

# ZAMBIA FINAL REPORT

October 1997–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



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**Final Report**  
**for the**  
**Implementing AIDS Prevention and Care (IMPACT) Project**  
**in Zambia**



**October 1997 to September 2007**





## **Zambia Final Report**

*Submitted to USAID  
By Family Health International*

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## **GLOSSARY OF ACRONYMS**

BCC	Behavior change communication
CBO	Community-based organization
CDC	U.S. Centers for Disease Control and Prevention
COVCC	Community OVC committees
CT	Counseling and testing
DATF	District AIDS taskforce
DHMT	District health management team
DOVCC	District OVC committees
FBO	Faith-based organization
FHI	Family Health International
FSW	Female Sex Worker
GRZ	Government of the Republic of Zambia
HBC	Home-based care
IMPACT	Implementing AIDS Prevention and Care Project
JICA	Japan International Cooperation Agency
M&E	Monitoring and evaluation
MOH	Ministry of Health
NGO	Nongovernmental organization
OVC	Orphans and vulnerable children
SCOPE-OVC	Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children
STI	Sexually transmitted infection
TA	Technical assistance
TDRC	Tropical Diseases Research Centre
USAID	U.S. Agency for International Development
VCT	Voluntary counseling and testing
ZHECT	Zambia Health Education and Communication Trust

## ACKNOWLEDGMENTS

Several partners—ranging from national governmental organizations to grassroots community groups—collaborated on the FHI IMPACT/Zambia Project. Knowledgeable and experienced individuals from diverse professional fields handled project design and implementation. The FHI/Zambia staff would like to thank all who contributed in one way or another to this successful implementation of activities and delivery of services.

At the national, policy-making level, FHI worked with the Ministry of Health (MOH) of the Government of the Republic of Zambia (GRZ). This high-level collaboration ensured the cooperation and involvement of key partners at the district and local levels. Specifically, we acknowledge the support of the district health management teams (DHMTs) in the planning and delivery of activities, including treatment for sexually transmitted infections (STIs) and HIV counseling and testing (CT) in sites serviced by the Corridors of Hope Project. During implementation, the DHMTs also played a supervisory role to ensure that clinical services followed the government's guidelines and met standards of quality.

We acknowledge the collaboration of family support units (FSUs) nested at the three children's hospitals: the University Teaching Hospital (UTH) in Lusaka, Mosi-O-tunya/Batoka Hospital in Livingstone, and the Arthur Davison Hospital in Ndola. We also wish to thank the community and districts members in the 12 sites of the Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children (SCOPE-OVC) Project for their tremendous support and involvement in ensuring that activities continued after the project ended.

We would like to acknowledge the critical roles played by the implementing partners in Corridors of Hope. World Vision Zambia, Society for Family Health (SFH), and the Zambia Health Education and Communication Trust (ZHECT) contributed significantly to our strategic planning, unity of purpose, and day-to-day work in implementing this project.

Finally we are grateful to the U.S. Agency for International Development (USAID), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and the U.S. Centers for Disease Control and Prevention (CDC) for providing FHI the opportunity and ongoing support to implement the range of projects made possible through IMPACT funds.

## EXECUTIVE SUMMARY

From October 1997 until September 2007, Family Health International (FHI) managed an investment of more than \$17 million in IMPACT funds to address the HIV crisis in Zambia, providing direct services to hundreds of thousands of individuals and numerous communities. FHI worked closely with the GRZ, USAID, and local partners to implement three major projects:

- SCOPE-OVC – a project addressing the educational and psychosocial support needs of orphans and vulnerable children (OVC) and their caregivers
- Psychosocial Support to HIV-Positive Children and Their Families – a program providing recreation, education, and entertainment to HIV-positive children and their caregivers with the overall goal of improving each child’s physical and emotional well-being
- Corridors of Hope – an initiative offering STI services and behavior change information to vulnerable communities—chiefly long distance truck drivers and female sex workers (FSWs)—as well as abstinence and be faithful messages for youth and CT services

Although these projects were in some ways very different from one another, their lessons have all been incorporated into strategies and practices at the national, district, and community levels. This has strengthened the nation’s response to the challenges presented by HIV and AIDS.

- SCOPE-OVC formed linkages between government, faith-based organizations (FBOs), and civil society in addressing the educational and psychosocial support needs of OVC. It built the capacity of nongovernmental organizations (NGOs) and reduced overlap in service provision. SCOPE-OVC also informed a national strategy for supporting OVC.
- Psychosocial Support for HIV-Positive Children and Their Families provided 763 children living with HIV/AIDS and 866 caregivers with psychosocial support at three children’s hospitals in Lusaka, Livingstone, and Ndola (this surpassed a target of 650 children reached). Before project’s end, activities were extended to two community health centers so children could be cared for closer to home.
- Because of Corridors of Hope’s behavior change communication (BCC) initiatives targeting vulnerable populations, the number of FSWs requiring clients to use condoms more than doubled by the end of the project. The number of long distance truck drivers who reported being faithful to their spouses in the last 12 months increased. And the number of sex workers who received HIV counseling, testing, and results tripled by the end of the project.

FHI also used IMPACT funds to support a CDC project designed to evaluate syndromic management algorithms for treating STIs in primary health clinics. Although the project is not yet complete, this report will still offer some preliminary results.

# PROGRAM STRATEGIES, IMPLEMENTATION, AND RESULTS

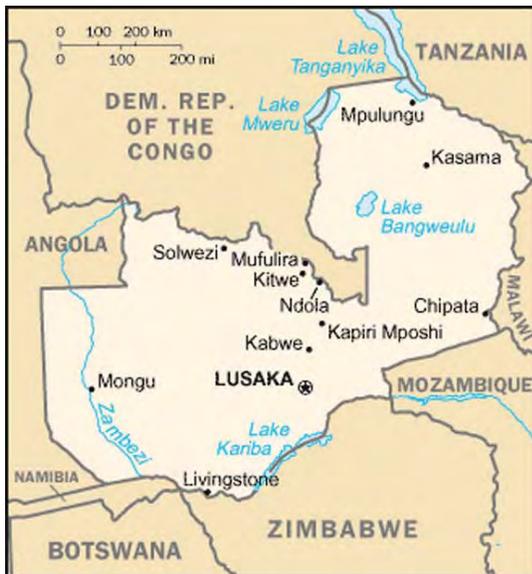
## Introduction

In 1997, FHI began working in Zambia to address the GRZ's priorities for preventing the transmission of HIV and caring for those affected and infected. In its first years with IMPACT funding, FHI managed a variety of projects: hosting workshops focused on lessons learned and best practices in STI management and evaluation; conducting a three-week assessment of STI services; hosting a two-day national STI consensus meeting titled, "Enhancement of STI Prevention and Control in Zambia."

