages of infection to a continuum of high quality care and support services

STEPS OVC enrolled 99,103 HIV-positive adults and 25,964 HIV-positive children [<18 years]. The program trained virtually all 44,019 CCs to provide BCS services to these clients. STEPS OVC supported PLHIV to a) achieve and maintain undetectable viral loads, b) educate PLWHA in prevention options, and c) build CC’s communication and counseling skills through PwP interventions. CCs provided antiretroviral therapy [ART] adherence support to 118,220 individuals, including adherence monitoring and counseling. CCs also assessed emerging ART drug resistance for these clients with a simple set of indicators, including decreases in body mass index (BMI), MUAC for

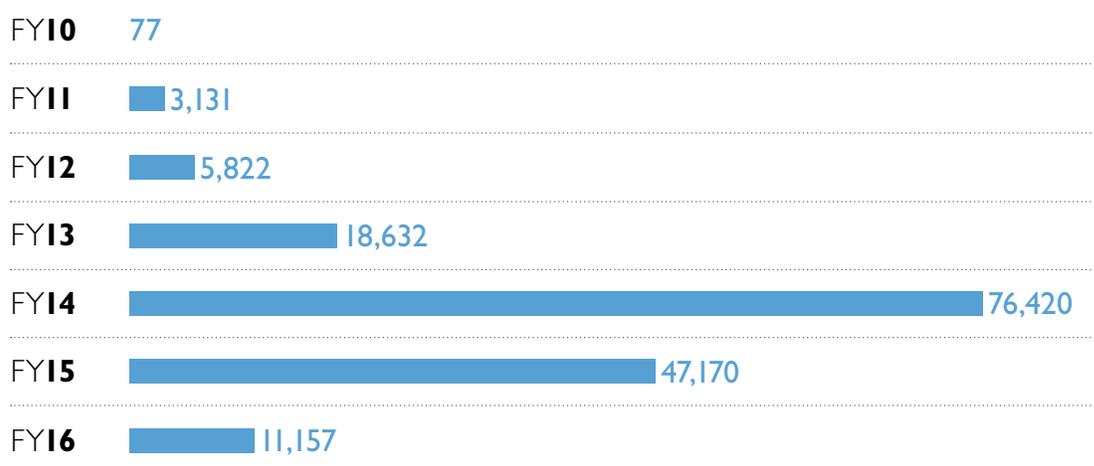
FIGURE 3 | Number of individuals provided with PwP services



adults, emerging symptoms of potential infection, clients self-reporting missing ART doses, and a spot check on the presence of ART in the home. At every visit, CCs would discuss CT, STI management, and family planning for the entire family; make referrals for PMTCT as necessary; give advice on alcohol and other substance abuse; and provide condoms from the DHMT. During the life of the grant, CCs reached 92,081 PLHIV with PwP interventions. Figure 3 shows the different PwP services provided:

Furthermore, the Household Dialogues prevention approach developed by STEPS OVC and ZPI enhanced the CCs capacity to provide PwP information to their clients either in their home or in any other setting. The Household Dialogues training modules, intended to build CCs' skills in the six core PwP areas developed with stakeholder input, underwent multiple revisions and were used to train master trainer of trainers [MToTs] in July 2011. MToTs then trained trainers of trainers (ToTs) and by the close of FY11, ToTs started training CCs. By the end of the project, STEPS OVC had trained 6,307 CCs in Household Dialogues, contributing to the achievements in this area. As shown in Figure 4, half of all PwP [51%] numbers reached in FY14 were largely due to the intensified CC training during this period.

FIGURE 4 | Number of individuals reached through PwP interventions by FY



STEPS OVC was represented on the Ministry of Health's [MOH] task team on prevention with positives [PwP] by the Prevention and Basic Care and Support [BCS] technical advisors. The task team looked at how prevention messages could be enhanced among those already infected.

1.1.3 Result 1.3: Improved resiliency against HIV and AIDS among HIV negative individuals and families at risk

STEPS OVC reached 630,248 individuals (Target 442,590) [142% of the target] with HIV and AIDS counseling and testing [CT] services. STEPS OVC provided testing kits from the GRZ to CCs who conducted static (9,413), mobile (248,666), and household CT (372,169). In all, 2,265 CCs were trained to provide CT through finger prick technology through additional technical support from health workers. Most partners observed that communities accepted house-to-house CT as an alternative to facility-based CT. The house-to-house testing method yielded higher testing numbers because the target beneficiaries regarded it as more confidential since nobody outside the household would be informed of the test result. Additionally, all household members could be tested simultaneously.

Lay counselors transitioned from previous projects were trained and contributed to reaching targets. To guide implementation, STEPS OVC developed a CT Strategy in collaboration with the MOH. The strategy focused on house-to-house testing, in line with the MOH's work plan, and focused on both BCS and OVC household members. For cost-efficiency and quality monitoring purposes, partners selected specific districts for initial CT scale-up activities and expanded into additional districts throughout the project. Routinely, STEPS OVC shared its program targets with other stakeholders to ensure that targets were included in the national forecast.

1.2 SO2: Strengthen the continuum of effective, efficient and sustainable HIV prevention, care and support

1.2.1 Result 2.1: Improved integration of HIV-related prevention, care, and support services

To enhance the quality of data collected within the project, STEPS OVC underwent a series of USAID/Zambia-led data quality assessments (DQA); the project immediately acted on the recommendations that came out of these DQAs. Responding to the need to enhance and encourage data demand and use among partners, the project trained 69 staff in data demand and use (DDU) and conducted data review workshops with all partner staff.

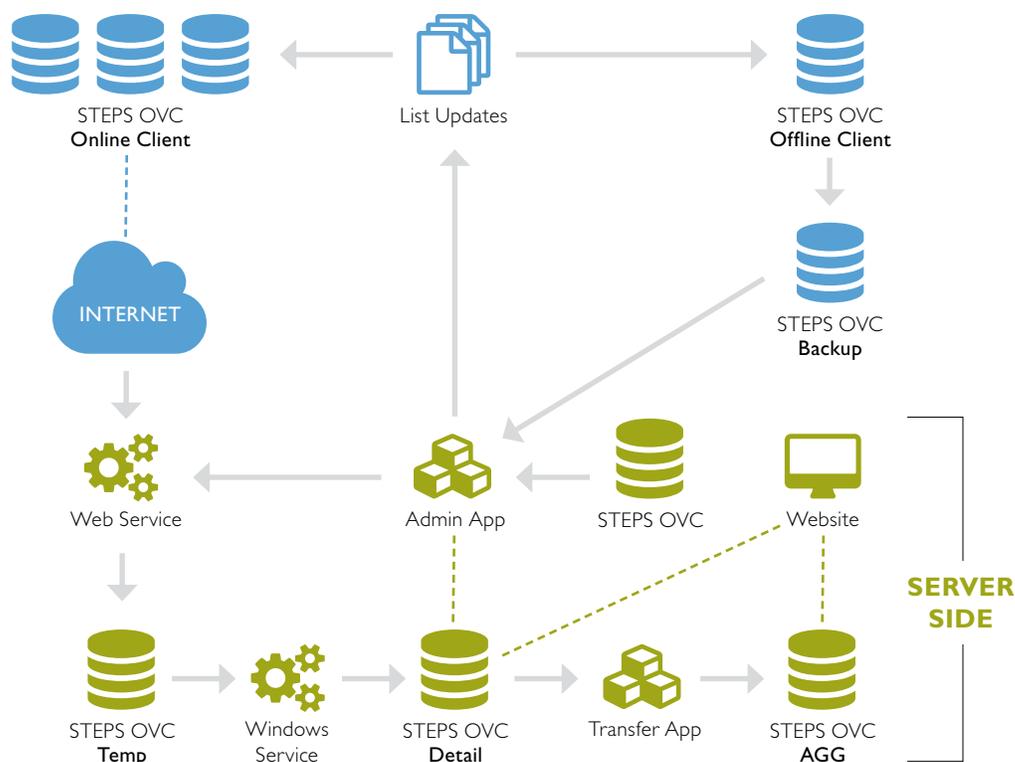
In partnership with key stakeholders, the project developed a community-based prevention information system (CoPIS) that allowed CCs and local partners to monitor, track, and report on services and their outputs. In total, 8,691 CCs and peer educators, CCCs, CATFs, and NHCs were trained in community-based monitoring and data use. The information contained in COPIS supported both planning and resource-allocation decisions at the community level as well as by clinics, the DHMT, and DATF. Data was also used to fulfill reporting obligations and advocacy. This database has since been handed over to USAID for use by other OVC projects.

The focus groups provided insight on DDU at the community level. Results indicated that while community caregivers understood the importance of their role in data collection, they were not sure how the data was used to improve the program or how it could be used at the community level to improve CCs' ability to monitor care group performance.

These discussions also made it apparent that project beneficiaries and community members were unsure why the project collected the array of data it did and how this data was used to improve the program. It was deemed critically important to improve caregivers' CCs' ability to use information at the community level and equip them with the skills to explain to beneficiaries when and why data is collected.

As a result of this exercise, STEPS OVC designed a routine community report, which was incorporated into the project management information system.

DIAGRAM I | STEPS OVC COPIS Database Workflow

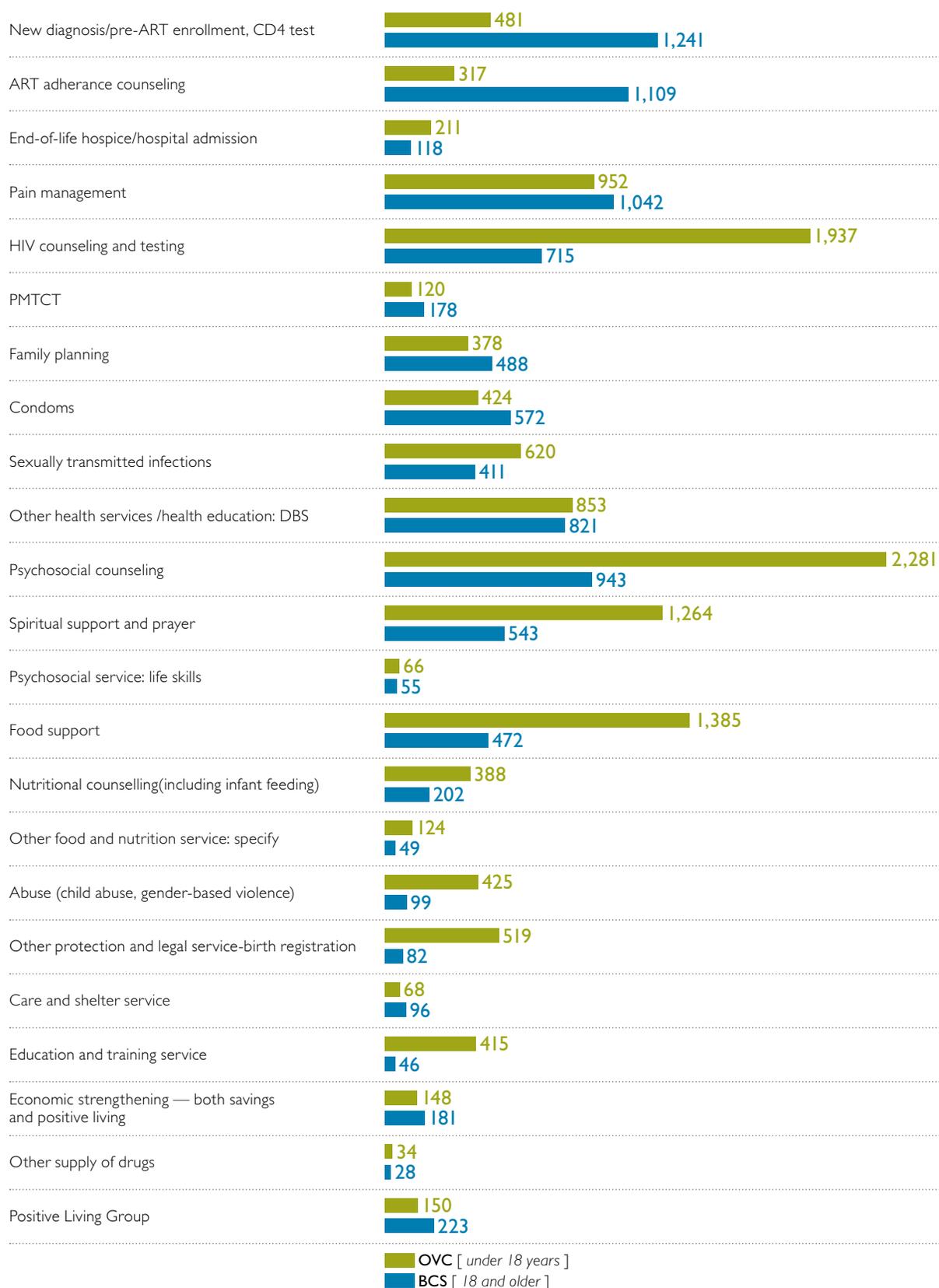


Understanding the needs of a population is critical to ensuring impact. STEPS OVC was committed to evidence-based programming and so carried out an extensive baseline survey of individuals who would benefit from the project. This data was informed project planning in the second year and catalyzed a series of programmatic changes. Three years later, when outcomes were measured again considerable improvements in beneficiary well-being were documented. The aforementioned process highlights the importance of 1) understanding what information is needed to guide programming, 2) appropriately collecting and analyzing high quality information, and 3) using that information to make programming decisions.

1.2.2 Result 2.2: Improved referrals and linkages between home, community and facility

For services not provided directly under the project, STEPS OVC CCs provided referrals. While there were challenges, STEPS OVC saw the improvement of tracking referrals through repeated CC trainings and printing referral forms. The use of referral forms helped improve tracking because the form had a feedback section added for service providers to fill in and send back to the initiating CC. There were still some challenges accompanying the referral forms as not all service providers would send back the form in order to complete the two-way feedback process. The project also explored the idea of using mobile phones to track referrals. This idea was implemented in the Chongwe district and showed that tracking referrals through mobile technology is a promising idea, but needs further testing and evaluation. Examples of services referred were ART and male circumcision. In total, 23,274 individuals were reported as referred under the project (see Figure 5). The fact that 40,886 of the 44,419 of CCs were registered with health facilities supports the use of health referrals.

FIGURE 5 | Number of individuals referred by type of service



Issues related to coordination, linkages, and inefficient stove pipe implementation at the community level result in the loss of clients between services, non-adherence to ART, and late presentation to health sites. STEPS OVC aimed to improve integration between services, referral systems to retain clients in a continuum of care, and coordination between service providers at community, district, and national levels. Preliminary assessments and experiences demonstrated that key gaps existed in the community based monitoring and evaluation systems. Notably, STEPS OVC was concerned about the lack of an effective and efficient mechanism for supporting the 44,419 trained CCs as they undertook their work. To address this, STEPS OVC piloted a mobile health solution to support 150 CCs to track referred clients as well as support health facilities to reduce loss to follow-up of individuals on ART.

STEPS OVC worked with the MOH BCS/CTC Officer to ensure that BCS trainers were involved in the training and monitoring of CCs. This not only ensured that CCs received certified training from MOH to reach STEPS OVC goals, but also that they supported the MOH in rolling out the MOH Minimum Standards for BCS throughout the country.

1.2.3 Result 2.3: Increased engagement with GRZ structures and efforts from district up to national level

STEPS OVC prioritized working with GRZ structures, particularly at the district level, and worked closely with the District Development Coordinating Committee (DDCC) in most districts. A key DDCC function relevant to the implementation of the grant is ensuring district level coordination of STEPS OVC partners avoid duplication and leverage comparative strengths. During regular meetings, district level implementers shared their achievements, lessons learned, and best practices to inform revisions for future implementation.

At the national level, STEPS OVC supported NAC reporting by providing input for the joint annual program review (JAPR) 2010. STEPS OVC provided technical support to review the progress achieved in responding to the HIV and AIDS pandemic at the national level. The review revealed positive progress in reducing HIV infections (from 16% to 13%). However, because HIV and AIDS mitigation and support services for OVC, youth, and PLWHA were determined to be inadequate, STEPS OVC sat on the National Palliative Care Technical Working Group (TWG) under the leadership of the MOH. A key part of this TWG's scope of work was the development of indicators for quality palliative care. STEPS OVC also participated in a number of technical meetings at the national level throughout the six years of the program, including the NAC prevention theme group, the NAC communication and advocacy strategy development task team, the national alcohol policy task team and the NAC M&E TWG.

In contribution to the GRZ Three Ones principles, specifically one national M&E system, STEPS OVC submitted 116 National AIDS Reporting Forms [NARF] to the respective DATF. STEPS OVC monitors submissions of the NARF by requiring partners to submit copies with their quarterly reports to the PMU. Similarly, STEPS OVC participated in at least 10 NAC M&E TWGs.

I.3 SO3: Improved efficiency, sustainability and Zambian leadership of HIV and AIDS related services including engagement with the private sector

I.3.1 Result 3.1: Replicated and scaled up effective new models [innovations] for economic strengthening.

STEPS OVC awarded sub-grants for program implementation. In total, 380 CBOs, FBOs, and NGOs were awarded three tiers of grants ranging from less than \$10,000 to \$300,000. Of these sub-grantees, STEPS OVC provided 65% with organizational capacity building as a means of ensuring sustainability of care. World Vision carried out the rest of the capacity building.

The STEPS OVC PMU drafted indicators of technical sustainability, which were captured by the organization capacity self-assessment (OSA) tool to measure the degree to which sub-grantees have the technical capacity to continue quality OVC, BCS, CT and prevention activities beyond the lifetime of STEPS OVC. The OSA tool assessed seven key capacity areas consisting of 17 questions/ discussion points. The highest score possible for OSA was 68. The following were main capacity areas assessed using the OSA tool:

- Organizational Purpose and Planning
- Organizational Structure and Procedure
- Group Dynamics
- Monitoring, Evaluation and Reporting
- Financial Management
- Resource Mobilization
- External Relations

Assessments were conducted in FY13 and FY14 (this area was eliminated by USAID after FY14) and results indicated improvements over time (see Figure 6).

Through its Economic Strengthening (ES) strategy, STEPS OVC reached 517,851 beneficiaries with ES services in an estimated 34,341 households (see Figure 7). In support of this, the project trained 25,141 individuals from STEPS OVC beneficiary households to support a national roll out of community savings groups, value chain analysis, and business training models.

FIGURE 6 | Summary Findings from OSA tool : Comparison of **First** and **Second Round** OSA Results by Partners

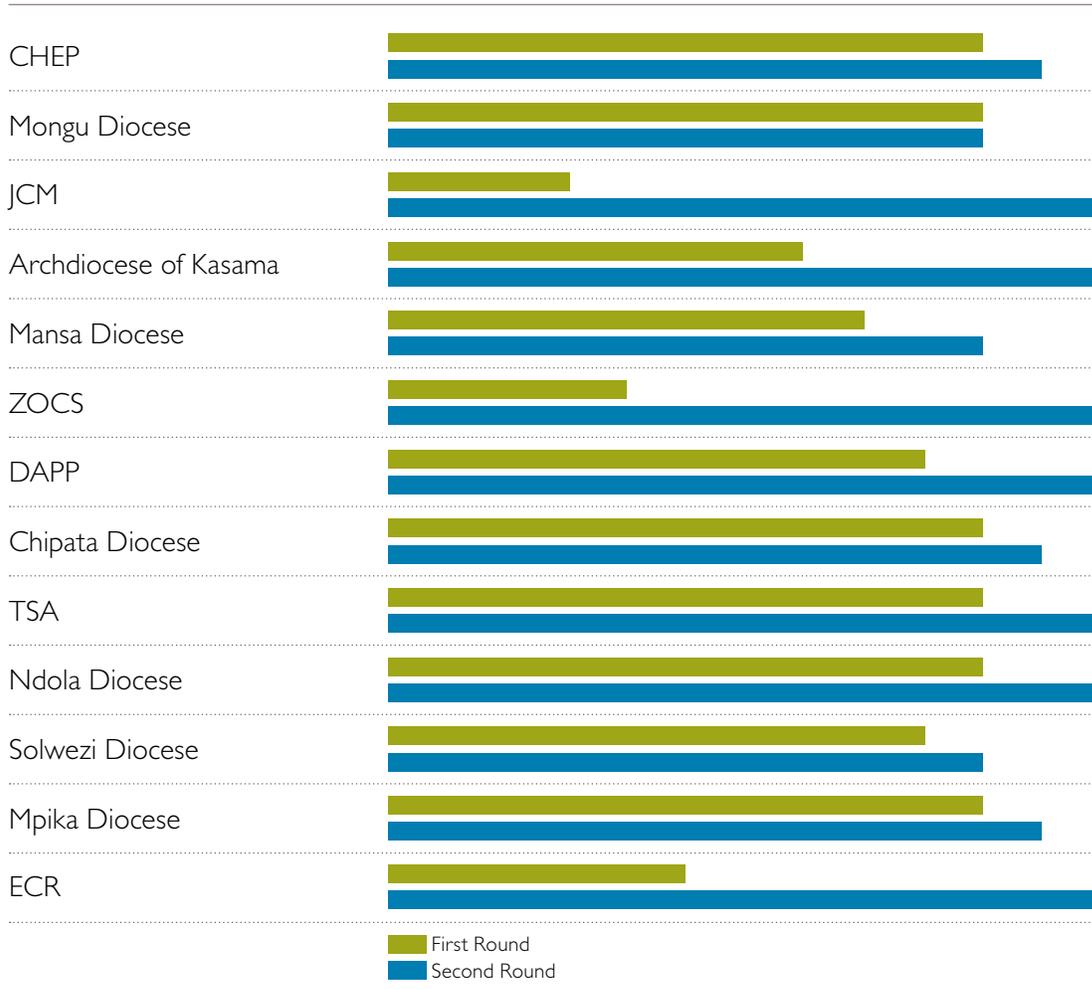
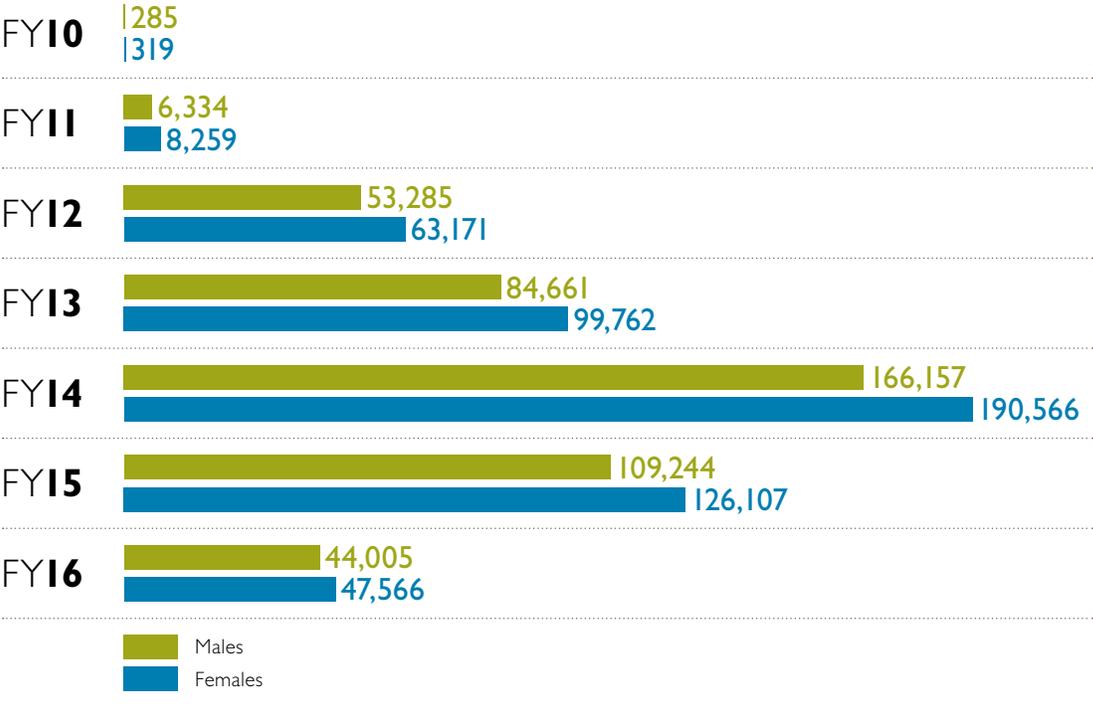


FIGURE 7 | Number of individuals reached through economic strengthening by sex and year



The project implemented a number of ES activities, including savings and internal lending communities (SILCs) and agricultural and vocational training. Select partners also implemented a backyard gardening intervention.

SILC, a community-based savings group model, rolled out in 2011. By March 31st, 2016, membership in 2,290 groups reached 42,445. Overall 83.8% (35,560) of participants were women. Cumulative savings reached US\$ 1,091,736.63 and loans were valued at US\$ 1,071,340.58

Other details related to SILC include:

- 33% of SILC members received Savings groups Performance Management (SPM) service to help them better utilize SILC loans and manage their businesses.
- 9 out of the 13 partners integrated gender in SILC group meetings using the “Journeys of Transformation” training manual developed by CARE International and Promundo NGO.
- 31 field agents were linked to the Zambia Centre for Communication Program (ZCCP) and were oriented in GBV prevention to support GBV reporting to appropriate institutions. As a result, a total of 265 SILC groups were sensitized and 48 cases reported to One Stop GBV centers.

One major achievement of the project’s Agriculture Strategy was the collaboration with the Ministry of Agriculture and Livestock (MAL) and Sylva Food Solutions Limited for vegetable processing, which led to the following achievements:

- The Lusaka and Southern Hubs rolled out the Agriculture Strategy, which focused on linking clients to information, extension, support, and markets to district stakeholders (public, private and sub-grantees).
- Total trained in vegetable gardening – 5,697
- Total trained in vegetable processing – 3,283
- Total trained in small livestock – 3,699
- Total linked to support services - 2,415

The World Vision Gift Catalog distribution of items to households (which included goats, vegetable seeds and garden tools, and fruit trees) enhanced the implementation of the Agriculture Strategy. The purpose of the Gift Catalog was to increase the nutritional status and income levels in OVC households. STEPS OVC developed implementation guides together with partners including the Ministry of Agriculture and Livestock. These guidelines were for the goat, vegetable seed, garden tools, and fruit trees distribution. Details on the number of supported OVC households are noted in Tables 2, 3, and 4. The adoption of the “pass on” mechanism for goat distributions funded by the Gift Catalog (i.e. 3 female kids to be passed on) ensures that many more OVC households will benefit beyond the life of the project.

TABLE 2 | Number of OVC Households supported with **vegetable seed/garden tools**

	# OF OVC HOUSEHOLDS SUPPORTED FY14	# OF OVC HOUSEHOLDS SUPPORTED FY15	TOTAL # OF OVC HOUSEHOLDS SUPPORTED
ACHIEVED	4,530	2,065	6,595
TARGET	5,324	1,000	6,324

TABLE 3 | Number of OVC Households supported with **fruit trees**

	# OF OVC HOUSEHOLDS SUPPORTED FY14	# OF OVC HOUSEHOLDS SUPPORTED FY15	TOTAL # OF OVC HOUSEHOLDS SUPPORTED
ACHIEVED	0	8,452	8,452
TARGET	0	5,475	5,475

TABLE 4 | Number of OVC Households supported with **goats**

	# OF OVC HOUSEHOLDS SUPPORTED FY14	# OF OVC HOUSEHOLDS SUPPORTED FY15	TOTAL # OF OVC HOUSEHOLDS SUPPORTED	TOTAL # OF GOATS DISTRIBUTED
ACHIEVED	1,612	1,897	3,509	10,605
TARGET	2,000	2,000	4,000	12,000

1.3.2 Result 3.2: Replicated and scaled-up emerging lessons and practices [program learning]

In the first three years of the grant, three regional Transition Hub (THs) offices were established in order to bring implementation closer to the ground; increase and document innovation; and provide coaching, capacity building, and support for local implementing partners, sub-grantees, and GRZ staff. The TH staff's main responsibility was to ensure sustainable transition and integration by building the capacity of sub-granted CBOs, FBOs, and NGOs as well as encouraging partnerships between the government and private sector. Southern TH staff mapped HIV prevention care, support services, and resources in the southern region (Mazabuka, Monze, Choma, Livingstone, Kalomo, Namwala, Kaoma, Senanga, Siavonga and Mongu districts). The other two THs were responsible for mapping Lusaka and the Eastern Provinces (Lusaka hub) and Copperbelt, Luapula, and North-Western provinces (Kitwe hub). Transition Hubs supported partners' processes of identifying stakeholders, systems, and resources that contributed to the identification and documentation of innovation, scale-up, and program handover. THs trained partners, caregivers, sub grantees, and DATF members in program technical strategies and organizational capacity areas. This included the PMP, Child Status Index, compliance and financial management, and organizational self-assessments. Partnerships and networking were initiated and established with government departments and ministries at district and provincial levels (DATF/DAC, PATF/PACA, DPO, PPO, DSS, and DMO) through TH staff. The effective and efficient coordination of key GRZ and NGO/CBO staff was limited at the beginning of the project so STEPS OVC built capacity in each geographical area to promote sustainability. Future programs should ensure technical and administrative coordination with the government by including technical representation at the provincial level (at least).

1.3.3 Result 3.3: Improved Private and Public Sector engagement

STEPS OVC's P3 strategy, which outlined the project's objectives and management approaches for private sector and GRZ collaboration, was integrated within the STEPS OVC's economic strengthening strategy to create synergies for microenterprise and microfinance development. The project rolled out savings and investment groups through development of microenterprise agents. Further, with the support from the GDA COMMETS project, which had been working with the major 16 private companies in Zambia, STEPS OVC was able to initiate discussion surrounding partnership with First Quantum Minerals in the Solwezi Musele area.

Details of notable achievements under the P3 include:

- 238 youth were trained in various skills by the Hotel and Catering Association of Zambia (HCAZ) member organizations and others.
- 411 youth were trained in job preparedness. This included résumé writing and job interviewing skills.
- G4S Security Firm donated an industrial cooker to the Needs Care Primary School in Ngombe, which supports OVC. The cooker alleviated cooking challenges that the school had experienced and helped generate income through bread production.
- Mikalile Trading Limited provided financial support to purchase school requisites for 50+ OVC.
- Barclays Bank Zambia Limited carried out financial literacy training for close to 200 people across STEPS OVC partners.

- STEPS OVC initiated and coordinated support from CitiBank Zambia on the CitiBank Global Community Day in World Vision's Kapululwe ADP at the Mwachilele clinic. The clinic was supported with painting, furniture, a fridge, construction of benches, and the installation of a solar panel.
- Ndola Diocese received the Maheu Drink from SabMiller and distributed it to 3,000 beneficiaries (OVC and PLWHA).
- Under DAPP in Chongwe, Stanbic Bank built a modern school for 220 OVC at the site of the Lumuno Community School.

Furthermore, STEPS OVC worked with the GRZ and NGO/CBO partners on two sector-wide programs: the Shelter Initiative and the Zambia Natural Fiber Forum. Both programs built sector-wide networks to better leverage affordable housing, skills training, and economic strengthening activities for target groups. STEPS OVC explored several sub-grant relationships within the Shelter Initiative in order to provide technical assistance to grassroots groups. One relationship was with the Copperbelt University's School of the Built Environment and the other was with the Civic Forum for Housing and Habitat (CFHH), a Swedish Cooperative Centre-funded umbrella group representing CBOS with more than 35,000 vulnerable poor members. Through the CFHH sub grant, STEPS OVC implemented prevention activities and training for community caregivers in CFHH member organizations and CFHH-developed training and alternative shelter approaches for STEPS OVCs CC and sub-grantee network. STEPS OVC program partners adopted a sustainability and transition strategy in January 2011, guiding all of the program's implementation mechanisms. This was further elaborated upon through sub-granting agreements, MOUs, and the development of relationships with GRZ Ministries. Owing to the wide range of program interventions, STEPS OVC and ZPI systematized relationships with key Ministries including Health; Education; Community Development Mother and Child Health; Youth, Sport and Child Development; Commerce and Industry; Agriculture; Forestry; Local Government and Housing; Labor and Public Works; and Finance and Planning.

MALARIA PROGRAMMING

STEPS OVC received funding from PMI and DFID (at the time) through USAID for the distribution of Long Lasting insecticidal Nets (LLINs) in Luapula and parts of Eastern and Western provinces. This was done in two phases, as described below.