In 1999, FHI began implementing the first of four significant programs presented in greater detail in this report. All projects were executed in partnership with carefully chosen NGOs and institutes. In total, FHI received \$17,792,339 in IMPACT funds. Of that, FHI provided approximately \$12.5 million to implementing agencies in the form of subagreements, task orders, and contracts.

## Country Context

Zambia was once a middle income country powered by the copper mining industry. At the beginning of 2000, however, the country struggled to reverse nearly three decades of economic decline despite an ongoing and extensive economic liberalization program. Living standards were also lower than they had been in the past.



In 2000, Zambia had a population 10.3 million.<sup>1</sup> Nearly 78 percent of Zambians lived below the poverty line. People suffered from chronic malnutrition and had insufficient access to basic social services, such as education and healthcare. The formal employment sector offered limited opportunities, with low-skill or informal labor providing the most jobs.

The country also seemed to be experiencing a decline in population growth. Between 1990 and 2000, the population grew at a rate of 2 percent per year, compared with a growth rate of 3.1 percent in the previous decade. HIV/AIDS was a major contributing factor to the decrease.

HIV/AIDS was—and continues to be—Zambia's most challenging development problem. In 1997, nearly 20 percent of people older than 15 were infected with HIV.<sup>2</sup> Females had a higher infection rate than males.

<sup>1</sup> Central Statistics Office (CSO), *National Census*, 2000.

<sup>2</sup> MOH/NAC, *HIV/AIDS in Zambia: Background Projections, Impact, Interventions*, 1997.

The epidemic contributed to the reversal of social and economic development achievements of the post-independence era (Zambia gained independence from Great Britain on October 24, 1964). After decades of improvement, infant and child mortality rates were rising. Tuberculosis rates escalated. Health facilities were stretched beyond their capacity to cope and provide care for patients. The costs of healthcare for persons infected with HIV were burgeoning and stretching family resources.

The government launched several initiatives to respond to the pandemic and ameliorate its negative socioeconomic impact. Among them were the following:

- a) In 1986, the government established the National AIDS Prevention and Control Program. It also developed an emergency short-term plan to ensure safe blood and blood product supplies.
- b) Between 1988 and 1992, the first medium-term plan prioritized eight operational areas: tuberculosis and leprosy information; education and communication; counseling; laboratory support; epidemiology and research; STI and clinical care; program management; and home-based care (HBC).
- c) Between 1994 and 1998, the government implemented the second medium-term plan, which was multisectoral in design, and incorporated a mechanism for intersectoral coordination and collaboration.
- d) Between 2001 and 2003, the government developed a national HIV/AIDS strategic framework.
- e) In 2002, the government produced the national HIV/AIDS/STI/TB intervention strategic plan (2002–2005).
- f) In 2004, the government produced the national HIV/AIDS/STI/TB monitoring and evaluation (M&E) plan (2002–2005).
- g) In 2005, the government developed the Zambia HIV and AIDS strategic framework (2006–2010) and the fifth national development plan (2006–2011).

Initial responses to HIV/AIDS in Zambia were inadequate to contain a problem that was more than just medical in nature. Subsequent programs and strategies, therefore, sought to foster political commitment at the highest levels and develop intersectoral approaches encompassing all government line ministries, the private sector, civil society, and people living with HIV/AIDS (PLHA).<sup>3</sup>

The following sections highlight the four major projects undertaken through IMPACT in Zambia: SCOPE-OVC, Psychosocial Support to HIV Positive Children and their Families, Corridors of Hope, and Evaluation of the Syndromic Management Algorithms for the Treating of STIs in Primary Health Clinics.

The chart on the following page provides a good orientation to the activities that will be discussed.

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<sup>3</sup>NAC, *National HIV/AIDS/STI/TB Policy*, January 2005.

PROJECT	RESULTS
<p><b>SCOPE-OVC</b> (Jan. 2000–September 2004) <i>Targeting OVC and their caregivers and communities</i></p>	<ul style="list-style-type: none"> <li>• Created community level structures and ownership of activities.</li> <li>• Promoted multisectoral partnerships.</li> <li>• Created linkages between the government, FBOs, and civil society to respond to the OVC crisis.</li> <li>• Helped reinforce traditional family values and reduce stigma by encouraging families to care for children instead of using sub-granting mechanisms that do not directly support an individual.</li> <li>• Enhanced local response: formed 12 district and 131 community committees dealing with the needs of OVC.</li> <li>• Reached over 500,000 OVC with at least one type of program support.</li> </ul>
<p><b>Psychosocial Support to HIV+ Children and Their Families</b> (October 2002–March 2005) <i>Targeting children in three hospitals living with HIV and AIDS and their caregivers</i></p>	<ul style="list-style-type: none"> <li>• 758 children with HIV and AIDS and 866 guardians/parents received psychosocial support.</li> <li>• 2,262 children admitted to hospitals received education support.</li> <li>• 21 capacity building trainings took place.</li> </ul>
<p><b>Corridors of Hope</b> (August 1999–June 2006) <i>Targeting groups at high risk for HIV transmission, especially sex workers and long distance truck drivers; also providing activities for youth</i></p>	<ul style="list-style-type: none"> <li>• HIV prevention activities covered major border and high-risk corridors.</li> <li>• Project accepted by key stakeholders.</li> <li>• Increased the number of FSWs reporting condom use with paying partner at last sex (from 49.6 percent in 2000 to 78.6 percent in 2006).</li> <li>• Increased proportion of FSWs tested for HIV (from 12 percent in 2000 to 50 percent in 2006).</li> <li>• Increased long distance truck drivers reporting not having sex with FSW from 79 percent in 2000 to 84 percent in 2006.</li> <li>• Reduced number of long distance truck drivers reporting sex with more than two regular partners from 18 percent in 2000 to 4 percent in 2006.</li> <li>• Trained 188 FSWs as peer educators and 50 as outreach workers.</li> <li>• In 2005, reached more than 200,000 local residents with BCC information and more than 36,000 adolescents with abstinence messages.</li> <li>• Distributed nearly 1.2 million condoms.</li> </ul>
<p><b>Evaluation of the Syndromic Management Algorithms for Treating STIs in Primary Health Clinics</b> (December 2002–July 2007)</p>	<ul style="list-style-type: none"> <li>• Spearheaded evaluation study to validate STI algorithms used in government primary healthcare of Zambia.</li> </ul>

## **HIGHLIGHTS OF MAJOR ACTIVITIES**

### **Strengthening Community Partnerships for the Empowerment of OVC (SCOPE-OVC)**

implemented by CARE Zambia

Start Date: January 2000

Completion Date: September 2004

Target Population: OVC and their guardians/caregivers, households, and communities

### **Program Context**

In Zambia in 2000, children bore an unfair impact of the HIV epidemic. Very young children carried the burden of the disease directly, passed on from their parents or through the loss of their parents or caregivers. Many other children came from HIV-impacted households. These households' coping strategies and safety nets were severely tested by the cumulative effects of poverty, disease, and an increasing dependency burden.

According to *Children on the Brink*, in 2000 Zambia had nearly 1.2 million orphan<sup>4</sup> children. Families were stretched to the point of buckling as they absorbed additional children into their households. Guardians were unable to pay school fees—both government and private—so children followed the informal community school structure instead of the formal school system. Families often ate one meal a day or less. Many orphans were looked after by grandparents, so this also caused concern about what would happen to these children as their grandparents aged or died.

In September 1999, USAID/Zambia asked FHI to manage a project called SCOPE-OVC. FHI initiated a competitive bidding process, awarding a two-year, nine-month, \$2.6 million subagreement to CARE Zambia. CARE Zambia served as the primary implementing partner, with FHI providing technical assistance (TA) and project monitoring. Four amendments were added to the subagreement with CARE, and the project lasted until September 2004. Funds committed totaled nearly \$5.2 million.

### **Program Strategies and Activities**

As important as it is to ensure that households have access to food, clothing, shelter, health, and education, SCOPE-OVC did not set out to offer direct service provision. Instead, program implementers tried to unite various OVC players at district and community levels and build their capacity to respond to the emerging OVC crisis. SCOPE-OVC created linkages and partnerships between government, FBOs, and civil society. It strengthened community based and community led responses to the needs of OVC at several levels, paying special attention to those affected by HIV/AIDS.

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<sup>4</sup>Children on the Brink defines an orphan as a child under 15 who has lost one or both parents.

Levels of interventions were as follows:

- **Multisectoral District Initiatives:** SCOPE-OVC worked with multisectoral district OVC committees (DOVCCs) to assess and respond to the situation of OVC in their districts. SCOPE-OVC provided training and other capacity building interventions to the district committees to enable them to fulfill this function.
- **Community Committees:** SCOPE-OVC built the capacity of community OVC committees (COVCCs) by engaging them in participatory assessment activities. SCOPE-OVC provided organizational training, financial management, and other related training to enable these committees to function independently.
- SCOPE-OVC united multiple organizations by strengthening multisectoral committees and forming networks that inspired wide community participation and action that has continued beyond the life of the project.

SCOPE-OVC's basic strategies included:

- **Community Mobilization:** SCOPE-OVC strengthened the mobilization capacity of the DOVCCs and COVCCs. This enabled them to help prioritize community needs and begin identifying local resources to meet needs.
- **Capacity Building:** Capacity building took place in many different areas, including financial management, fundraising, proposal writing, and various OVC technical interventions, such as psychosocial support skills-building and organizational skills.
- **Grants Mechanisms:** Only after communities were strong enough to support OVC programs were grants used to support household responses. SCOPE-OVC disbursed grants to community-based organizations (CBOs), FBOs, and NGOs to engage in OVC activities.

These strategies complemented the following interventions:

- Providing enough food and other resources to enable children to attend school.
- Offering psychosocial support to create awareness in communities and households of the importance of providing for the psychological and social needs of children, equipping both adults and children with coping and negotiating skills.
- Providing an environment for children to attend both conventional and community schools and creating opportunities for children to move on to secondary and higher education.

## **Implementation and Management**

As primary implementing partner, CARE Zambia provided overall management and implementation of SCOPE-OVC: hiring staff, procuring equipment, and handling other issues related to effective implementation. At the end of the project, SCOPE-OVC had activities in 12 of the 72 districts of the country covering six of the nine provinces in Zambia.

The structures established by CARE to oversee the project were:

- The project management team
- The SCOPE-OVC advisory committee
- The grants management committee

The composition of the project management team evolved as CARE learned about the communities' emerging needs. Project management team senior staff included the project manager, two assistant project managers, a grants manager, two regional supervisors, the education coordinator, a household economic security coordinator, an information officer, and an M&E coordinator.

The SCOPE-OVC advisory committee was set up at the national level to provide broad guidelines and recommendations on project direction. The committee comprised key stakeholders, including government ministries.

The grants management committee developed the grant award criteria, assessed proposals, approved awards, and monitored grants. It met quarterly and, using the criteria provided in the grants manual, approved 161 proposals for a total of \$997,525.

SCOPE-OVC placed a community mobilization officer in each district to facilitate activities there. Working with the project management team, the community mobilization officers helped carry out participatory learning activities with communities and districts. Each community mobilization officer also served as a liaison between district partners, including the Lusaka office.

As noted above, SCOPE-OVC worked with existing structures, district- and community-level OVC committees, FBOs, CBOs, and NGOs to identify, plan, and organize activities supporting OVC directly and their communities indirectly. A review team identified the following challenges to this central strategy:

- a) There was a lack of recognition of the DOVCCs in a formal permanent district structure, such as the District Development Coordinating Committee (DDCC) or the district AIDS taskforce (DATF) because it was not a registered committee and therefore not a legal entity. In some districts even the DDCC and DATF were not functioning.
- b) Funding provided by SCOPE-OVC for the cost of running the DOVCCs was inadequate to carry out planned activities.
- c) DOVCC members faced time constraints and multiple responsibilities.
- d) Some of the communities where SCOPE-OVC worked did not have experience working together.
- e) Capacity building and linkages to resources needed to be ongoing and not "one-off" activities.
- f) The larger needs of communities beyond the scope of the project needed to be considered, such as access to improved infrastructure.
- g) There was a lack of immediate assistance for food in some homes that received household economic support in the form of agriculture inputs such as seeds, fertilizer, or tools. These people still did not have food until the harvest period.