Phase I: Luapula and Parts of Eastern Province

STEPS OVC partnered with the National Malaria Control Centre (NMCC) at the MOH in planning the distribution campaign and organizing the District Malaria Task Forces (DMTF). Based on malaria prevalence, it was jointly determined that the Luapula Province and two districts in Eastern Province (approximately 1.8 million people) should be prioritized for LLINs distribution. Two key distribution strategies were adopted:

1. "Door-to-door" distribution, meaning LLINs would be delivered directly to each household rather than passed out at a community distribution event. This approach had not been tested at scale in Zambia but the MOH felt it was the best way to increase ownership and utilization.
2. A "bed space" LLIN distribution approach, meaning that each household should receive enough LLINs to cover all bed spaces.

World Vision's ability to mobilize community volunteers through the STEPS OVC program was integral to the success of this intensive approach. World Vision worked with the DMTFs to mobilize and train STEPS OVC volunteers at the district level in malaria basics, behavior change communication, registration, and distribution exercises.

Information, education, and communication (IEC) materials were developed with the NMCC IEC Technical Working Group and printing costs were met through the USAID-funded Community Support for Health (CSP) program. This level of collaboration and partnership guaranteed standardized messages, avoided duplication of efforts, and ensured cost-efficiency.

Implementation and Follow Up in Luapula Province

Before launching the project and distributing LLINs, each DMTF conducted a registration of bed spaces to quantify the exact number of LLINs needed in each household and community. Validation of the data was conducted in partnership with local leaders, World Vision staff, and community volunteers to ensure that there were no missed households and the number of nets needed for each household was accurate. This was important as district census data underrepresented the number of individuals living in each household, as well as the number of bed spaces. During the door-to-door registration of households, volunteers shared malaria messaging with households, and village leaders promoted the upcoming campaign in community fora.

Traditional leaders were engaged throughout the intervention by working closely with the volunteers distributing the nets, ensuring transparency in the distribution, and providing an entrée for volunteers to the households, so that they could hang the nets and discuss appropriate usage. Traditional leaders identified appropriate repercussions for misuse of nets and reinforced this messaging during and after distribution. By the end of the distribution in June 2011, 844,162 nets were distributed in seven districts of Luapula province.

Following the distribution, community leaders and volunteers were trained in how to use a monitoring tool that allows the clinic and district to identify households not using nets appropriately. Other partners continued to emphasize malaria prevention and treatment through local advertisements, community events, health worker household visits, and STEPS OVC community programming work.

The distribution in Luapula Province was extremely successful. The Principal Long Lasting Insecticidal Net (LLINs) Officer at the National Malaria Control Program explained that it was "... the best distribution that has ever been done in Zambia" and that there was "so much efficiency and coordination amongst all the involved stakeholders."

Phase 2: Western Province

During this phase, STEPS OVC partnered with the MOH to distribute 738,366 PMI/DFID supported LLINs in all 16 districts of Western Province.

The approach for distribution was centered on the theme of universal coverage, which targeted all sleeping spaces in households by using a door-to-door hanging of LLINs. To achieve this, community involvement was required for the program to succeed and therefore the following events/steps were undertaken:

1.0 Malaria stakeholder meetings

Discussions were held with malaria stakeholders, including donors, the Ministry of Health, partners (e.g., CHAZ, SFH, CSH, and Government Stores), and district partners such as the Malaria Task Forces.

The purpose of these meetings was mainly for planning and agreeing on the approach for LLIN distribution. During these meetings, the MOH also shared epidemiological data on why the Western province was a target area for this intervention. This was because the 2012 Malaria Indicator Survey showed that the province had recorded the highest malaria incidences and levels of LLINs had decreased since the last mass distribution was done in 2006.

It was also important to learn from other partners who had experience with LLIN distribution in the Western province. At the time of this planning stage, CHAZ had already collected data for LLIN distribution in some parts of the province like the Lukulu district. Figures were shared but STEPS OVC felt there was a need to restart the process since the numbers were lower than those projected using the sleeping spaces formula ($\text{pop}/1.8 + 10\% \text{ buffer}$).

Since the Western Province has very strong community leadership structures, the project resolved to involve the community from the planning stage. The Barotse Royal Establishment was invited to meet during the Malaria Task Force orientation in each district. Therefore, commitments were pledged to address the concerns on LLIN abuse like in fishing. Some of the resolutions put in place include appointing committees to monitor bad fishing gears, extensive health education, and fines.

Trainings

Door-to-door distribution of LLINs cannot succeed without the involvement of the beneficiaries and the Health Centre staffs. Therefore, one-day trainings were conducted in all the districts targeting community representatives' Health Centre Advisory Committee Chairpersons (NHCs leaders), and Health Centre staffs.

Trainings focused on how to conduct door-to-door LLIN distribution by targeting the sleeping spaces in every household. Key for the approach was limiting the number of households each community volunteer covers during data collection, malaria messaging, and hanging of LLINs. During the orientation, the project's guidelines stipulated that one community volunteer would only be assigned 25 households. Furthermore, project implementers stressed the issue of coverage and usage in order to achieve the reduction of malaria incidence.

At the end of the training, each district gave its own timeline regarding when they would finish data collection and forward it to the district for aggregation. This was done in order to determine the number of LLINs each community would need. Individual community accessibility mainly determined the period for data collection. Data collectors (LLIN distributors) were also tasked with sharing malaria messages during data collection and LLIN hanging as well as after net distribution.

Data verification

To ascertain the actual number of LLINs needed by each community, a data verification process was completed at each level of data aggregation, i.e. HC, District, and Provincial/National by STEPS OVC malaria staff and relevant

government stakeholders. The correlations of figures between population, households, and sleeping spaces was also analyzed, helping confirm the actual number of volunteers involved in the exercise and determine the exercise's workload.

Transportation and storage of nets

Four hubs were established—Lusaka, Kaoma, Mongu, and Senanga—to facilitate storage of nets. The John Snow Inc (JSI) contracted a transporter who ferried nets from the port in Beira to Lusaka and then to Kaoma, Mongu, Senanga, and Sesheke according to the planned figures. The four hubs kept nets as follows: The Kaoma hub (Lukulu and Kaoma districts), Mongu hub (Kalabo and Mongu districts), Senanga hub (Shangombo and Senanga districts), Sesheke hub (Mulobezi and Sesheke districts) and Lusaka hubs. The hubs held nets for all districts so top-ups could meet the required quantities. The World Vision trucks then transported nets from the Lusaka hub to all districts in order to meet the required quantities after data capturing.

TABLE 5 | Actual number of LLINs distributed per district

DISTRICT	POPULATION	# OF HOUSEHOLDS	# OF SLEEPING PLACES	# OF VOLUNTEERS	TOTAL NETS DISTRIBUTED
1 Kaoma	271,979	56,226	144,587	2,330	144,587
2 Lukulu	130,754	27,767	78,832	1,118	78,832
3 Senanga	185,252	41,660	107,872	1,668	107,872
4 Sesheke	139,156	29,359	82,043	1,185	82,043
5 Shangombo	138,674	30,932	77,817	1,118	55,450
6 Mongu	268,776	68,473	168,204	2,739	168,204
7 Kalabo	175,990	57,842	101,378	1,617	101,378
Total	1,310,581	309,259	760,733	11,775	738,366

Lessons learned

1. The MOH must provide leadership.

The MOH directives to the district level ensured that district staff worked closely with World Vision from the beginning of the project. The districts allowed the LLINs to be stored in government warehouses and for the use of government vehicles for distributions. District staffs were able to mobilize local leaders and provide ongoing supervision. Without this critical leadership, the LLIN distribution would not have been as successful as it was in Luapula province. Taking the time to ensure these links are in place is absolutely essential for any large-scale bed net distribution project.

2. Adopt a Door-to-Door approach.

The “door-to-door” approach, while time-consuming and costly, was tremendously successful in ensuring each household had the right number of LLINs and that each LLIN was hung immediately upon receipt. However, this approach relies upon a longstanding and comprehensive community-based network of volunteers and staff. Working through community-based organizations is a recommended best practice for successful door-to-door bed net distribution. In areas where there are weaker community networks, a door-to-door distribution strategy may not be feasible.

3. Stagger LLIN shipments.

The LLINs were ordered in bulk, which led to unforeseen warehousing costs and logistical complications. Future malaria programmers should consider ordering LLINs in a staggered manner and matching the timetable for distribution. This will reduce transportation and warehousing challenges.

4. Engage the community.

The involvement of local leaders, government staff and community volunteers was essential to successful distribution, particularly to ensure full coverage at the household level. The remoteness of certain communities would have made distribution impossible had it not been for the ingenuity and resources of community stakeholders. By using creative local transportation such as boats, motorbikes, and wheelbarrows, no house was left without bed nets.

5. Ensure health center commitment.

The district health centers and health partners in the district covered nearly all storage and distribution costs. Also, health centers provided warehouse space, vehicles, fuel, and a significant amount of volunteer time. When considering LLIN distribution, it is worthwhile to work closely with health centers to take advantage of their resources and enthusiasm to prevent malaria in their districts.

6. Consider equipment to hang nets in distributions.

In addition to LLINs, households need nails and ropes to hang the LLINs. These supplies were an unforeseen cost, and materials had to be procured locally. In the future, distributors might explore procuring and packaging LLINs and equipment to hang the nets together.

7. Community caregivers are a crucial resource.

Volunteer caregivers have a large role to play not only in large, community-based projects, but also in one-off distribution campaigns and other activities. Utilizing critical community resources continues to be one of the most effective ways to reach the most vulnerable households with public health messaging and resources for the prevention of infection and promotion of well-being.

FINAL EVALUATION: KEY STEPS OVC END-LINE EVALUATION SURVEY FINDINGS

Orphans and Vulnerable Children (OVC)

Food security

Children surveyed at end-line were more food secure, with one-quarter reporting going a whole day and night without eating in the last four weeks compared to one-third at baseline. Improvements were seen across food security indicators, showing reductions in children reporting going to bed hungry (from 58% to 51%), and eating smaller (from 68% to 63%) or fewer meals than needed (from 73% to 69%).

Violence

At the start of STEPS OVC, half of children had reported physical violence in the previous six months. Over the intervention period, children's reports of violence dropped to 21%, or one in five. Additionally, the proportion of children reporting abuse who indicated they sought help increased from 34% at baseline to 39% at end-line.

HIV/AIDS knowledge, attitudes, and behavior

HIV/AIDS knowledge among children was fairly high (over 75% responding correctly) at baseline and end-line across the following indicators: having heard of HIV/AIDS, knowing HIV can be transmitted by shared needles, and knowing abstinence reduces HIV risk. Knowledge across the following indicators was lower (50%-75% responding correctly): a mother can transmit HIV to her child during pregnancy, condom use can reduce HIV risk, HIV cannot be transmitted by sharing a meal with a person living with HIV, HIV cannot be transmitted by witchcraft, HIV cannot be cured by herbs, and a healthy-looking person can be HIV positive. Less than 50% of children responded correctly that HIV cannot be transmitted by kissing. Across each of these indicators, modest improvements were documented between baseline and end-line among children in urban settings, but the percentage of children agreeing with correct statements in rural settings decreased over time across all indicators.

Uptake of HIV testing among children improved by 8%; one in three children were tested by the time the project ended. While age of sexual debut remained consistent at 13.2 years, the proportion of adolescents reporting condom use during their last sexual encounter improved from two in five at baseline to half of sexually active adolescents at end-line. However, at end-line children aged 13-17 years were less likely to report that they had heard of condoms (81% at end-line, 87% at baseline) or that they were "confident" or "somewhat confident" that they could obtain a condom compared to children surveyed at baseline (46% at end-line, 51% at baseline).

Malaria prevention

Children surveyed at end-line were more likely to report that their household had a mosquito net compared to children at baseline (52% at end-line compared to 47% at baseline). Also, children surveyed at end-line were more likely to report that someone in their household slept under a mosquito net the night prior to survey (84% at end-line compared to 78% at baseline).

General health

Although the proportion of end-line respondents who rated their general health as excellent or very good increased almost 20% from baseline to end-line (11% vs. 30%), end-line respondents were more likely to report that their physical health was poor at some point over the previous month (66% at baseline, 78% at end-line) and that physical or mental health issues prevented normal activity during the same period (68% at baseline, 79% at end-line).

Economic well-being and household food security

Economic well-being improved by 30% with two out of three adults reporting gainful employment at end-line. However, only 6% of respondents at end-line reported that their income (combined with support from relatives and organizations) met their needs. While end-line respondents were less likely (58%) to report that a household member went to bed hungry in the four weeks prior to taking the survey compared to baseline respondents (68%), the figures remained high. No other differences in household food security were reported between baseline and end-line.

HIV/AIDS treatment adherence

Baseline and end-line respondents were equally likely to report taking antiretroviral therapy (ART), although when specifically asked about the week prior to taking the survey, end-line respondents were less likely to report strict adherence than baseline respondents (89% at baseline, 82% at end-line).

HIV/AIDS knowledge, attitude, prevention

Knowledge of how HIV is transmitted was relatively high at baseline and end-line, though a slightly higher number of end-line respondents had incorrect knowledge about HIV transmission modes. For example, the percentage of respondents agreeing that a person cannot acquire HIV by sharing a meal with someone who is HIV-positive decreased from 96% at baseline to 92% at end-line, and fewer end-line respondents agreed that an HIV-positive woman can transmit HIV to her child through breastfeeding (82% at end-line, 89% at baseline). Sexual behaviors related to HIV transmission such as disclosure of HIV status to regular partners, use of condom at last sex, and sex with casual partners remained unchanged from baseline to end-line.

With respect to stigma, at baseline nearly half of adults said that people living with HIV were treated as outcasts; by end-line only one in three adults reported such stigmatization. Additionally, by the project's end fewer adults reported being subjected to name-calling (21% at end-line, 33% at baseline) or losing a friendship after disclosing their HIV status (16% at end-line, 24% at baseline). However, other stigma and discrimination-related indicators remained unchanged over the study period, many of which related to respondents feeling the need to hide their HIV status from others.

Gender-based violence

Before STEPS OVC, over one-third of adults said that a husband is justified in hitting or beating his wife; at end-line only one-fourth of adults felt this way. Furthermore, the proportion of respondents who agreed or strongly agreed with the statement, "When a husband wants sex, a wife cannot refuse," declined from 49% to 39%. Despite these changes in attitude, the proportion of respondents reporting a history of forced sex increased from 33% at baseline to 58% at end-line.

Malaria prevention

There was some improvement in malaria prevention knowledge from baseline to end-line. At end-line, a greater proportion of respondents (80%) cited sleeping under a bed net as a prevention method compared to baseline respondents (33%). However, fewer respondents noted spraying the house with repellent as a method for preventing malaria at end-line than at baseline (11% vs. 21%), and knowledge of other prevention methods remained low and unchanged.

Community caregivers

Service delivery

Community Caregivers (CC) reported visiting a greater number of households at end-line (mean 18.5 households) compared to baseline (mean 12.5 households), though visits were less frequent, with a shift from multiple weekly visits to monthly visits.

CCs reported delivering a wide range of services and information. The percentage of CCs delivering specific services such as HIV treatment adherence counseling and child and PLHIV nutritional assessments increased over the study period, as did the percentage who reported receiving training to better serve their clients.

Compared to baseline respondents, community caregivers at end-line were somewhat less likely to know where to refer clients for a number of support-related services such as livelihood support, PLHIV support groups, and kids' clubs. However, they reported several improved methods for tracking clients' referrals and were more likely to follow-up with clients when they did make referrals for them.

Community caregivers reported, at baseline and end-line, a high level of confidence in a range of caretaking tasks. The vast majority of community caregivers said that they were able to handle their responsibilities.

HIV/AIDS knowledge and attitudes

While basic knowledge about HIV/AIDS was fairly high and remained generally stable between baseline and end-line, community caregivers showed some improved knowledge at end-line regarding the timing of HIV treatment and the importance of strict adherence. However, at end-line respondents were 10% less likely to agree that a woman who has HIV can transmit HIV to her child while breastfeeding. At both baseline and end-line, community caregivers indicated accepting attitudes toward PLHIV.