- h) Some households that received loans were unwilling to pay them back.
- i) Some psychosocial support concepts in English—grief, insecurity, children’s rights, and peer counseling—were difficult to comprehend and difficult to interpret in local languages. As a result, some of the people trained still misunderstood the concepts.
- j) Given their meager incomes, some households were unable to contribute to community school volunteer teachers’ salaries.
- k) School infrastructure was poor. Essential school facilities—clean water and latrines—were in limited supply.
- l) There was low capacity at the COVCC level for improving management competency despite the training.
- m) There were language barriers in training for capacity building activities at the COVCC level.
- n) It took a long time to award grants. This led to delays in implementing approved proposals.
- o) There was a lack of salaries and regular incentives for teachers. This adversely affected teacher retention in community schools.

## **Program Results**

### **Outputs**

#### ***Reports, Assessments, and Studies***

- 1) *Case Studies of Success in the SCOPE-OVC Project: A Guide to Assist OVC Programming.* July 2004.
- 2) Craft, Don. *Education Evaluation of the SCOPE-OVC Project: The Impact of the SCOPE Education Sub-Grant on Community Schools in Selected Districts.* March 2003.
- 3) *Final Project Review Report SCOPE-OVC.* March 2004.
- 4) Harland, Charlotte and Andrew Mlewa. *Case Studies of Success in the SCOPE-OVC Project: A Guide to Assist OVC Programming.* July 2004.
- 5) Harland, Charlotte and Guy Scott. *Food Insecurity, HIV/AIDS & Children.* January 2003.
- 6) Simasiku, Mary. *Orphans and Vulnerable Children Psychosocial Survey.* January 2003.
- 7) *Orphans and Vulnerable Children Head of Household Baseline Survey in Four Districts in Zambia.* October 2002.
- 8) Mulenga, Sharon A. *Grants Management Evaluation of SCOPE-OVC Project.* March 2003.
- 9) Sikwibele, Anne, Chipso Mweetwa, and John Williamson. *A Review of the SCOPE-OVC Program (Mid-term Review).* October 2001.
- 10) *Training Programme Psychosocial Support for Orphans and Vulnerable Children, Facilitator’s Manual.* March 2004.

- 11) Tembo, Stephen P. M. “A Preliminary Qualitative Review of the Performance of SCOPE–OVC,” in *Livingstone, Lusaka, Mongu and Kitwe since Inception*. April 2001.

### ***Materials***

A Toolkit for Multisectoral Care for OVC comprising the following manuals:

- Introduction to the SCOPE-OVC Project
- Mobilizing Communities to Provide Support for Their OVC
- Strengthening Districts to Respond to the OVC Situation
- Psychosocial Initiatives for OVC and Their Caregivers
- OVC Educational Initiatives
- Facilitating Household Economic Security Initiatives
- Administering Small Grants for Improved Economic Well-being of OVC and Their Households
- Dissemination of Information to Advocate for Strengthening Services
- District Inventory Directories
- Guide for Organizing an OVC Dissemination Forum

*Orphans and Vulnerable Children in Zambia: A Rapid Assessment, Analysis, and Action Planning Report*, July 2004.

*Telling Our Stories*—a book developed from the stories of 20 children who had lost either one or both parents

Training Guidelines for Community School Teachers

### ***Media Initiatives***

- SCOPE-OVC established a quarterly OVC forum in cooperation with UNICEF and FHI. It was open to all OVC stakeholders and attended regularly (quarterly) by approximately 250 persons. After each forum, SCOPE-OVC published *OVC Notes*, which was distributed to 3,000 people. *SCOPE-OVC Media Network* facilitated six monthly discussions and produced 15 radio programs to disseminate ideas about OVC. SCOPE-OVC also produced and disseminated five editions of a quarterly newsletter.

### ***Capacity Development in Twelve Participating Districts***

- 12 DOVCCs formed and functioning
- 131 COVCCs formed in 12 participating districts
- 379 OVC stakeholders identified: 163 (43 percent) completed a self-assessment; 284 (75 percent) benefited from capacity building activities (e.g., defining roles and responsibilities, community resource mobilization, action planning, children's rights, advocacy, proposal writing, basic business management, psychosocial support, record keeping, report writing, leadership skills development, and HIV/AIDS prevention).
- 148 psychosocial trainers trained
- 736 caregivers trained
- 83 traditional leaders trained in psychosocial skills

### ***Service Outputs***

- 523,166 OVC reached with at least one type of program support
- 161 grants totaling \$997,525 were given for OVC support activities in education, psychosocial support services (PSS), food security, economic empowerment, health promotion, and HIV/AIDS prevention. In order to help organizations scale up good practices, five national organizations were given subgrants by SCOPE-OVC to enhance activities of their branches in the districts. Approximately 89,056 OVC and 38,904 households benefited. The activities for the five national organizations that received large grants (above \$20,000) included training of communities on HIV and AIDS and issues related to child abuse; sensitizing special groups such as teachers, police officers, and church leaders on issues related to child abuse; revolving funds for income generating activities including pass-on-the-gift loans and support for primary education; establishing and supporting youth centers for skills training; and training caregivers in psychosocial counseling.

### **Outcomes and Impact**

- Forming DOVCCs and COVCCs reduced overlap in OVC service provision. Through stakeholder meetings, people got to know who was working in what area and the type of service provided. Organizations started sharing information on beneficiary lists so they could avoid supporting the same households or children (e.g., at one point, four organizations at one site discovered they were all paying school fees for the same child).
- The DOVCCs and COVCCs helped select areas in need of support since they knew where people were poorly served and where there was a concentration of service providers.
- A directory of service providers was developed for each district to facilitate networking.
- Organizations operating in similar catchment areas shared information on OVC programming.
- Through efforts to strengthen household economic security and provide psychosocial and educational support, SCOPE-OVC reached nearly 400,000 children. As a result, households had enough to eat (and children are more likely to attend school when they

have food and school supplies). Psychosocial support improved communication and relationships in households. The children reported a better understanding of their own feelings and their guardians' behavior.

- SCOPE-OVC enabled the DOVCCs and COVCCs to provide input into policy and programming for OVC at national and district levels. Community mobilization catalyzed genuine ownership which, in turn, has engendered wide community participation to support OVC.



After SCOPE-OVC ended, the USAID Displaced Children and Orphans Fund<sup>5</sup> commissioned a study of the project's impact. The study's findings are summarized here:

- All except two SCOPE-OVC community committees continue after the end of the project despite a lack of funding.
- Partnerships among organizations implementing OVC activities at district and community levels continued after the end of the project.
- The project reinforced traditional family values. It encouraged families and communities to care for children instead of providing support directly to individual children.
- In target communities, people began to view programs in terms of what they could offer the community as opposed to individuals. They recognized the value of working together as a community to achieve goals as opposed to operating solely as individuals. This has led to fewer conflicts among community members and organizations.

## **Lessons Learned and Recommendations**

- The capacity of DOVCCs can be built to respond to the challenges of OVC. This requires stakeholder commitment to helping communities analyze and prioritize needs.
- The stigma surrounding HIV and OVC decreases when communities actively participate in related activities.
- Most OVC problems are linked to HIV/AIDS and poverty. Therefore, poverty reduction strategies are critical in programs to support OVC. Such strategies should address material needs that may be related to hunger, followed by longer term economic needs of households. OVC should be ensured adequate nutrition and access to education and healthcare.

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<sup>5</sup> Jill Donahue and Louis Mwewa, "Community Action and the Test of Time: Learning From Community Experiences and Perceptions. Case Studies of Mobilization and Capacity Building to Benefit Vulnerable Children in Malawi and Zambia," USAID Displaced Children and Orphans Fund, July 2006 (draft).

- Project design should incorporate strategies to ensure that activities are community- and district-driven as opposed to project-driven. This will ensure their long-term sustainability.
- OVC community-based programs need time to mature. Community development should be undertaken with a minimum of a five- to seven-year timeframe to allow communities to evolve and develop minimal institutional structures and responses.
- The problems of OVC need to be recognized by government at all levels, including at the district level. The household-COVCC-DOVCC chain can be a starting point.
- Capacity building and training specifically targeted to prepare members of DOVCCs to coordinate and collaborate will identify and harness essential local opportunities.
- Psychosocial interventions should be scaled up to provide activities that engage traditional/community leaders, parents, guardians, and children at the community level. Advocacy efforts should reinforce issues around normal child development, nurturing, affection, and issues related to HIV/AIDS.
- Assisting partners should be mentored so they can better understand the link between capacity building activities and the direct implementation of activities that will better support households and children.

## **Psychosocial Support to HIV-Positive Children and Their Families**

implemented by Family Support Unit, Department of Pediatrics and Child Health, University Teaching Hospital; Livingstone General Hospital; and Arthur Davison Hospital, Ndola

Start Date: October 2002

Completion Date: March 2005

Target Population: Children living with HIV/AIDS and their caregivers

### **Program Context**

In 1990, the department of pediatrics and child health at Lusaka's University Teaching Hospital (UTH) had an opportunity to participate in a World Health Organization multicenter study on pediatric nosocomial HIV transmission. To take part, subjects needed to be uninfected newborn babies of uninfected mothers. In order to recruit suitable subjects, UTH needed to first test mothers and babies for HIV. This required careful pretest and post-test HIV counseling. The results of the testing were shocking—most mothers and their children were HIV positive.

The study team realized that it would be unethical if they didn't offer some kind of support to HIV-positive children, their parents, and HIV-positive mothers whose children may not be positive. So in June 1992, UTH developed a pediatric HIV/AIDS counseling unit.

Soon, wards at major hospitals in Zambia were admitting more children living with HIV/AIDS. These children were often very poor—their poverty exacerbated by downturns in Ndola and Livingstone's economies. They and their parents or caregivers needed educational and psychosocial support. And nurses, counselors, and caregivers in the hospitals needed specialized information and skills to more effectively meet their needs.

In October 2002, the FSU at the UTH launched a support program for them. Its success encouraged Livingstone General Hospital and the Arthur Davison Hospital in Ndola to develop similar programs.

### **Program Strategies and Activities**

The overall goal of this project was to improve the physical and emotional well-being of HIV-positive children.

Specific objectives included:

- Providing physical health and psychosocial interventions to children in the under five, 6 to 10, and 11 to 14 age groups
- Providing health and psychosocial interventions to either parents or guardians of HIV-positive children
- Integrating pediatric HBC into existing projects and developing hospital staff skills to be able to deal with issues related to HIV-positive children and their guardians
- Strengthening linkages and referral systems between hospitals and community based groups providing child-focused care and support for HIV/AIDS-affected households

## **Implementation and Management**

The project was funded through subagreements to three implementing agencies: the UTH in Lusaka, the Batoka Hospital as part of the Livingstone General Hospital, and the Arthur Davison Hospital in Ndola. FHI provided TA and support through the in-country technical officer and through TA visits from FHI headquarters. At each hospital, a project manager worked closely with a project management team. The project management team held regular consultative meetings with a project advisory committee made up of leaders from the DHMTs, the DATFs, the provincial office of the Central Board of Health, and from other organizations working with children living with HIV/AIDS.

To achieve the aforementioned objectives, the FSUs provided recreation, entertainment, and information to HIV infected children and guardians. At UTH in Lusaka, kids clubs organized picnics and visits to animals, reptile zoos, and botanic gardens. The FSUs also provided academic support to school-going children. FSU staff carried out home visits tracing guardians and children who did not return and providing them care at home. FSUs also provided academic support to school-going inpatients; provided child counseling; collaborated with local CBOs and FBOs; and developed a referral system between hospitals and the DHMTs and FBOs.

For the caregivers, recreational activities included crocheting and knitting. They also received psychosocial support—including counseling, seminars, and educational programs for parents and guardians using video programs. For hospital staff, the FSUs provided training and capacity building.

## **Program Results**

### **Outputs**

- A total of 762 children (versus a target of 650) living with HIV/AIDS and 866 guardians/parents received psychosocial support at the three FSU centers.
- 5,785 children accessed recreation activities and facilities at the “Kids Clubs” established by the project.
- Among children who received clinical care in the three hospitals and health centers supported by the FSU, 2,262 were admitted to these hospitals and health centers where they received educational support.
- 21 capacity building trainings took place. 184 participants took part, including staff members from the hospitals, psychosocial counselors, and community members. The training focused on play therapy, psychosocial support counseling, child counseling, HIV rapid testing, ARV training, couples counseling, and project proposal writing.

## **Outcomes and Impact**

- Besides improving the lives of children and their caregivers, UTH extended its support activities to two community health centers—N’gombe and Kanyama—in Lusaka for children to be cared for close to home. Caregivers affiliated with the health center were equipped with knowledge and information on caring for HIV-infected children. Caregivers and teachers followed children who were not attended to at home.
- Project activities have continued beyond the life of the project. The capacity developed by the centers has made them attractive candidates for financial support from other projects. Zambia’s RAPIDS Project (Reaching HIV/AIDS Affected People With Integrated Development and Support), for instance, is supporting activities at these children’s hospitals as part of its larger OVC project.