Physical abuse

The STEPS OVC baseline assessment echoed findings from existing research indicating that physical abuse and sexual violence impact a significant number of Zambian women, children, and PLHIV, and that gender-based violence (GBV) is commonly accepted. This kind of GBV not only compromises physical and emotional health, but also acts as a constraint in accessing HIV testing and services.

In response to these findings, STEPS OVC worked to empower women, increase access to GBV-related information and services, and combat harmful social beliefs and behaviors. Because women make up 85% of the 40,000+ individuals benefiting from savings groups, STEPS OVC intensified economic empowerment programming and GBV

information sharing through savings groups in order to empower women and reduce GBV. Additionally, STEPS OVC strengthened referral networks and response centers and trained community caregivers to address GBV as it relates to cultural beliefs and behaviors.

These interventions have likely contributed to the precipitous drop in the proportion of children reporting physical violence between baseline and end-line, from nearly 50% to 21%, and the increase in children seeking help after being abused. Child respondents also reported being less accepting of GBV at end-line.

However, the number of children and adults reporting a history of forced sex, including forced sex at sexual debut, increased at end-line. While at the surface this would appear to indicate an increase in sexual violence from baseline to end-line, the increase may also reflect a greater willingness to report past abuse.

Regardless, future programs will need to consider how to address apparent increases in forced sex among youth.

Household economic strengthening and food security

Zambia has one of the highest rates of poverty in the world, with 74.5% of people living in extreme poverty. The majority of Zambians, including PLHIV, work in the informal sector, where services and support are not always available. Furthermore, research indicates that 45.4% of Zambia's children under 5 are stunted. As a result of household food insecurity, both adults and children frequently report either going to bed hungry or going a whole day and night without eating.

It is against this backdrop that STEPS OVC developed a household economic strengthening (HES) strategy aimed at improving the livelihoods of its beneficiaries. To date, the STEPS OVC program has reached 70% of its beneficiaries with HES interventions. There is evidence that STEPS OVC's strategic focus in HES has led to improved outcomes. Two-thirds of respondents reported that they had gainful employment at end-line, compared to just over one-third at baseline. This increase may be attributed to a combination of the STEPS OVC HES interventions and the government of Zambia's investment in HIV care and treatment, the latter of which has greatly reduced HIV/AIDS-related morbidity and enabled more PLHIV to re-enter or remain in the work force.

STEPS OVC also prioritized interventions that would enable households to meet their dietary needs, including food processing, storage, livestock production and beekeeping, small business trading, and improved market access, among other interventions. The STEPS OVC program database indicates that through the program, 91% of the 642,255 OVC and basic care and support (BCS) beneficiaries received food and/or other nutrition services. Furthermore, the proportion of respondents reporting going a whole day and night without eating in the last four weeks dropped between baseline and end-line, from one-third to one-quarter. Those reporting going to bed hungry also decreased over the study period. These findings indicate that the program has had meaningful change in the lives of its beneficiaries.

However, continued focus on improving overall household food security is recommended.

HIV and AIDS knowledge and attitudes

General knowledge of HIV and AIDS has been consistently high among the general population in Zambia, and knowledge among young people about how to prevent HIV has been increasing in recent years. However, comprehensive knowledge of HIV is low among men, women, and adolescents. A decrease in the proportion of young people who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission is also concerning.

Recognizing these HIV and AIDS knowledge gaps, STEPS OVC has supported the distribution of information, education, and communication (IEC) materials in addition to strengthening its prevention interventions. Throughout the program, STEPS OVC reached 803,044 adults and children with small group prevention interventions and provided HIV-related education to almost half (7,100,757) of all Zambians.

These program interventions have likely contributed to the increase in accepting attitudes toward people living with HIV and AIDS among adults from baseline to end-line. Improved knowledge may also have contributed to the increase in individuals taking positive actions, such as HIV testing.

The end-line survey also captured some gender differences. At end-line, boys reported being more confident than girls that they know a place for HIV testing, and that they could obtain a condom. Discerning whether boys reporting more confidence than girls is due to program messages and information better reaching boys, or simply cultural gender differences in confidence and comfort discussing such topics would require further investigation.

HIV knowledge among children and adults remained high from baseline to end-line. However, future programming should continue to address persistent misinformation among both populations related to transmission modes including mother-to-child transmission of HIV, kissing, mosquitoes, and witchcraft.

Malaria

Malaria is the leading cause of morbidity and mortality in Zambia, with nearly 4.3 million cases and 50,000 deaths per year. It is responsible for one-quarter of childhood deaths and accounts for almost 50% of hospitalizations nationwide. With the support of the Zambian government, this data moved STEPS OVC to distribute 1.58 million insecticide-treated nets in Luapula and the Western provinces.

There is evidence that STEPS OVC's efforts have led to improved outcomes, with more children at end-line reporting having a household mosquito net and someone in their household sleeping under a mosquito net the night prior to the survey. While use of mosquito nets as a prevention method increased across households during the study period, knowledge of other prevention methods decreased. Care should be taken in future programs to ensure that information on all prevention methods is disseminated.

Community caregiver training

Like many countries, Zambia does not have enough community health workers to provide services and support to all households who need them. STEPS OVC worked to build CC's knowledge and skills in order to provide a broader range of services and correct information for increased access to community-level care.

The baseline study found that some community caregivers provided services and information on topics for which they had not received training. To improve services and build caregiver confidence, STEPS OVC implemented a training program that, according to the program database, trained each of the 45,605 program-registered volunteer community caregivers at least once. Additionally, the program linked nine out of ten caregivers to health facilities to strengthen the referral system.

At end-line, there is clear evidence of increased service delivery, with an increase in the mean number of households visited. Furthermore, community caregivers were more likely at end-line to report providing a variety of services, referring clients appropriately, and tracking referrals.

Based on these findings from the STEPS OVC end-line survey, the following actions are recommended to improve programming in CC support:

- Review the community caregiver-to-household ratio and develop a standard household workload guideline for all community caregivers. STEPS OVC currently recommends five households per community caregiver.
- Measure the effect of enhanced cell phone provision and use as a strategy for easing community caregiver workloads and improving the quality of care and support services provided.
- Address gaps in the provision of information and services to beneficiaries, train new community caregivers in all services and informational areas covered by the project, and provide refresher trainings for active community caregivers. Provide this training in partnership with District Health Management Teams (DHMT) to promote sustainability.
- Scale up dissemination of information, education, and communication materials to community caregivers to ensure that they have access to correct and up-to-date information on the services they provide.
- Considering that a number of caregivers are semi-literate, future programs must ensure caregiver capacity building in an ongoing activity to avoid deterioration in the quality of services provided.

CHALLENGES

Despite all of the previously noted successes, as is to be expected, STEPS OVC faced some challenges over the six years of implementation. The table below summarizes some of the major challenges experienced, actions taken, and suggestions for future OVC projects.

TABLE 6 | Challenges, actions taken, and further action proposed for OVC Projects

CHALLENGE	ACTIONS TAKEN	FURTHER ACTION PROPOSED FOR OVC PROJECTS
Stock outs of HIV test kits at facilities.	The district health management teams (DHMT), through a series of discussions, agreed to resolve the problem by ensuring that health facilities were given buffer stocks.	Given the routine stock-outs of test kits, grants should explore how to escalate the discussion to the national level with Ministry of Health officials.
The project realized during implementation that the design did not take into consideration the active recording of the test results of all the HIV CT beneficiaries. Yield analysis per dollar spent therefore showed skewed results indicating that the project was yielding less positive results compared to the average of other projects due to the high numbers of unknown test results.	The project intensified the capacity building of counselors in the recording of test results.	Future projects should ensure that all test results are properly recorded.
CC kits lacked essential items such as painkillers. Additionally, CCs continuously indicated that they lacked the necessary aids to perform their functions effectively, e.g., protective clothing and bicycles for those required to cover large distances. Anecdotal evidence suggested that these item shortages affected CC morale.	To motivate CCs, the project prioritized distribution of gifts-in-kind (GIK) to CCs. Many CCs were also encouraged to join SILC groups to build the economic resiliency of their families.	Targeted sourcing of GIK should be implemented to ensure that received items reflect what is needed.
Linking CCs to government structures was a challenge for partners who do not work directly with health centers.	Sub-grantees were encouraged to share CC registers with health centers and governments that address the needs of OVC.	Partners should ensure that sub-grantees share registers with all relevant government departments.
Towards the end of the project, some OVCs exceeded the cut-off age for receiving services (<18 years).	Considering the revised PEPFAR OVC guidance, technical teams explored appropriate transition strategies to ensure those who needed to continue, received further support while others graduated out of the program.	It is recommended that future projects provide programming for young adults who are just graduating from being OVCs.
Of those provided with HIV-related services, e.g. PwP, one in three were listed as having unknown HIV status.	The project embarked on targeted CT of individuals who continued to receive these services but had an unknown HIV status.	Community volunteers will need to be re-oriented to ensure they do not provide these services to individuals with established HIV-negative status.
There was a delayed transition of project activities to sub-grantees due to staff capacity and institutional readiness among other reasons.	Institutional and technical capacity development for sub-grantees was intensified in FY13, when a number of sub-grantees with improved capacity mentored and coached other sub-grantees.	Capacity building of CBOs and volunteers groups should be ongoing.

LESSONS LEARNED

The project emphasized the importance of stakeholder consultative meetings at the district and national levels. An important lesson learned is that these collaborative meetings with government agencies and NGOs create a forum that facilitates the sharing of ideas and adoption of best practices. These meetings have helped STEPS OVC identify thematic areas under prevention and OVC that other NGOs support and have enabled the project to avoid any duplication of efforts.

The *SILC model* encourages the active participation of CCs and guardians of school-aged OVC to join community savings groups. This approach has motivated CCs to start up small businesses of their own while guardians of OVC can now pay school fees for the children under their care.

Include social transfers as part of a diversified mix of ES strategies

Not all vulnerable households can engage in ES activities of a productive nature, such as agriculture, without some form of external support. Social transfers in the forms of cash and assets (seeds, garden tools, fruit trees, livestock, etc.) are needed. ES services work better if there is a logical link. For example, the demand for SPM is heightened after SILC members begin getting loans and investing. Integrating gender and any other relevant issues must be considered and at the right time. A simplified approach or package could be (Social transfer + SILC + SPM + Linkages + Gender) when starting with a destitute household.

Integrate intangible benefits and mitigate intangible challenges in ES programming

SILC may provide intangible benefits such as improved self-efficacy or reduced HIV and AIDS stigma. But there are also challenges, such as ingrained gender norms about financial decision making at household level, inappropriate money management, and alcohol abuse. SILC groups provide a natural platform for providing an array of services on ES and unrelated topics. Under STEPS OVC, these issues were addressed through a tested approach (Journeys of Transformation).

Communication and feedback

In working with sub-grantees, the project has learned that constant communication and feedback between partner organizations and sub-grantees, especially in relation to data quality and service provision, minimize challenges in data capture.

The “Safe from Harm” approach received overwhelming support in the communities. When compared to other prevention approaches, communities expressed that Safe from Harm directly speaks to their needs regarding supporting household-level communication about sexual health between parents and adolescents.

By administering the technical sustainability tool and organizational capacity assessment exercise at the same time, sub-grantees were able to receive technical support in the various areas of organizational management while establishing areas of the organization that needed improvement.

Having DHMT trainers for OVC/BCS management trainings ensures easier linkages between CCs and local health centers. STEPS OVC learned that managing trainings jointly with DHMTs enhances the identification of BCS clients, health care referrals and the provision of health services to clients.

STEPS OVC used GIK to motivate CCs and help them support registered clients. However, due to the size of the project, the GIK sent out to field offices were insufficient. It has been suggested in instances of inadequate supplies that items should be distributed in one select community or district rather than across a larger area.

Given that membership of SILC groups is determined by self-selection, not all program beneficiaries and CCs joined these groups. STEPS OVC staff then needed to deliberately identify the households being left out and support them with other ES activities.

Through routine data review of beneficiary records captured in the program database, STEPS OVC staff and partners learned that there is a need to ensure that CCs understand the necessity of re-profiling beneficiaries if key attributes change over time. The program learned that the use of the status update form helped ensure that only traceable beneficiaries remained active in the database. Although not all partners successfully used this tool, the PMU recommends that future programs should plan to update client and CC registration information periodically throughout the program.

NETWORKING AND COLLABORATION

Collaboration with other stakeholders was an explicit implementation strategy of the project. STEPS OVC provincial facilitators and District Coordinating Committees collaborated with ZPI, DHMT, DATFs, the MCDMCH, provincial health offices, and district health offices on various issues. Key outcomes of this collaboration and these partnerships include the following:

- There was increased sharing of best practices and lessons learned among development practitioners, including the government due to engaging them regularly.
- The project found improved governmental understanding of how STEPS OVC contributed toward national HIV and AIDS prevention and mitigation goals. The project's relationship with the government paved the way for a smooth transition of STEPS OVC activities into the government. STEPS OVC PMU and partners participated in two national events annually, World AIDS Day and Youth Day, as part of their continuing support of the government.
- Virtually all HIV test kits used in testing 630,248 individuals throughout the project were sourced from government health facilities.
- By participating in provincial- and district-level health management meetings, STEPS OVC partners have been able to map areas where other partners implement programs, which has resulted in reduced duplication and double counting.
- STEPS OVC partnered with the National Food and Nutrition Commission (NFNC) and accessed 67,700 MUAC tapes that were used to monitor the nutritional status of both OVC and BCS beneficiaries.
- STEPS OVC collaborated with the Ministry of Home Affairs in facilitating nation-wide Mass Birth Registration Exercises. Consequently, 12,549 (3%) of OVCs have collected birth certificates from the Ministry of Home Affairs. This exercise was only carried out between 2014 and 2015. One lesson learned here is that the birth registration activities should have started much earlier to reach more children.

- STEPS OVC, through its links to the Gender Based Violence Survivor Support (GBVSS) Project, trained 14 project officers in Prevention of Gender Based Violence. This training was then rolled out to CCs, which enabled them to identify GBV cases as they served their beneficiaries and referred clients to GBVSS one-stop centers as needed.
- STEPS OVC partnered with Land O Lakes to conduct the Zambia Local & Regional Procurement Project (ZLRP) project. The project targeted 10,000 households with chronically ill heads of household and 2,500 malnourished children in response to learning that some of the chronically ill clients who were on ART were inconsistent in taking their medication because they did not have enough food at home. Project activities included gardening, fish farming, nutrition monitoring, High Energy Protein Supplement (HEPS) distribution, and cooking demonstrations.
- STEPS OVC partnered with HASBRO to train 66 community school teachers; rehabilitate four schools; and procure 5,675 text books, 988 desks, and two trucks.

STEPS OVC developed working relationships with the following US government partners and projects:

- ZPI: This collaboration involved conducting joint trainings on the PMP, CSI, OVC, and BCS as well as holding joint DCCC meetings. ZPI was also invited to attend and participate in 'The Faithful House' training pilot in Ndola. Furthermore, STEPS OVC collaborated with the ZPI at the Chief of Party level, conducting a joint visit to the offices of the provincial Permanent Secretaries to conduct project briefs.
- Corridors of Hope (COH): STEPS OVC held two consultative meetings to discuss activities in the districts in which there was project overlap with COH.
- Afya Mzuri: STEPS OVC worked closely to identify existing materials that could be rolled out. Through consultation, STEPS OVC selected the Safe from Harm curriculum for scale-up. Afya Mzuri supported the scale-up by providing manuals and facilitating a Master TOT workshop for STEPS OVC.
- USG Care and Support Forum – STEPS OVC fully participated in the quarterly USG Care and Support Forum meetings and submitted the STEPS OVC Care and Support Work plans to support coordination with other USG partners.
- Elizabeth Glaser Pediatric AIDS Foundation (EGPAF): The project met with EGPAF to identify lessons learned on issues related to pediatric HIV and OVC care.
- Communication Support for Health (CSH): STEPS OVC participated in CSH meetings to review IEC materials and to support coordination across projects through IEC/BCC mapping.
- President's Malaria Initiative: STEPS OVC entered into a successful partnership for the distribution of LLINs under the MOH/NMCC in Luapula, Eastern and Western Provinces.
- Peace Corps: STEPS OVC identified a third year Peace Corps Volunteer to support the PMU in FY11.
- CDC: STEPS OVC participated in PwP technical review meetings, which led to ZPI and STEPS OVC Technical Advisors collaborating to identify appropriate PwP materials both inside and outside of Zambia. STEPS OVC sat on the PwP Technical Working Group advocating for services and reviewing IEC materials for circulation.

- Society for Family Health [SFH] (PSI local affiliate): SFH allocated 500,000 bottles of chlorine to STEPS OVC to distribute to PLHIV households AIDS.
- John Snow Inc. (JSI): STEPS OVC and JSI communicated about HIV and AIDS CT targets in relation to the national forecast for test kits. STEPS OVC attended quarterly CT forecasting meetings at JSI.
- CHAMP: STEPS OVC met with CHAMP to discuss workplace CT activities and how STEPS OVC could learn from CHAMP experiences, including how workplace CT could be linked to broader HIV prevention interventions, such as PMTCT and community door-to-door CT activities.
- Human Rights Commission [HRC]: STEPS OVC closely collaborated with the HRC, specifically with the victim support unit, in assisting children who have been abused.

STEPS OVC also met with other non-governmental organizations to explore areas of collaboration and learning:

- International Organization for Migration (IOM): STEPS OVC learned about the toolkit called “An Action-Oriented Training Manual on gender, migration and HIV” used by CHAMP.
- UNICEF – STEPS OVC discussed child protection and replication of the birth registration model and participated in the interagency coordinating committee on maternal and child health.
- REPPSI - STEPS OVC participated in a stakeholder’s meeting on collaboration to support open and distance learning for community-based work with children and youth.
- AIDS Alliance: STEPS OVC discussed training plans for the stigma intervention for which the AIDS Alliance trained partners/sub-grantees.

PROGRAM MANAGEMENT AND SUSTAINABILITY

The STEPS OVC PMU finalized seven strategy papers [CCs, OVC, BCS, CT, Prevention, Nutrition, and Economic Strengthening] and a sub-granting manual to ensure the consistent application of technical approaches across all STEPS OVC communities. Although the strategy papers are unique to each program area, they were implemented in a comprehensive, integrated manner within communities and targeted populations. Government ministries provided input regarding the design and review of the strategy papers, such as the Home Based Care Unit of the MOH and the National Food and Nutrition Commission. In particular, the MOH participated in the CC’s strategy development to ensure that STEPS OVC engaged CCs in a way that promoted their integration into existing health structures and systems. STEPS OVC and ZPI discussed interventions in the Prevention strategy, which went through a second revision in July 2011 to reflect new interventions. All prevention interventions follow the PEPFAR Next Generation Indicators’ guidance, are evidence-based, and respond to specific drivers of the HIV epidemic in Zambia.

The STEPS OVC Technical Advisors organized internal TWGs with representation from each consortium partner as well as occasional external participation from the GRZ or other stakeholders when addressing a specific topic. TWGs enabled consortium members to receive technical updates, address challenges with implementation, coordinate activities, and share lessons learned. Monthly TWGs were organized by OVC, BCS [combined in Year 2], prevention/counseling and testing, economic strengthening, sub-granting, M&E and nutrition (which met quarterly).

PMU Technical Advisors and TWG members represented the consortium on various stakeholder working groups. At NAC, STEPS OVC was represented on the M&E, OVC, and Prevention task groups. At MOH, STEPS OVC was represented on the home-based care/CT, palliative care and child health working groups. Participation in national working groups enabled STEPS OVC to address capacity gaps in order to promote transition. For example, in September 2010 STEPS OVC supported the MOH in a MTOT for home-based care after learning about the lack of GRZ employees certified to run these trainings in their districts.

The STEPS OVC PMU also actively engaged the technical expertise of ZPI. Meetings between the two Senior Technical Advisors about HIV prevention took place in December 2010, followed by two quarterly joint meetings between 2010 and 2013. After 2013, these coordination meetings did not continue because STEPS OVC stopped implementing prevention interventions after redesigning the project. The March meeting was followed by several smaller sub-group meetings on gender, PwP, alcohol interventions, and household dialogues.

STEPS OVC developed a number of materials and reports meant to be separate from informing programing in order to also facilitate knowledge sharing. These materials include 22 Technical Briefing Papers produced over the life of the project (see Appendices for the list of publications).

Program managers held monthly meetings during the first three years of the grant to further share and exchange information and best practices relating to program implementation. In the last two years, program managers, M&E officers, and finance staff met quarterly to review performance and plan for the upcoming quarter. The change in meeting frequency was necessitated by the wider geographical coverage of local partners during the cost extension. In addition, monthly one-on-one meetings were conducted by the Deputy Chief of Party or PMU technical team with each consortium partner program manager to ensure smooth implementation of the program and address any challenges. During these meetings, the Deputy Chief of Party or PMU technical teams would share strategies to improve implementation and achieve the organizational objectives and targets.

M&E staff across the consortium participated in the M&E TWG to ensure that the project was collecting, managing, and using high quality information. This group conducted data validation exercises with select partners and their sub-grantees each quarter to validate data reported to the PMU as well as to provide technical assistance.

To support the routine field monitoring of outcomes, STEPS OVC developed field visit guidance, which was rolled out to all partners. During the LoP, the PMU M&E unit conducted quarterly monitoring, DQA, and site visits for each sub-grantee and sub sub-grantees. The outcomes of these visits were instrumental in informing program review and realignment. Notable decisions that stemmed from these field visits include: revision of data collection tools, identification of the need to support literacy classes for CCs, development and implementation of a data cleaning strategy, creation of a client profile update register, and a caregiver report highlighting achievements in service provision at the ward level.

The hub offices in Kitwe, Lusaka and Choma were successfully established in the first phase of STEPS OVC and supported the project in conducting step-down trainings on the PMP, CSI, and compliance.

Following the redesign of the project in 2013, World Vision changed its capacity building approach by dropping all international sub grantees and replacing them with 13 local sub-grantees.

The Chief of Party led the PMU team in discussions with local sub-grantees in the development of transition and sustainability plans for their respective areas. These discussions were supported by quarterly follow-up visits that monitored progress in the implementation of the transition and sustainability plans. In addition, World Vision, through STEPS OVC, used a three-pronged approach to build the capacity of 13 local organizations:

1. The Organization Capacity/Sustainability Assessment (OCA/OSA), was a self-assessment as discussed above. It acted as a baseline setting and review tool for organizational capacities.
2. CBOs were provided capacity building through trainings to address the gaps identified through OCA/OSA, including grant finance management, M&E training, and technical-approach training. Another method used involved one-on-one-mentoring and coaching for all staff, including management.
3. Program monitoring was also used as a capacity-building tool through the feedback from program reviews, including financial and M&E compliance reviews.

Mentoring an organization required continuous refreshers to ensure adherence to quality programming standards. Through STEPS OVC, these CBOs had the opportunity to learn, ask questions, gain experience, have a mentor, and grow. Although they experienced challenges, setbacks, and even serious internal organizational issues, WV's watchful eye and support ensured that any difficulties were resolved and used as opportunities for improvement. WV's oversight enabled the CBOs to "learn by doing" and minimized the risk of serious failure or non-compliance. Without this support, they may have been burdened by responsibilities they were not yet prepared for and posed a tremendous risk to Zambian OVC beneficiaries.

This process also enabled these organizations to increase their capacity to handle greater funding values under their subaward and to sub grant to smaller CBOs as well. As a result, two of the organizations (the Expanded Church Response and Development Aid from People to People) were awarded ZAMFAM projects to implement.

GENDER EQUITY

Gender mainstreaming is a major concern of HIV and AIDS programming and has been emphasized throughout STEPS OVC implementation. Gender participation was not exactly at 50% male/female ratios in all areas, even though all partners worked to achieve full participation. This is especially true in terms of volunteer community caregivers because females are culturally viewed as the primary caregivers during illness and women appear to be more willing to take on care responsibilities than their male counterparts. Project partners were gender-sensitive in the registration process of both clients and CCs, encouraging male participation. By the end of the project, two out of five [33%] CCs were male. STEPS OVC also emphasized the importance of male participation in BCS services.

Three Technical Advisors attended a gender workshop led by ZPI, which aimed to deepen the TAs' understanding of gender as an analytical approach to addressing HIV and AIDS activities for OVC, PLHIV, and youth. Technical

Advisors used this knowledge to work with TWGs and examine gender in STEPS OVC. For example, the OVC Technical Team continued to work with partners to examine gender issues across the seven core OVC service areas with a specific focus on child protection and violence against children.

The ZPI Gender and BCC Advisors were also part of the brainstorming meetings between ZPI and STEPS OVC on a number of issues such as prevention interventions, collaboration, and communication between the two organizations, etc.

APPENDICES

I.4 Index of Research and Publications

During the life of the grant, the following publications were finalized:

1. Chapman, J., M. Ngunga, J. Kamwanga and J. Simbaya. 2012. *STEPS OVC Baseline Evaluation Report: Key Findings*. Lusaka, Zambia: STEPS OVC.
2. STEPS OVC. 2012. *Conducting and Adapting an RDQA Tool to Improve Project Data: Lessons Learned from the STEPS OVC Experience*. Lusaka, Zambia: World Vision's STEPS OVC Program. Lusaka, Zambia: STEPS OVC.
3. STEPS OVC. 2012. *Key Elements of a Nationwide Community Based Information System: A Case Study of STEPS OVC in Zambia*. Lusaka, Zambia: STEPS OVC.
4. STEPS OVC. 2012. *Managing Community Expectations While Emphasizing Community Ownership: Lessons Learned from STEPS OVC*. Lusaka, Zambia: STEPS OVC.
5. STEPS OVC. 2012. *Building Resilience through Economic Strengthening: A Case Study of SILC Groups under STEPS OVC in Zambia*. Lusaka, Zambia: STEPS OVC.
6. STEPS OVC. 2012. *Conducting and Adapting an RDQA Tool to Improve Project Data: Lessons Learned from the STEPS OVC Experience*. Lusaka, Zambia: STEPS OVC.
7. STEPS OVC. 2012. *Preventing Malaria through STEPS OVC: Best Practices in Bed Net Distribution*. Lusaka, Zambia. Lusaka, Zambia: STEPS OVC.
8. STEPS OVC. 2012. *Public Private Partnerships in Practice: Lessons Learned from the STEPS OVC Program in Zambia*. Lusaka, Zambia: STEPS OVC.
9. STEPS OVC. 2012. *Addressing the Shelter Component of PEPFAR's OVC Shelter and Care Guidance: Lessons Learned from STEPS OVC Shelter and Community Design Initiative*. Lusaka, Zambia: STEPS OVC.
10. STEPS OVC. 2012. *Targeted HIV Behavior Change Interventions: Evidence Based Prevention at the Community Level*. Lusaka, Zambia: STEPS OVC.
11. STEPS OVC. 2012. *Changing Dynamics of Care and Support for People Living with HIV and AIDS*. STEPS OVC. Lusaka, Zambia: STEPS OVC.
12. STEPS OVC. 2010. *Acceptance, Resistance and Quality of the Permanent Mosquito Nets [ARQ] study*. STEPS OVC. Lusaka, Zambia: STEPS OVC.
13. STEPS OVC Triangulation Report [unpub].
14. STEPS OVC. 2013. *Building the Case for Social Transfers: Addressing the Vulnerability of Households within STEPS OVC*. Lusaka, Zambia: STEPS OVC.
15. STEPS OVC. 2013 *Community Trace and verify: Improving Data Quality at Community Level*. Lusaka, Zambia: STEPS OVC.

1.5 Success Stories

1.5.1 Reducing HIV Risk Behavior in Adolescent Boys

Fidel Ngoma is one of six children living with his mother in the crowded Ngombe Compound of Lusaka, Zambia. His mother has been working hard to provide for her family. Since her earnings as a maid did not meet the family's needs, Fidel's eldest brother took a job to supplement the family income. With his mother and older brother busy providing for the family, Fidel received little guidance at home. As a result, he ended up indulging in many risky behaviors. He started drinking and smoking with his friends as well as chasing girls so that others would see him as cool. His schoolwork suffered as he often skipped school and spent little time on his homework.



Picture 1: Fidel relaxes at home

In May 2012, Fidel was invited to attend a life skills training organized by Needs Care, a community-based organization receiving financial and capacity-building support from STEPS OVC. Through the training, Fidel increased his knowledge of reproductive health and obtained skills on how to protect himself from HIV infection. With the knowledge he gained at the training, as well as the positive social support received through the community organization, Fidel's life changed in multiple ways. He stopped hanging out with the friends he thought were so cool. He stopped drinking, smoking, and chasing girls and now spends more time doing his schoolwork and household chores. He has even started to attend church where the Needs Care Ministry is based. He knows that there will always be someone at Needs Care to mentor him when he feels lost.

"I am so grateful for this training because my life has been transformed and I know that I will achieve my goals," he says.

1.5.2 Savings Pulls OVC Household Out of Vulnerability



Picture 2: Moddy used a loan from her savings group to purchase inputs for a successful business.

"My life has changed" says Moddy Manda, a 40-year-old widow with three girls and two boys aged 4-21. Moddy lives in Fibunde Village in the Copperbelt Province of Zambia. Depressed following the death of her husband in 2010 and with a dwindling household income, Moddy was inadequate to meet the family's basic needs.

In December 2011, Copperbelt Health Education Project (CHEP) introduced the idea of community savings in Fibunde through the STEPS OVC project. The main goal of the community savings initiative was to empower vulnerable households through increased access to community-based financial and non-financial services such as business and financial education. Community members voluntarily create a self-managing group and make regular contributions to a loan fund from which any of the members can borrow.

Loans are paid back at an agreed-upon interest rate, allowing the fund to grow. At the end of an agreed-upon period, the accumulated savings and interest were shared out among the membership.

Moddy was one of the initial ten members of the Munama savings group. She recalls how difficult it was to save money and feed her family in the early stages of the savings group. "When I started saving with Munama, I had no idea how much money I would be able to borrow. As time progressed, the idea began to make sense when one of our members got a loan of US\$24."

Moddy first borrowed US\$30 and used it to buy foodstuffs for resale in her village. Today Moddy generates greater than 30% of net profits from her fast-growing business. Her first loan ignited a spate of other business opportunities, and she now employs community members to assist her. Since she became a member of Munama savings group, Moddy has accessed four loans, which she has promptly been able to repay. Moddy proudly notes that she has more than US\$100 in savings and has reserved 20 sacks of corn to feed her family and help pay for casual labor during the next farming season. Her positive experience with the savings group has prompted Moddy to encourage other vulnerable households in her community to join a savings group in order to improve their living standards.

Expressing herself emotionally, Moddy says, "I pay special gratitude to CARE and CHEP for introducing the savings concept which has shielded me from taking the risks that other widows go through as they struggle to fend for their family, particularly in the wake of HIV and AIDS."

1.5.3 Mobile ART Services Save and Sustain Lives in Remote Villages

Two-year old Chipo is learning to walk, which is remarkable given the challenges of her early life. Chipo's mother passed away a month after her birth. Chipo was diagnosed with HIV, was severely malnourished and consequently suffered from constant illness.

Chipo's grandmother, who lives in the remote village of Chitanda in Zambia's Central Province, cared for her. In order to get Chipo the care she needed, the two had to travel 82 kilometers to the nearest hospital because the (local?) Rural Health Center had no medication. This journey was costly and Chipo's grandmother wasn't sure how long she could manage. "Chipo was very small and sick; I feared she would die," she said.

In April 2008, mobile Antiretroviral Therapy (ART) outreach began at the nearby Chitanda Rural Health Center and Chipo obtained treatment in her community. Today Chipo is a thriving, active two-year old.

Mobile ART outreach currently covers seven remote locations across Central Province. The program, organized under the Provincial Health Office, is supported by USAID's Health Services and Systems Program with funding from the President's Emergency Plan for AIDS Relief (PEPFAR). The mobile ART team includes a doctor, nurse, pharmacy technician, and counselor who visit every two weeks to provide counseling, testing, and ART services. The community mobilizes clients to gather on ART outreach days.

As the mobile ART team provides services, they train the health center staff. Over time, program responsibility will shift to the health center, freeing the mobile team to expand services to new locations.

1.5.4 Mukobe Kalilwa Salutes VCT

Forty-two-year-old Mukobe Kalilwa made up her mind to go for Voluntary Counseling and Testing (VCT) after falling ill several times. Mukobe came to Kala Refugee Camp in Zambia's Luapula Province from the Democratic Republic of the Congo after war broke out in that country in 1998. Her husband had died earlier, leaving her to take care of three children.