## **Lessons Learned and Recommendations**

- There were more infected children who needed care than had been projected. This underscored the need for child-friendly institutions and the involvement of community and families to take up care of those who need it. The support for providing care needs to extend to all continuum of care centers, including facilities providing antiretroviral therapy (ART).
- A lot of children required play therapy, but the facilities available for these activities were not enough. In addition, they were not child-friendly. Counseling rooms were inadequate and did not provide necessary privacy. Adequate resources are needed. More sites should be opened so children can be cared for near their homes. Alternatively, catchment areas can be divided into zones—especially Livingstone. This will ensure that as many clients as possible are reached. Play therapy can help children overcome their emotional and psychological problems.
- Education support for hospitalized children is very important because it helps them stay on top of their school work.
- It is possible to have male involvement. Many men participated—especially during seminars. Therefore, more activities and deliberate efforts to involve men are necessary and possible to enable them to work with their spouses in caring for their children.
- The children’s teachers need adequate tools, such as appropriate books, games, toys, and visual learning aids. Learning and teaching aids help hospitalized children to learn effectively. Parents/guardians need edu-entertainment, such as videos with appropriate information.

## **Corridors of Hope (originally called the Cross Border Initiative)**

implemented by World Vision; Society for Family Health/Population Services International (PSI); ZHECT; TDRC, Ndola; Institute of Economic and Social Research, University of Zambia; and the Institute of Tropical Medicine, Antwerp, Belgium

Start Date: August 1999

Completion Date: June 2006

Target Population: FSW, Long Distance Truck Drivers, Uniformed Personnel, Youth

### **Program Context**

Zambia's major highways run alongside the two major rail lines, from Livingstone (bordering Zimbabwe) to Chililabombwe (Kasumbalesa bordering Congo DR), and from Kapiri Mposhi (inland) to Nakonde (bordering Tanzania). The major trucking border crossings are Chirundu and Livingstone (both bordering Zimbabwe), Kazungula (bordering Botswana), Chipata (bordering Malawi), Nakonde, and Kasumbalesa. Kapiri Mposhi, a major internal trucking town, is at the junction of the two railway routes.

In the Copperbelt Province—named because it contains the richest copper deposits and is home to the largest copper mines—Ndola is a center for most truck depots, the collection of oil coming through the Tanzania Zambia pipeline, and the collection of coal from the Bwana Mkumbwa mine. HIV/AIDS prevalence rates in Zambia are highest along these major corridors.

Mobility can facilitate the spread of HIV, with highways and borders considered to be environments of elevated HIV vulnerability. FSWs are a subgroup considered to be at higher risk of HIV transmission because they frequently change sex partners. Long distance truck drivers are also thought to be at higher risk because of the nature of their work: They spend much of their time and nights away from their homes and spouses and engage in extramarital sexual relationships, putting themselves at risk for HIV and other STIs.

Recognizing that some subpopulations have an elevated risk of HIV and that the prevalence of HIV/AIDS is high along major transport corridors where these groups spend time, in 1999 USAID and the Japan International Cooperation Agency (JICA) decided to fund the Cross Border Initiative, a program targeting sex workers and their clients. Through IMPACT, USAID initially funded FHI's management of this project through the Southern Africa Regional HIV/AIDS Program. In turn, FHI awarded a subagreement to World Vision/Zambia to manage initial sites. JICA directly funded World Vision/Zambia for some administrative costs and also to purchase drugs to treat STIs. As described below, in 2003 USAID/Zambia supported a scaling up of the program, which at that time became known as Corridors of Hope.

At the end of 2005, Corridors of Hope—a \$6.5 million project that also received \$500,000 in support from the Southern Africa Regional HIV/AIDS Program (RHAP)—was working in six of the nine provinces of Zambia covering 10 district sites: Chirundu, Livingstone, and Kazungula in the Southern Province; Chililabombwe/Kasumbalesa and Ndola in the Copperbelt; Kapiri Mposhi in the Central Province; Nakonde in the Northern Province; Chipata and Katete in the Eastern Province; and Lusaka in Lusaka Province. Chipata was one of the early sites, but it was closed in 2001 because most clients were not from the primary target groups. However, in response to an outcry and pressure from the DHMT, Chipata was re-established in 2003. Two of

the sites (Lusaka and Ndola) were established in April 2004 with funds from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

Target populations for the project were FSWs and their clients—specifically long distance truck drivers. The project aimed to change behavior through peer education, promotion of condoms, voluntary counseling and testing (VCT) services, and provision of STI care.

In 2004, with increased financial support from PEPFAR, three components were added to the Corridors of Hope program: 1) a youth component targeting in- and out-of-school youth, ages 10 to 19, with abstinence messages; 2) a workplace component encouraging trucking companies to develop HIV/AIDS workplace policies and undertake HIV information activities; and 3) an HIV VCT component added to existing interventions offered at all drop-in centers.

## **Program Strategies and Activities**

Through the National HIV/AIDS/STI/TB Council, Corridors of Hope contributed to the GRZ's multisectoral approach addressing HIV/AIDS. In the project's early years, Corridors of Hope complemented the GRZ's efforts to lessen HIV transmission by reducing STIs and promoting correct and consistent condom use. Later, the project added VCT and abstinence messages, which promoted increased knowledge and behavior change among youth. The project worked closely with DHMTs, which provided supervision and quality control for the clinical aspects of Corridors of Hope services. The DHMTs also provided free condoms, which were distributed by healthcare providers treating STIs and counselors providing behavior change messages at the drop-in centers. Corridors of Hope established condom outlets at places that were frequented by vulnerable populations, the target group for socially marketed condoms. Corridors of Hope and DATFs led development and coordination activities along with other partners to increase understanding of HIV/AIDS and reduce stigma. Corridors of Hope task forces were established and played an advisory role to the project, provided a community perspective, and participated in planning activities. Comprised of target group members and stakeholders, including the chairperson of the DATF, the group met quarterly.

The implementation strategy focused on the 10 Corridors of Hope drop-in centers established in seven border towns and three transit towns along transportation routes.