While living in the camp, Mukobe was constantly ill, regularly visiting the camp's clinic. There, Mukobe heard about a United Nations High Commissioner for Refugees (UNHCR) and the President's Emergency Plan for AIDS Relief (PEPFAR) VCT center through a community campaign. Mukobe decided to go for VCT where she tested positive for HIV. Due to her poor health, she was referred to Kawambwa Hospital for further assessment.

Mukobe was put on ARV drugs and her health improved considerably. "I have made unprecedented progress and am proud to have taken the decision to go for VCT," says Mukobe with a smile. She recalls how counselors at the VCT center helped her overcome her fears about taking an HIV test. As she looks back, she recounts the many times she got sick, saying "I lost weight so much that people could talk behind my back that I suffer from SIDA, meaning AIDS."

Mukobe worried about who would take care of her kids and what kind of life they would lead. "It would have been a great setback for my children and worse still I could have died a sad person. Now I am able to go to the fields and do my house chores for my family and gained the weight that I had lost. I look in the mirror and smile to myself."

Today, Mukobe is happy, an active member of a support group, and speaks highly of VCT to people in the camp. "I salute VCT," she says.

1.5.5 Young Zambian Musician Reaches Thousands with HIV/AIDS Messages

"I know my HIV status... how cool is that!?" remarks Justine Mulenga, one of Zambia's top musicians (popularly known as Mozegater) with his trademark youthful enthusiasm. "I went for counseling and testing and now I know." When Mulenga sings, he touches Zambia's soul, and Zambia rocks with him. Zambia listens to him. One day, Mulenga realized that his songs contained many messages, but one was missing. "I sang my heart out about everything under the sun, except the biggest problem facing Zambia today—HIV," Mulenga says with uncharacteristic seriousness. "That changed six months ago after my training and now I am an effective HIV/AIDS changeagent."

Mulenga underwent training as an HIV/AIDS advocate, leader, and peer-educator in a PEPFAR-funded leadership training program implemented by the USAID SHARe project through the Tourism HIV/AIDS Public Private Partnership. The training helped him understand the importance of knowing one's status. "I talked to my wife and my band members about Counseling and Testing and we all got tested. Now we know."

The training has changed the messages in his music. "All my music shows now have HIV/AIDS messages. I sing about the importance of counseling and testing, the need to fight stigma, and I encourage young people to get involved in the fight against HIV. My fans have thanked me for the HIV/AIDS messages in my music. I am blessed and honored;

blessed by my music and honored to contribute to the HIV/AIDS fight in Zambia, thanks to USAID and SHARe.” Since his training, Mozegater has performed in front of a combined audience of more than 100,000 people at major national events. The HIV/AIDS fight in Zambia has a new champion!

1.5.6 A Father and Daughter Empowered

Valarie Sikombe is a single orphan who lost her mother to HIV-related illness when she was just six years old, leaving her under the care of her HIV-positive father. Valarie struggled with chronic illness, stunted growth, and a severe bout of tuberculosis, and she was diagnosed with HIV in 2006. With encouragement from a community caregiver, Valarie’s father made sure that his daughter received HIV treatment from the local clinic and accessed community support under the TRaKK Home Based Care Program in Kitwe (Zambia), supported under STEPS OVC with USAID funding.

As a beneficiary of the STEPS OVC program, Valarie receives psychosocial counseling and is an active member of the KIDS life skills club where they discuss issues such as adolescence and sexuality. Valarie is passionate about her education and believes that she can succeed, but she has a hearing problem that affects her ability to understand and perform in class. Her caregiver and father are working hard to help her succeed by assisting her with extra lessons after school. The program has provided school shoes and books to further support her education. The caregiver also works to sensitize the school as to how they can best work with hearing-impaired students.

STEPS OVC builds community capacities to provide integrated HIV prevention, care, and support for orphans such as Valarie while also empowering the household members to increase their ability to support their families. Valarie’s father was linked with a Savings and Internal Lending (SILC) Group that has provided him with additional income to meet the financial needs of the family. Valarie is grateful for the help and support she has received through STEPS OVC and has a great deal of hope for the future.

1.5.7 Feeding Ourselves, Feeding our Future

Grace Mudala is a single mother who supports herself and her six children through subsistence farming. Her youngest child, Dorcus, is two years old. Grace noticed that Dorcus was not growing at the same rate as her other children and feared that her baby was HIV-positive. Both mother and child were tested several times at the local clinic and each time, the results came back negative. Recognizing that Dorcas was severely malnourished, a community caregiver referred Grace to the Positive Deviance (PD) Hearth program, which was started under STEPS OVC with USAID funding. Grace joined a group of women from her community for nutrition sessions, where mothers teach one another how to feed their children using locally available foods.

Grace says, “...by the end of the sixth day I observed a change in my child’s health. The child had gained 400g during this rehabilitation period...” Dorcas is now a happy, healthy two-year old and Grace is able to prepare healthy and nutritious food for her entire family.

PD Hearth is just one of the ways that STEPS OVC promotes good nutrition as a part of comprehensive care for orphans and vulnerable children. Community caregivers provide household growth monitoring by reviewing growth

curves on under-five cards and measuring arm circumference to diagnose malnutrition in young children. STEPS OVC encourages community gardening for both nutritional and economic support.

With encouragement from STEPS OVC, Beauty Mwaanga started a home garden with pumpkin leaves, rape, tomatoes, and maize. She uses the vegetables to feed four orphans under her care and sells any surplus to earn money for school support. Beauty says that she is very happy about her additional income and is working hard to encourage others in the community to start home gardens, realizing that nutrition awareness can benefit both the health and the economic status of an individual. Encouraged by her success, community caregivers have started an organic garden at a local community school.

1.5.8 Communities Come Together to Support the Most Vulnerable Children

Mulumbenji Sakala is a 15-year-old orphan residing in Petauke (Zambia) who suffers from cerebral palsy, a condition that affects body and muscle coordination. Mulumbenji is unable to communicate hunger or other needs, and as a result she is clinically malnourished. Her mother used to lock her in the family hut with a bowl of water and food when she went to the field to farm the little food she could for her six children. In 2011, caregivers trained under STEPS OVC discovered Mulumbenji and linked the family to the government's Social Welfare department. Social Welfare enrolled the family into the social assistance program, where Mulumbenji was given blankets and the family received maize. Social Welfare paid for Mulumbenji's younger brother's school fees and is collaborating with STEPS OVC to find a home where she can get professional care.

With USAID funding, STEPS OVC trains caregivers to provide comprehensive care for orphans and vulnerable



children through home visits, and promotes links to community and government structures. Mulumbenji is one example of how a community joined together to pool collective strengths and support a vulnerable family. In Kapiri Mposhi, Habitat for Humanity has built six new houses with toilets in Kawama Compound for STEPS OVC beneficiaries. Maximizing integration with other resources in the community will ensure a smooth transition of support to beneficiaries at the end of the project.



Eleven-year-old Cleopatra ("Cleo") Mwansa also benefits from STEPS OVC links in her community. Cleo lives with her grandmother in Chitulika Village, Mpika. In 2003, Cleo was diagnosed with TB and HIV and was later enrolled by caregivers under St. Joseph's Parish of Mpika Diocese. With the support of STEPS OVC, caregivers continue to visit Cleo, providing adherence support for her HIV medications while the Diocese utilizes funding from the Solidarity Fund for Cleo's primary school education.

Picture 3: The Mwansa's House Before and After

1.5.9 A Balm for the Chazanga Community

Balm of Gilead is a faith-based organization committed to serving the needs of the vulnerable in the Chazanga compound (Lusaka). To address the gap in accessible education to Chazanga residents, Balm of Gilead's community school reaches 600 OVCs from grades one to seven; the organization also supports another 525 OVC in government secondary schools and manages a network of volunteer caregivers who support people living with HIV and orphans and vulnerable children in their homes. The director, Rachel Kasanga, proudly acknowledges, "This has been made possible by the generous financial and material support and organizational capacity building of the American people and government, first through RAPIDS and now STEPS OVC."

STEPS OVC is building the capacity of over 240 local community organizations, including Balm of Gilead, to be able to sustain their community work after the project ends. The organizations receive capacity-building in compliance, financial utilization, governance, and reporting. Local organizations are trained to improve the quality delivery of services such as HIV prevention, basic care and support, and economic strengthening for community members.

Ms. Kasanga says, "We now have a functioning board and clear vision, which has helped us in governance, resource mobilization and utilization, and networking and partnership. We are now able to mobilize some additional resources both from GRZ and private companies such as Holiday Inn and the local Rotary Club of Nkhwazi." Rachel also expresses gratitude that their association with STEPS OVC has made them realize the importance of networking and partnerships.

As a result of the increased capacity, Balm of Gilead is now expanding their coverage both within Lusaka and into neighboring districts.

1.5.10 Public-Private Partnership in Action: Cushioning Adverse Impacts of Mining in Musele

Mr. Olix Kakwata was the newly elected Area Councilor for Musele Area in Solwezi (Zambia) where First Quantum Minerals (FQM) was opening a new mine. Mr. Kakwata was fully aware of the diverse impacts that come with a mine; although there were positive economic opportunities, it would disrupt people's livelihoods, degrade the environment, displace community members and social networks, and contribute to an increase in risky behavior and HIV prevalence. Mr. Kakwata felt discouraged that he would not manage to represent the community's concerns regarding these issues because he had little experience in partnership engagement. Fortunately, this began to change when he attended the Extractive Industry Workshop organized by STEPS OVC, a part of capacity-building for Public Private Partnership engagement with the extractive industry. The workshop equipped Mr. Kakwata with skills to engage the community so they could realize their rights and responsibilities. He also learned about how a community can advocate for their benefits in a non-confrontational manner.

The STEPS OVC Public Private Partnerships (P3) strategy aims at bringing together public and private entities operating in a sector in order to seek synergies and new avenues of interaction. STEPS OVC is pursuing a partnership with FQM to implement economic strengthening through saving groups and HIV awareness and prevention in the mining compound and surrounding areas. The P3 activities are building on private sector partnerships developed under another USAID project, CHAMP COMETS, through the Global Development

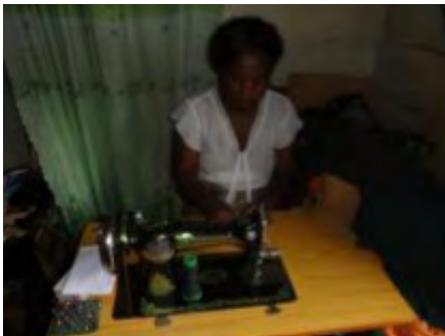
Alliance (GDA) with 16 of Zambia's largest companies. Both STEPS OVC and CHAMP will continue using USAID funds to coordinate the whole process and ensure that both parties are held accountable to their responsibilities while optimizing available resources to realize their common interests.

Mr. Kakwata now feels confident enough to take a leading role in mobilizing the community to act proactively and plan with the mines as an equal partner. He is happy that he has learned so much and will share this information with Chief Musele so he can plan ahead for his area to mitigate the impact of the mines on his people.

1.5.11 Caregivers + Savings Groups = Everyone Benefits

Daisy has been a tailor for the past five years, which is how she makes her living. Previously, her business was very poor because she could not manage to get enough money to expand her business. "My business was doing poorly and I could not manage to get most of [what] my family needs because when I just started this business, I used to make less than K 80,000 a month," says Daisy. Whenever there was a family problem that needed to be solved, Daisy would always have to close down her tailoring business and use all of her capital to solve the problem.

Despite her burdens as the main breadwinner in her household, she decided to volunteer with Pastor's Fellowship as a community caregiver for the vulnerable in her community. Pastor's Fellowship is a faith-based organization in the Itezhi-tezhi district that receives a sub-grant under the USAID-funded STEPS OVC project. Through the organization, she joined a Savings and Internal Lending Communities (SILC) group. Group members contribute money each month to the group, while issuing small loans to group members. Through SILC, Daisy has been able to gain capital, which has helped her to expand her business tremendously. She has additionally acquired new business skills and has been linked to new customers, leading to larger profits.



Picture 4: Daisy, a caregiver and SILC group member, makes a dress for sale.

Daisy can now manage to successfully educate her two daughters through high school and feed her family while continuing to support vulnerable children within her community. But she is most proud of the fact that she is the first person in Itezhi-tezhi to buy a new over-locking sewing machine, a purchase that has helped her innovate her tailoring (and made her the envy of her community).

"I never imagined that my life could change like this one day and this is all thanks to ECR and the training under SILC from USAID. I now make more than K 300,000 per month and I can now walk with my head up high in the community."

1.5.12 A Woman Overcomes Denial to Live a Positive Life

Denial nearly cost Anna Zulu her life. Born in 1951, Anna lives in Nyimba, a rural district in eastern Zambia, where she engages in a small business of selling ground nuts by the roadside. In 2008, she suffered from severe diarrhea and other ailments. However, she did not know the cause of these diseases. Her only suspicion was that she had been bewitched.

In 2010, a community caregiver under the USAID-funded STEPS OVC visited her and advised her to go for an HIV test. She did not take this lightly and actually demanded an apology from the caregiver for thinking she might be HIV positive. She said, “I right away demanded that Tamara do apologize to me for such an outright insult.”

The caregiver did not give up on Anna. With persistence and tact, the caregiver finally managed to break through to Anna, who agreed to go to VCT. She received a positive test result. By that time she remembers, “I could not manage to walk due to weakness as a result of several days of severe diarrhea.” After starting ART treatment, Anna’s health improved significantly and she has continued to enjoy good health to this day.

Anna encourages others with similar self-stigma not to waste time but rather to quickly seek VCT services and to enjoy help from community caregivers. She thanks the caregivers for their work in her life. She testifies: “Caregivers do visit me with a number of lessons on ART adherence, prevention with positives, and many others. I really thank them.”

1.5.13 Zambia’s “Best Practice Ever” in Mosquito Net Distribution

It’s not often that a public health campaign is called “the best ever,” but these were the words of praise from the National Malaria Control Program of Zambia about the year-long campaign of long-lasting insecticidal nets distribution. The campaign, funded by DFID through USAID, supported the Ministry of Health to reach nine districts that had high malaria incidence rates. The USAID-funded STEPS OVC project worked with District Health Management Teams to train volunteers and community health workers. These trained cadres visited every household in Luapula Province and two districts in Eastern Province, distributing one million long-lasting insecticidal treated nets to achieve universal coverage. With the door-to-door distribution, volunteers physically hung the bed nets in every sleeping space and conducted follow up visits to ensure nets were used.

Clara Nkoma, an employee at Ndaiwale Rural Health Center, noted improvement over past distribution activities. “As a center we really appreciate this because the intervention will go a long way. We did the mass distribution in 2007 and we had a lot of challenges. We did not cover everyone. Many people were left out and had long lines of people waiting to receive the LLINs. We had a lot of people complaining of favoritism by volunteers who were involved in the distribution that time as they used to give basing on their discretion or size of the household and many people who were not in good relationship with the volunteers were left out. All because the system we were using that time was not as good as this one. This is the best because we were told to consider all sleeping spaces. Even the community appreciated this approach because we were able to cover the entire household. With this coverage we are expecting malaria cases to reduce”.



Picture 5: A community volunteer distributes mosquito nets to households.

Mr. Tembo, the Area Councilor for Kamimba Ward, stated: “People in the area have for long time suffered from malaria, but the mosquito nets have helped alleviate malaria cases.” Mr. Tembo, who also owns a drug store, observed a decrease in positive malaria tests and in sales of Coartem, a malaria drug. He said the nets have made a great impact on his community and applauded the work being done by the government and STEPS OVC.

While the National Malaria Control Center (NMCC) has seven years of experience with mass net distribution, this campaign stood out for several reasons, as pointed out by Cecilia Katebe, the Principal LLIN Officer at Zambia's NMCC: "The exercise was done with so much efficiency and coordination amongst all the stakeholders involved. There have been no grievances from any stakeholders...Through monitoring, we were able to see that the Neighborhood Health Committees were well trained and gave the households LLINs based on their need (sleeping spaces). I should comfortably say all the districts in the affected provinces have been 100% covered."

The NMCC plans to share lessons learned through stakeholder meetings and documentation in order to encourage replication of the model in future distribution exercises.

1.5.14 Brighter Future for Mary

Mary Wabusa comes from a family of nine members and stays with her mother, a Basic Care and Support (BCS) client and caregiver trained by the STEPS OVC project. Mary has been receiving support from STEPS OVC Project since 2010 when she was in grade nine. Through receiving educational support, she managed to complete high school. Subsequently, through links with STEPS OVC, Mary was selected for vocational training through an attachment at a local hotel in Mongu –the Rehoboth Hotel- for three months.



Picture 6: Wabusa N. Mary an Older OVC Beneficiary at Rehoboth Hotel

Mary's industrious attitude and commitment to work earned her a job as a cashier within of the first two weeks of her apprenticeship with the Rehoboth Hotel. This offer was based on her excellent work during on-the-job-training.

She is happy that what seemed to be just a training opportunity granted her full time employment and a monthly salary.

"I am grateful for this opportunity because I will now be able to assist my mother who is not employed."

She remains grateful to STEPS OVC for this opportunity, especially since she was raised by a single parent without a stable income in a family of nine. She further believes that her dream of being in college will come true.

This opportunity is indeed a stepping stone into a brighter future for Mary Wabusa.

1.5.15 From Humble Beginnings: Martha Mwape

A broad smile and "kalibu", the local welcome remark, greeted the STEPS OVC team as they visited Martha Mwape at her home.

Martha is a 31-year-old woman who lives in the Chiiba community in Kasama, the capital of the Northern Province of Zambia. Martha is married with three children and is one of the hard-working caregivers under the STEPS OVC



Picture 7: Martha Mwape at her foot pedal sewing machine

program in the Chiiba community. In addition to her role as a community caregiver, Martha is an entrepreneur with many business ideas.

When asked about her entrepreneurship skills, Martha explained, "I learned these skills from the economic strengthening training in 2012 organized by STEPS OVC. They trained us in entrepreneurship and saving skills. With the knowledge acquired, I and other community members formed a Savings and Internal Lending Communities (SILC) group with initial investments of about K2 as saving and K1 as social fund. With these meager savings, we successfully managed to raise K48 as savings and K20 as social fund fees in the first two weeks." Martha

then got a loan of K5 and purchased a needle, cotton, and thread to start a tailoring business where she sewed people's garments and charged a fee for the service.

"My life has changed drastically!" she exclaimed. Martha started her business with a few threads, cotton, and a needle, while renting a two-room house. Her business has since expanded; she bought a foot pedal sewing machine and lives in the five-room house that she owns. Martha also recently got a loan of K70 to fund her many other business ideas.

The group that Martha belongs to has responded positively to the STEPS OVC economic strengthening program. The majority of the members are female (25) while only three are males. The program deliberately targets empowering women as they are critical to the social and economic stability of their families. The group savings increased to about K100 within the first four weeks, prompting members to open a savings account. The loans borrowed by the group members vary from as low as K5 to as high as K100 with a 20% interest rate. No member has defaulted on a loan thus far. Total group savings currently stand at K600.

As the STEPS OVC team concluded its visit, Martha said, "I would like to see more people forming and joining savings groups not only in my community but in other communities as well. I have realized that people can be economically empowered through SILC groups. At the rate at which my businesses are expanding, I hope to build a house made of concrete blocks with an in-house toilet and kitchen."



Picture 8: Peter Kampamba in the St. James HBC Office counterchecking the caregiver visitation report

1.5.16 STEPS OVC Caregiving: An Opportunity to Save Lives

Peter Kampamba is a 50-year-old father of four who resides in Northern Province, Kasama district with his wife and children. His wife was found to be HIV-positive during an antenatal visit while pregnant with their youngest daughter in 2006. After his wife disclosed her status to Peter, he was supportive but chose not to be tested himself. In 2007, he suffered from tuberculosis and was compelled take an HIV test, which confirmed his suspicion that he was HIV-positive. The test results for his newborn baby were also positive. The news of Peter's HIV status left him feeling helpless and hopeless, and it seemed like the

end of life for him and his family. Although a counselor at his clinic linked him to a local positive-living support group, Peter did not feel like the group provided enough comfort for him. Fortunately, through adhering to his medication, Peter and his family's health improved. This improvement gave him both hope and the resolve to help other people in his situation.

His desire to serve those in need reached fruition in December 2010 when the STEPS OVC program came to St. James Parish, his local church... He quickly volunteered to be among the 20 community caregivers (CCs) and said that "from that day my life changed for the best," a statement that reflects how Peter chooses to narrate his life-changing story. Registered as a caregiver under STEPS OVC, he was privy to a number of trainings that included home-based care management. He recites that "STEPS OVC has trained me in OVC and HBC management, nutrition assessment counselling and support for people living with HIV. I can now do a Child Status Index (CSI) and MUAC on my fellow HIV positive colleagues. I have also been linked [to] and refer my clients to the Local Clinic where I was first diagnosed, and all this makes me feel good and useful to my community." He added that "I enjoyed training in Household dialogues as this has really equipped me to talk to not only other people, but also my children, on HIV prevention issues."

During the life of the project Peter has been able to recruit 13 Basic Care and Support (BCS) clients and 34 OVC clients STEPS OVC program by encouraging people to take HIV tests and using himself as a prime example. He has even disclosed his HIV status to his children and all of the members of his extended family. He feels that this disclosure has been a lesson of encouragement for those close to him, an idea supported by the fact that his older children voluntarily took HIV tests during a recent counseling and testing session.

1.5.17 I Am Now a Bread Winner!

Kalaba Musenge is a 28-year old young man who lives in the Mutendere compound of Lusaka. He lost both his parents at a very critical stage in his life—when he was supposed to begin his tertiary education. Through struggle and hard work, he managed to complete his secondary school, but no one came forth to support his higher learning.

When Kalaba noticed that things were getting worse and no one was willing to help, he started engaging in piecemeal work and would save money to start a business. He started a barbershop, and after working hard, was able to sponsor himself for training in Tourism and Hospitality at Fairview. He unfortunately had to drop out after a year due to insufficient funds.

Kalaba approached the STEPS OVC project for support and was told about the Vocational Training program. He accepted right away and was enrolled at the Protea Arcades Hotel. After undergoing attachment for three months, Kalaba was offered a job and eventually full employment. "I am happy STEPS OVC has such a program and I am happy to be part of it; I am now a breadwinner at home," said Kalaba who stays with his two siblings and two uncles. His two uncles are not formally employed so Kalaba has been the main source of income for the household ever since he got his job. Kalaba plans to save to go back to school and finish his studies.



Picture 9: A youth [on the right] who has received vocational training and is currently employed at a local hotel chain with his supervisor

World Vision STEPS OVC, via the PPP initiatives, entered into a partnership with the Hotel and Catering Association of Zambia [HCAZ] to avail youths who have dropped out of school or completed school but lack sponsorship for tertiary education. This initiative is an HIV/AIDS prevention model as well as a skill and job empowerment tool. Through its partnership, STEPS OVC aims to enroll as many youths as possible to the HCAZ 600-plus members across the country for an opportunity like the one given to Kalaba.

1.5.18 PD/Hearth: An Approach to Tackle Malnutrition in Limited Resource Settings

In August 2012, the program of PD/Hearth (positive deviance) was introduced in Mumbwa district by World Vision's STEPS OVC program. PD/Hearth is a community-based rehabilitation and behavior change intervention for families with underweight pre-school children. The 'positive deviance' approach is used to identify behaviors practiced by the mothers or caretakers of well-nourished children from poor families and to transfer such positive practices to others in the community with malnourished children. The 'Hearth' (or home) is the location for the nutrition, education and rehabilitation sessions. The PD/Hearth approach was initiated in the 1970s in Vietnam by Save the Children and has since been implemented all over the world by many different organizations, including World Vision.

As part of the PD/Hearth approach, an initial assessment identifies children at risk of malnourishment. Elias was identified during one of these assessments. Born on January 26th, 2011, Elias was found to be severely malnourished.

Elias's mother started attending PD/Hearth sessions, but she found it difficult to walk long distances. Eventually, instead of attending daily meetings, Elias's mother and siblings met once a week to continue the PD/Hearth practices in the home with the support of a volunteer community caregiver.

The mother recalls, "My child almost died, I became a laughingstock in the community because my son was so thin and appeared not to have flesh."

This ordeal started when Agnes got pregnant while she was still breastfeeding Elias. In the Zambian community when this happens, one has to stop breastfeeding because of the belief that the breast milk of a pregnant mother is tainted (unclean) and can cause death if the child continues to breastfeed. After she had stopped breastfeeding her child, he lost weight and eventually became malnourished to the point of death. Elias was three and could not do anything. He could not walk or crawl; he was just lifeless.

"When I joined the PD/Hearth session I continued to practice what we were being taught in the sessions and my child started improving bit by bit. Now my boy is walking and playing with other kids," She narrated. "I thank God for World Vision for coming up with such a wonderful program which brought my child to life. I pray that many other children in our community may be helped," said Agnes.

Indeed the STEPS OVC program has proved working for the mothers and their children. Many children's lives have changed for the better.

1.5.19 “I was abused by my father..”

Incest is an abomination in African culture. Unconsented incest is a wretched act, particularly when the abuser is the father whose role is to protect. The news spreads like wildfire as village people gossip. People can't believe it, who is it, I told you I don't know, some man from the other village is what I heard, but do we know her, tell me how old is his daughter? Everyone wants to see the man who can do such a thing—sexually abuse his daughters.

Domestic violence includes physical, sexual, emotional, psychological, or economical abuse committed by a person against a spouse, child, or any other member of a household—including dependents/parents of a child in that household (CSO,2009)². Abuse normally takes the form of men using their position of power to threaten the women and children in their lives.

In June 2013, the Site Coordinator of St. James Chiba project went to visit a home of one of his beneficiaries, Mirriam [pseudonym], who has a disability. Mirriam was married with two daughters, aged 8 and 12 at the time of the Site Coordinator's visit. Both girls were registered under the STEPS OVC program.

During the visit, the Site Coordinator, Emmanuel, counseled the girls on the importance of school, HIV prevention, and the need to report any abuse. He noticed that when he mentioned sexual abuse, the 12 year old girl grew impatient. When he tried to probe further, the father (who was in the house at the time) called the girl and sent her to buy bread.

Two days later, the girl went to the HBC office crying and refused to talk to anyone but Emmanuel and narrated the sad story to him. “This morning I caught my father having carnal knowledge of my young sister in the house. What is painful is that I thought I was the only one he was doing that to, I cannot stomach this anymore. Please help me and my sister to leave that home,” she pleaded.

Apparently her disabled mother was aware of her husband's sexual escapades that took place each time she went to the market, but she kept quiet about them. The father threatened to withdraw support if the girls refused to give in to his sexual advances. Emmanuel confronted the father, who dismissed the story. However, the Site Coordinator decided to involve the Parish Priest as the man was a well-known parishioner of St. James parish. Surprisingly, the man confessed in the presence of the Parish Priest, and Emmanuel decided to refer the matter to the police. Before he could conclude the referral procedure, the man fled and has not been seen since.

Visits from caregivers provide much needed counselling sessions to their beneficiaries helping them overcome some of their problems. The two girls are now with their mother and receive educational support from the CHAZ education program under St. James. “I want to thank USAID and STEPS OVC for the wonderful work they are doing. I do not know what could have become of me if the evil deeds of my father were not exposed,” concluded the older sister.

²Central Statistical Office (CSO), 2009. Zambia Demographic and Health Survey 2007. Calverton, Maryland, USA: CSO and Macro International Inc.



Picture of a healthy crop of rapeseed being grown in key hole gardens built with rocks in Luyeye Village.

1.5.20 “Our plants grow on stones...”

Initially popular in other parts of Africa, keyhole gardens are catching on in Zambia. Keyhole gardens hold moisture and nutrients due to an active compost pile placed in the center of a round bed. They can improve growing conditions in just about any climate.³

Luyeye village in the Kasama district is highly populated, denying people any reasonable space for gardening. The Kasama district has the highest population in the Northern Province with 238,035 people.⁴ People have to walk long distances to access arable land for gardening, which is now scarce. STEPS OVC beneficiaries have been affected by land scarcity and appealed for assistance to help alleviate the situation.

In response, Archdiocese of Kasama STEPS OVC trained 101 affected OVC and BCS households in keyhole gardening. Keyhole gardens are built from stone and use materials that can be obtained freely in people's communities. They do not require large tracts of land, and use very little water (and even water waste). Once built, they have a lifespan of five years.

After training, participants were equipped with the technical knowhow to build keyhole gardens. Each participant was encouraged to build at least one garden in their own homes. The Luyeye village reported that at least five households who did not have gardening space have built the keyhole gardens and successfully grown assorted vegetables in them.

Keyhole gardens are bringing diversity to limited diets. They also provide the nutrients that people who rely on staple crops (like maize) often lack, especially in colder months when leafy crops fail to grow properly. Since the development of keyhole gardens, villagers reported that they now grow a variety of vegetables in the gardens and have improved food security in their homes.

Keyhole gardens not only put food on the table—they also put money in people's pockets. Villagers reported that they can now afford to buy other foods with the proceeds of their vegetable sales. They can feed their families and can even sell some produce to pay for their children's school fees. The villagers also reported that they are now able to grow vegetables throughout the year as the keyhole gardens do not need much water.

³www.inspirationgreen.com/keyhole-gardens.html

⁴CSO (2011). 2010 Census of population and housing. Preliminary population figures. Lusaka. Central Statistics Office.

I.6 Program Indicators

I.6.1 | Qualitative Indicators

QUALITATIVE INDICATORS	ACCOMPLISHMENTS	CHALLENGES
1 Technical Assistance support provided to PCAZ	STEPS OVC worked with the MOH and Palliative Care Association of Zambia [PCAZ] to monitor and review MOH trainings and training materials used by partners. The monitoring revealed the need to conduct a TOT for both MOH and STEPS OVC trainers, which was conducted in FY11.	N/A
2 New models for piloting developed	Pilots started in FY2012	N/A
3 Mapping of services conducted	Phase I: there are at least 17 organizations in Zambia that have conducted a mapping exercise of resources, facilities, equipment, HIV/AIDS services, OVC services, and other socio-economic variables, of which almost half or 50% (8) are national-level-based and the rest are district-level-based, including community. Fifteen (15) of the seventeen (17), or nearly 90% of these organizations, have conducted their mapping since 2010. The earliest mappings were done in 2003 and 2005 respectively by a Faith Based Organization (Arise) and a Bilateral Development Partner (JICA).	N/A
4 Service delivery models developed	FY2012	N/A
5 Community Based Prevention Information System (COPIS) developed	The COPIS database was developed and rolled out to all implementing partners	N/A
6 Proactive Case Management System Piloted	FY2012	N/A
7 Mobile phone health platform piloted	The pilot started in FY2012	N/A

I.7 Implementing Partner and Sub-Grantee List⁵

Implementing Partner and Sub-Grantee List

1. Abana Chuma
2. Adolescent Reproductive Health Advocates
3. Africare*
4. Amec Quins Feeding Transit Care
5. AMEC Venture of Mercy
6. Antioch Outreach Ministries
7. Archdiocese of Kasama*
8. Archdiocese of Kasama-Chilubi
9. Archdiocese of Kasama-Chilubula
10. Archdiocese of Kasama-Ipusukilo
11. Archdiocese of Kasama-Kapatu
12. Archdiocese of Kasama-Kayambi
13. Archdiocese of Kasama-Lubushi
14. Archdiocese of Kasama-Luena
15. Archdiocese of Kasama-Luwingu
16. Archdiocese of Kasama-Malole
17. Archdiocese of Kasama-Mambwe
18. Archdiocese of Kasama-Mbala
19. Archdiocese of Kasama-Mporokoso
20. Archdiocese of Kasama-Mpulungu
21. Archdiocese of Kasama-Mungwi
22. Archdiocese of Kasama-Nondo
23. Archdiocese of Kasama-Nseluka
24. Archdiocese of Kasama-Nsombo
25. Archdiocese of Kasama-St. Annie's
26. Archdiocese of Kasama-St. John's
26. Archdiocese of Kasama-St. John's
27. Arise Community School
28. Assemblies of God – Chadiza
29. Balm Of Gilead Ministries
30. Baptist Fellowship of Zambia
31. Bethel Baptist-Samaritan Project
32. Bethel Christian Community School
33. Bethesda Zambia
34. Bread of Life
35. Bulanda Disabled Group
36. Butondo Home Care Programme
37. Busokololo Community Care Coalition
38. Bumi Bwesu Youth Centre
39. Buyantanshi Development Group
40. Bwafwano Community Home Based Care
41. Bwino Support Group
42. Care Youth Foundation
43. Chainda Tithandizane
44. Charity of Hope
45. Chibinganyama
46. Chingola Home Care Programme
47. Chipata Home Care Programme
48. Chisomo Community Programme
49. Chiyota Support Group
50. CARE International in Zambia*
51. Catholic Diocese of Chipata*
52. Catholic Relief Services*
53. Chabilo Support Group
54. Chibote HBC
55. Chilalantambo FBO –SDA
56. Children In Crisis
57. Children of the Most High
58. Child Participation Inclusive Education Mpika (CPIEM)
59. Chimane Mapenzi Association
60. Chisomo Community Programme
61. Chitaka Cooperative Group
62. Chitema Lesa Tunyamfwane Caregivers
63. Citadel League of Mercy (Livingstone Citadel)
64. CMML
65. Community Development Committee
66. Covenant OVC Project
67. Copper Belt Health Education*
68. Development AID From People to People*
69. Development organization for People's Empowerment
70. Diocesan of Catholic Women club
71. Diocese of Mongu*
72. Diocese of Mongu-Lourdes
73. Diocese of Mongu-St Agatha
74. Diocese of Mongu-St Francis
75. Diocese of Mongu-St John's (Katongo)

⁵Organizations with denoted with a star "*" have been a direct partner and implementer at one point of the program.

Implementing Partner and Sub-Grantee List, cont.

- | | |
|---|---|
| 76. Diocese of Mongu-St Jude | 116. Diocese of Solwezi-St Daniel |
| 77. Diocese of Mongu- St Lawrence | 117. Diocese of Solwezi-St Dorothy |
| 78. Diocese of Mongu- St Martin | 118. Diocese of Solwezi-St Francis |
| 79. Diocese of Mpika* | 119. Diocese of Solwezi-St Kalembe |
| 80. Diocese of Mpika-Chalabesa | 120. Diocese of Solwezi-St Kizito |
| 81. Diocese of Mpika-Chilonga | 121. Diocese of Solwezi-St Mary's |
| 82. Diocese of Mpika-Ilondola | 122. Diocese of Solwezi-St Philips |
| 83. Diocese of Mpika-Katibunga | 123. Dove Christian Fellowship Church |
| 84. Diocese of Mpika-Kopa | 124. Dunamis PAOG |
| 85. Diocese of Mpika-Mulanga | 125. ECR- Chanjowe BCS |
| 86. Diocese of Mpika-Mulilansolo | 126. ECR- Sindemisale Church Committee |
| 87. Diocese of Mpika-Nakonde | 127. ECR_True love waits/Baptist Mission |
| 88. Diocese of Mpika-St Mark's | 128. ECR-chanida Tithandizane |
| 89. Diocese of Mpika-St. Andrew's | 129. ECR-ITEZHI TEZHI Pastors' Fellowship |
| 90. Diocese of Mpika-St. John's | 130. ECR-Kanzwaa OVC Project |
| 91. Diocese of Mpika-St. Joseph's | 131. ECR-Kapachi Churches Committee |
| 92. Diocese of Mpika-Tazara | 132. ECR-Long life Support Group |
| 93. Diocese of Ndola* | 133. ECR-Luzando HIV Support Group |
| 94. Diocese of Ndola-St Annie | 134. ECR-Maanu Kwabana OVC Support Group |
| 95. Diocese of Ndola-St Annualit | 135. ECR-Mkumbudzi Churches HIV/AIDS project |
| 96. Diocese of Ndola-St Anthony's | 136. ECR-Muchenjeza CATF Committe |
| 97. Diocese of Ndola-St Elizabeth | 137. ECR-Mwana Maria Project |
| 98. Diocese of Ndola-St Mary's | 138. ECR-NZP+ |
| 99. Diocese of Ndola-St Maximillian Kobe | 139. ECR-RCZ (Tilipamodzi) BCS |
| 100. Diocese of Ndola-St Mbanga | 140. ECR-RCZ Chimanimni (Tabitha) BCS |
| 101. Diocese of Ndola-St Peter's | 141. ECR-RCZ Kabwe Central (Chifundo) BCS |
| 102. Diocese of Ndola-St Theresa | 142. ECR-RCZ Railways (Chisomo) BCS |
| 103. Diocese of Ndola-St. Saviour | 143. ECR-Shekinah Ministries to Widows & Orphans |
| 104. Diocese of Solwezi* | 144. ECR-Siavonga OVC/BCS CBO |
| 105. Diocese of Solwezi-Holy Family | 145. ECR-Tuisunge BCS |
| 106. Diocese of Solwezi-Holy Trinity | 146. ECR-Victory Bible Church |
| 107. Diocese of Solwezi-Mother of God | 147. ECR-Zamtan Foundation |
| 108. Diocese of Solwezi-Mt Camel | 148. EFZ Chipata Pastors Fellowship |
| 109. Diocese of Solwezi-Our lady of consolation | 149. Emmanuel Transit Centre |
| 110. Diocese of Solwezi-Our lady of Fatima | 150. Evangel-Oasis of Love |
| 111. Diocese of Solwezi-Sacred Heart Chinyingi | 151. Expanded Church Response* |
| 112. Diocese of Solwezi-Sacred Heart Ikelenge | 152. Fitole Kanengo Development Group |
| 113. Diocese of Solwezi-St Andrews | 153. Foundation for Wildlife and Habitat Conservation |
| 114. Diocese of Solwezi-St Andrews kim | 154. God Our Help |
| 115. Diocese of Solwezi-St Anthony | 155. God's Faithful Fruitful Ministries |

Implementing Partner and Sub-Grantee List, cont.

- | | |
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| 156. Group Focused Consultation (GFC) | 196. KLuZZ Home Care Programme |
| 157. Grassroot Soccer Zambia (GRSZ) | 197. Kocebuka Community Foundation |
| 158. Hearts of Compassion | 198. Kokwe Parish |
| 159. Helping Hand-Muchila SDA | 199. Konkola HBC |
| 160. Hippo Pool BCS | 200. Kuomboka Youth Group Proposal |
| 161. HODI | 201. Kuunika Community Project |
| 162. Hope Cavalry OVC Project - Zambia | 202. Latkings Outreach Programme |
| 163. Hope Orphans and Vulnerable Children in Schools | 203. Lazarus Project |
| 164. Hope for the Needy | 204. League of Mercy – Chifubu |
| 165. Ibolelo Community OVC Committee | 205. League of Mercy – Chirundu |
| 166. Ipusukilo Home Care Programme | 206. League of Mercy – Chipata corps |
| 167. Itimpi Home Care Programme | 207. League of Mercy - Kabwe (Tuyimwine) |
| 168. Jesus Cares Ministry* | 208. League of Mercy – Kapirimposhi |
| 169. Kabanda Community Based Organisation | 209. League of Mercy – Livingstone |
| 170. Kabuta Convent for OVC | 210. League of Mercy – Malakata |
| 171. Kachima Community Development Initiative | 211. League of Mercy – Choma |
| 172. Kachiweshi CCC OVC Support Group | 212. League of Mercy - Nakambala |
| 173. Kaindu Community Trust | 213. Life Liner |
| 174. Kalichero Parish | 214. Longlife Support Group |
| 175. Kanyanga Catholic Parish | 215. Luanshya Home Care Programme |
| 176. Kamach | 216. Lulamba Community Outreach |
| 177. Kampekete Home Based care | 217. Luminary Foundation |
| 178. Kanshiwa OVC/ HBC | 218. Lumimba Parish |
| 179. Kalomo Boma Youth Club | 219. Lushomo Community Based Organisation |
| 180. Kalomo Interdenominational Christian Fellowship | 220. Lusumpuko Youth Club |
| 181. Kalomo Mumuni Centre | 221. Luyando Home Based Care and Support Group |
| 182. Kalomo NZP+ District Chapter | 222. Luyando SDA |
| 183. Kanakantapa Youth Resource Centre | 223. Luyando Support Group |
| 184. Kanakantapa OVC | 224. Luyobolola Community School (Mazabuka) |
| 185. Kampemba OVC/PLWA | 225. Maboshe Memorial Foundation |
| 186. Kapachi Churches Committee | 226. Maipalile Community School |
| 187. Kapisha Home Care Programme | 227. Makungwa Area Development Programme |
| 188. Kapilamikwa Community Development Committee | 228. Mapesho Orphans and Vulnerable Children Club |
| 189. Kapululwe Area Development Committee | 229. Malelekwa Kwasheka Women's Group |
| 190. Kasama Art Theatre | 230. Mansa Diocese- Chibote |
| 191. Kasama young Media | 231. Mansa Diocese* |
| 192. Kashikishi Home Based Care | 232. Mansa Diocese-Milenge |
| 193. Kataji Community Based Organization | 233. Mansa Diocese-Mwense |
| 194. Kawama Widows and Orphans Project | 234. Mary Mother of God |
| 195. Kazembe Home Based Care | 235. Mansa Diocese-St Marys |

Implementing Partner and Sub-Grantee List, cont.

236. Masahanana
237. Mazabuka Community Enterprise
238. Mbwindi Parish
239. Minga Parish
240. Mphangwe Prayer Centre
241. Maraoundi Caregroup Coalition
242. Msipadzi Catholic Parish
243. Matipa Development Association
244. Mpatamatu HBC
245. Mawaya Behavior Change Club
246. Mayo mpapa PD Hearth Nutrition Group
247. Mboole Rural Development Initiative
248. Mtendere Community Child Care Forum
249. Messiah Ministries
250. Milubamfwa BCS
251. Milulu Care Group
252. Moobola BCS Manza Gwasha
253. Moment of Hope Counseling Centre
254. Mongu Diocese-Kalabo
255. Mongu Diocese-Lukulu
256. Mongu District Farmers Association
257. Monze Women Development Association
258. Monze League of Mercy
259. Mlawe OVC Project
260. Mphatso Development Foundation
261. Mufulira Home Care Programme
262. Mukalangala CBO
263. Mushili-Kaloko Home Care Programme
264. Mumbwa Community Trust
265. Mumbwa Home Based Care
266. Mumbwa NZP+
267. Munene Community Outreach (MUCO)
268. Mushota Community Care Coalition
269. Mutende BCS
270. Mututa Memorial Day Centre
271. Muzeyi Home Based Care
272. Mwaiseni BCS
273. Mwanachingwala care and support Association
274. Ndekeleni Development Foundation
275. Ndola Home Care Programme
276. Nakambala Community Based Care and Awareness Initiative
277. Nakasika Cluster Level Women Association
278. Namumu Orphanage Centre
279. Namuso Community Development Organisation (NACODO)
280. Nangwenya Village Support Group
281. Nanoko Youth Group
282. National Organisation for Agricultural Development in Communities (NOCAD)
283. Natwafwane Support group
284. Nchelenge Inter-Denomination Youth and Sharing Initiative Group
285. Needs Day Care Center
286. Nega-Nega Home Based Care
287. Network of People Living with HIV/AIDS
288. New Hope Support Group
289. New Kachema Musuma Childern's Home
290. Ngungu Youth Association
291. Northern Health Education Programme (NOHEP)
292. Not by Might
293. Nsenga Cultural Heritage
294. Nyamphande Anti AIDS Project
295. Nyimba Adventist Men Organisation (NAMO)
296. Nyimba Corps League of Mercy
297. NZP+ Mongu
298. NZP+ Mwinilunga
299. NZP+ Namwala
300. NZP+ Nchelenge
301. NZP+ Nyimba
302. NZP+ Siavonga
303. NZP+ Sinazongwe
304. NZP+ Kaoma
305. NZP+ Katete
306. NZP+Kawambwa
307. Our Lady of Victory (Lumezi Parish)
308. Palliative Care Association of Zambia (PCAZ)
309. Pentecostal Holiness Church in Zambia
310. Peoples' Progress on Housing and Poverty in Zambia

Implementing Partner and Sub-Grantee List, cont.

- | | |
|---|--|
| 311. Petauke Nutrition Group | 350. St. Paul's Parish (Lundazi) |
| 312. Pillar of Love | 351. SS Peter and Paul (Chassa Parish) |
| 313. Ponde HIV/ AIDS Foundation | 352. Sukumuna Centre for the Needy |
| 314. Programme for Vulnerable Children and Women (PVCW) | 353. Tabitha |
| 315. Ray of Hope Association | 354. TRaKK Home Care Programme |
| 316. RCZ – Chifundo HBC | 355. Twaima Multipurpose Organisation |
| 317. RCZ Integrated Project - Mbala | 356. Twapia Home Care Programme |
| 318. RCZ – Railways (Chisomo) HBC | 357. TAZARA HIV/AIDS/STIs Club. |
| 319. RCZ – Kabwe Prisons (Chombo) | 358. Thandizani Community Based |
| 320. RCZ – (Tilipamodzi) HBC | 359. The Salvation Army* |
| 321. Reaping Year Support Group | 360. Tisungane Support Group |
| 322. Reformed Church in Zambia – Mbala | 361. Treatment Advocacy and Literacy Campaign |
| 323. Reformed Church in Zambia- Lesa waluse | 362. Tubalange OVC Care & Support Cooperative |
| 324. Renato Community Society | 363. Tubombelepamo PMTCT HIV/AIDS Community Support Organization |
| 325. Rise Community Aid Programme | 364. Tubombeshe Nutrition Club |
| 326. Rising Fountain Development Programme | 365. Tuisunge HBC |
| 327. Selantambe Popular Theatre | 366. Tuzumanane |
| 328. Senga Koselela HIV/AIDS Support Group | 367. Twaima Multipurpose |
| 329. Shalom Project | 368. Twanguluke Support Group |
| 330. Shamah Workshop Carpentry and Metal | 369. Twanwane BCS |
| 331. Shuko Home Based Care | 370. Twasekela HIV/AIDS Support group |
| 332. Siachibondu HIV/AIDS Prevention Education(SHAPE) | 371. Twikatane Nensasa Youth Club |
| 333. Siavonga Apostles Faith | 372. Ukwimi Parish |
| 334. Siavonga OVC/ HBC CBO | 373. UCZ – Lilelo VCT Centre |
| 335. Silukwiya BCS | 374. UCZ_ Mirriam Ebenezer BCS |
| 336. Sinazongwe Youth Club | 375. UCZ – Youth Project |
| 337. Sport In Action | 376. Venture of Mercy |
| 338. Spring of Hope | 377. Victory Bible Church – Liberty House |
| 339. Sisters of the Holy Spirit | 378. Vineyard Pentecostal Holiness |
| 340. Social Development Agency | 379. Vision Africa Regional Network Zambia |
| 341. St. Anne's Cathedral Parish | 380. Wakumbu Womens Club |
| 342. St. Anna OVC Project | 381. Women Empowerment Alliance |
| 343. St. Atanazio | 382. Women, Widows, Orphans and Youth League of Mercy |
| 344. St. John's Parish | 383. Womens Lobby Group |
| 345. St. Joseph Anglican Home Based Care | 384. Womens Malelekwa Kasheka Club |
| 346. St. Joseph Catholic Church (Chikungu) | 385. Word of Salvation Church |
| 347. St. Mary's Home Based Care | 386. World Vision Zambia* |
| 348. St. Mathias Mulumba | 387. Watershade Zambia |
| 349. St. Oscar's Parish | |

Implementing Partner and Sub-Grantee List, cont.

- 388. YMCA – Chibombo
- 389. Youth Activists Organization
- 390. Youth Against HIV/AIDS
- 391. Youth Alliance For Development
- 392. Youth and Child Care Foundation
- 393. Youth Development Association, Mapalo care for OVC project
- 394. Youth Hope Initiative
- 395. Zambia Anglican Council
- 396. Zambia Interfaith Network Group (ZINGO)
- 397. Zambia Open Community Schools*
- 398. Zambia National Women Lobby – Nchelenge Chapter
- 399. ZAMTAN Foundation
- 400. ZNAPH
- 401. Zambia Women Development Association
- 402. Zambia Youth Development
- 403. Zambia Youth Workers Initiative

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