At the drop-in centers, the following services were provided:

- STI diagnosis and treatment
- HIV CT
- Referrals to other medical facilities for conditions beyond the capabilities of the centers
- Activities such as dramas providing information about sexual health and positive living to promote behavior change

Information, education, and promotion activities also took place at the centers. These included:

- Night watches (e.g., visiting bars, guest houses, and certain hotels to tell sex workers and their clients about Corridors of Hope drop-in centers and encouraging them to visit)
- Information sessions and activities, including regular group meetings and one-on-one conversations

- Support groups for sex workers testing positive for HIV (post-test clubs)
- Provision of socially marketed condoms at condom outlets in locations frequented by vulnerable groups
- Meetings and activities with anti-AIDS clubs in schools and with FBOs and other community organizations/groups

For its workplace component, the project established a relationship with 32 trucking companies employing more than 600 workers. Companies were encouraged and provided with TA to develop an HIV/AIDS policy. Employees received peer educator training and provided information and education to their colleagues/peers and spouses within the companies.

Addressing the needs of youth, Corridors of Hope outreach workers and BCC coordinators developed linkages with local schools, community groups, and FBOs. The project identified facilitators in the organizations and helped them coordinate activities promoting abstinence to the target group, youth ages 10–19.

## **Implementation and Management**

As mentioned previously, with financial support from USAID, FHI implemented the Cross Border Initiative through a subagreement with World Vision/Zambia. World Vision provided STI and behavior change services. Under a task order with USAID, Society for Family Health established condom outlets in locations frequented by vulnerable populations and provided socially marketed condoms.

Later, in 2003, FHI again selected World Vision as primary implementing partner (through a competitive process)—with reorganized management that included strong BCC and M&E components.

In 2004, the project’s name was changed to Corridors of Hope, in line with other projects in southern Africa supported through the Southern Africa Regional HIV/AIDS Program under FHI.

To ensure the level of management necessary for scaling up, FHI took on more formal TA, management, and monitoring roles under the leadership of a chief of party.

Under FHI, a task order was signed with PSI/the Society for Family Health to provide behavior change activities and promote socially marketed condoms.

The subagreement with World Vision/Zambia was modified to include provision of STI diagnosis and treatment, HIV counseling, and management of the 10 sites. A subagreement with ZHECT was established to implement the workplace component of the program. JICA continued to provide funds directly to World Vision/Zambia for purchasing STI drugs and covering some site-level operating costs.

These changes provided the strong financial and program management foundation enabling significant scale up.

## Program Results

### Outputs

- There were initially four program sites in 2000. By 2006, there were 10, and the program had a presence in six of Zambia's nine provinces.
- Program staff developed and produced a peer educator's facilitator training manual; a peer educator's manual and STI slide atlas; a healthcare provider's training manual and STI management guidelines; and an HIV counselor's standard operation procedure guidelines.
- Nearly 188 FSWs and 50 outreach workers were trained in peer education. Other key staff who were trained include: 20 healthcare providers in enhanced STI management; 10 HIV counselors in providing counseling and HIV testing services; 10 site managers in providing HIV counseling and STI services.
- In 2005, the program reached more than 200,000 local residents with BCC information and more than 37,000 adolescents with abstinence messages only. Nearly 1.2 million condoms were distributed through the drop-in centers, and more than 5,200 individuals (including but not limited to those considered high-risk) were counseled and tested for HIV. The program also supported workplace initiatives in 32 trucking companies, of which 28 were assisted in developing an HIV/AIDS workplace policy. The program provided STI services to over 10,600 male and female clients through static and outreach activities.
- The program carried out a behavioral monitoring survey among clients receiving services, three rounds of behavioral surveillance surveys among sex workers and long distance truck drivers at three sites, one round of behavioral surveillance surveys among light truck and bus drivers and uniformed personnel, an additional baseline behavioral and biologic surveillance survey among FSWs and long distance truck drivers in Ndola, and one qualitative study targeting beneficiaries and stakeholders.

During the project, the following assessments and studies were carried out:

- 1) Round 3: Behavioral Surveillance Survey Zambia, 2006: Long Distance Truck Drivers in Transportation Routes, Trend Analysis 2000–2006.
- 2) Round 3: Behavioral Surveillance Survey Zambia, 2006: Female Sex Workers in Border and Transportation Routes, Trend Analysis 2000–2006.
- 3) Qualitative Assessment/Documentation, Corridors of Hope Project, Zambia, 2006.
- 4) Behavioral Surveillance Survey, Ndola, Zambia, Long Distance Truck Drivers, Light Truck and Minibus Drivers and Uniformed Personnel in Ndola Transportation Route, 2005.

- 5) Behavioral and Biologic Surveillance Survey in the City of Ndola, Zambia, Among Female Sex Workers, 2005.
- 6) Round 2: Behavioral Surveillance Survey, Zambia, Long Distance Truck Drivers, 2003.
- 7) Round 2: Behavioral and Biologic Surveillance Survey, Zambia, Female Sex Workers, 2003.
- 8) The Psychosocial Context of Sex Work, Report on the Formative Assessment for the Zambia Cross Border Initiative, September 2003.
- 9) An Assessment of Management of Sexually Transmitted Infections in Female Commercial Sex Workers (CSW), June 2000–December 2002, February 2003.
- 10) Female Sex Workers' Perceptions of STI Care in the Six Cross Border Initiative Project Sites of Zambia, February 2002.
- 11) Behavioral Monitoring Survey of Long Distance Truck Drivers in the Six Sites of the Cross Border Initiative Project, Zambia, February 2002.
- 12) Round 1: Behavioral Surveillance Survey, Zambia, Long Distance Truck Drivers, 2000.
- 13) Round 1: Behavioral and Biologic Surveillance Survey, Zambia, Female Sex Workers, 2000.

### **Manuals/Guides Produced**

- 1) *Peer Educator Training, Facilitators Manual*, October 2004 (also available on FHI website)
- 2) *Peer Educator Training, Companion Manual*, October 2004 (also available on FHI website)
- 3) *Workplace Peer Educator Training Manual*, December 2004 (also available on FHI website)
- 4) *Corridors of Hope* promotional brochure (Leaflet), December 2004
- 5) *STI Management Facilitator's Manual*, October 2004
- 6) *STI Management Guidelines*, June 2003, Revised 2005
- 7) *An STI Atlas for Peer Educators*, October 2004

## **BCC Materials Produced**

As part of promotion and BCC activities, the project developed and produced different BCC materials for the target audience that were posted and/or distributed in strategic areas. The following are some of the materials produced:

- Billboards, signs in bus shelters (two in each of the 10 Corridors of Hope sites)
- Wall calendars for sex workers and truck drivers that included HIV prevention messages.
- Posters covering the following themes:
  - 1) Have you gone for VCT? (two for work place and for uniformed)
  - 2) Worried about your HIV status? (two different posters produced, for uniformed services and high-risk women)
  - 3) Your family and your job are important
  - 4) A Leaking Engine May Knock (pertains to STIs)
  - 5) Do Not Delay STD Treatment
  - 6) Don't Share Your STD Treatment
  - 7) Your Health Matters
  - 8) HIV/AIDS Work Place Program (poster and brochure)
- Delayed Debut posters
- Transit Tunes tapes 1, 2 and 3 (cassettes with HIV/AIDS information accompanying music targeting truck drivers)
- *Trucker's Cry: HIV/AIDS in the Workplace* (a video for use by workplace peer educators)
- Community drama productions
- "Edusport" that included games, quizzes, pool, and other activities organized at community drop-in centers

## **Capacity Building**

Throughout the program, supervision, mentoring, and training were important components of capacity building. The following are some of the trainings provided to build capacities of staff and volunteer peer educators:

- In 2005, the project trained all 23 key staff (from both partners) in team building and management to improve management of sites.
- In 2005, all 10 finance assistants from the 10 Corridors of Hope sites received additional training to improve financial management at site level.
- In 2005, all 20 healthcare providers received updated training in STI management, counseling, and HIV testing to enhance the project's STI counseling and management.
- In 2005, all 10 data entry clerks and assistant finance officers at the sites received training in database management at site level.
- In 2004, all healthcare providers, outreach workers, and peer educators in the project were trained in stigma reduction.
- In 2004 and 2005, the project trained 188 FSWs and 50 outreach workers in behavior change activities targeting FSWs at project sites. In addition, the project trained 216 peer educators for workplace BCC activities to take place in the trucking companies' workplaces.

- In 2004, the DHMTs signed a memorandum of understanding for an HIV CT strategy to carry out HIV CT as a project activity. As a result, all 10 HIV counselors were hired and 20 healthcare providers offering STI services received additional training in HIV testing and counseling for high-risk populations.
- In 2003, all project staff from the seven sites and peer educators (10 at each site) were trained and carried out a behavioral monitoring survey (BMS) among FSWs receiving services at drop-in centers and truck drivers at truck stops. Results were used to inform service provision in the project.
- In 2002, all seven site managers and all 14 healthcare providers received training in data management and use of data collection tools.
- In 2002, all 17 project staff (project and site managers from both Corridors of Hope partners) received training in community based BCC strategies.
- In 2001, the project trained all eight healthcare providers (including site managers) in management and counseling of STI patients.

The following results were also achieved during the life of the project:

- 7,172 individuals received HIV counseling and received their results
- 28,196 cases of STIs were managed
- 547,616 individuals received behavior change messages through group meetings and one-on-one conversations
- 36,605 youth, ages 10 to 19, received abstinence messages
- More than two million condoms were socially marketed through the establishment of 963 outlets in locations frequented by vulnerable populations
- More than 86,000 information, education, and communication materials were produced and distributed

## **Outcomes and Impact**

In the project, behavioral surveillance surveys have been used to measure the outcome of the program's interventions. The tables that follow show trends in the data among FSWs and long distance truck drivers over three rounds of study in two of the intervention sites, Chirundu and Livingstone, between 2000 and 2006:

- In 2006, the number of FSWs who were adolescents, age 15–19, reduced statistically significantly from 31.7 percent in 2000 to 19.1 percent in 2006. The proportion of FSWs using a condom at last sex and consistently during transactional and non-transactional sex increased statistically significantly from 49.6 percent in 2000 to 78.6 percent in 2006 with paying partners and 32.7 percent to 53.5 percent with non-paying partners between 2000 and 2006, respectively.
- Among long distance truck drivers, the number without a history of transactional sex 12 months prior to the survey increased statistically significantly from 67.7 percent in 2000 to 77.1 percent in 2006. While among those with a history of paying for sex, the number with more than two transactional sex partners reduced from 22 percent to 9 percent, a statistically significant reduction.

- At the beginning of the project, those who patronized the drop-in centers were stigmatized by their communities. This changed with advocacy that included involvement of key partners through a Corridors of Hope taskforce and the extension of coverage to include the wider community. The centers were viewed as additional service delivery points and not as centers catering exclusively to FSWs. The project observed an increase in patronage among those outside targeted groups visiting the drop-in centers seeking HIV counseling services. In 2005, the records showed that of the 5,200 counseled and tested for HIV by project staff, 55 percent fell outside high-risk populations.
- In 2006, as part of close out, project staff carried out a qualitative study to document beneficiaries' perceptions of the project. The survey found that most FSWs were informed about HIV and STIs and understood the risks associated with their work. Many decided to search for alternative jobs that didn't compromise their health.
- Corridors of Hope's success can also be seen in the involvement of volunteers, such as the peer educators and queen mothers.<sup>6</sup> These groups do not receive monetary incentives to work with Corridors of Hope. What motivates them is the possibility of making a difference among their peers. They are proud to be role models and are motivated by this as well as the desire to make changes in their own lives. Because of the training they received, many have changed their behaviors by reducing their number of partners, acting more responsibly, using condoms with every partner, and refusing a client if he will not wear a condom.
- Peer educators and FSWs have a high level of knowledge about HIV and STIs. They are very comfortable and capable of passing on their knowledge to others and correcting people when they hear them speak incorrectly about HIV. For example, one can clearly see the difference between a trucking company employee who has not been reached by a peer educator and one who has. In fact, it is because the peer educators have gained so much knowledge that they have the confidence to approach others and speak about HIV.

### ***Changes and Trends in Behavior of FSW in Chirundu and Livingstone***

Three rounds of behavioral surveillance surveys targeting FSWs and long distance truck drivers were carried out at the time project activities began in 2000, at the midpoint of the project in 2003, and at the end in 2006. The surveys took place in the project sites of Livingstone and Chirundu. Combined results showed statistically significant trends in some behavioral variables between the start point (2000) and the end of the project (2006). FSWs were older in 2006 than in 2000, more of them had condoms at hand in 2006 than in 2000, and more used a condom at last sex in 2006 than in 2000. The most clear cut trend among sex workers has been their increased use of condoms with both paying and non-paying partners.

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<sup>6</sup> "Queen mothers" are older, experienced sex workers, or former sex workers, who provide information, guidance, and various kinds of support to young FSWs.

**CHANGES AND TRENDS IN BEHAVIOR OF FSW  
IN LIVINGSTONE AND CHIRUNDU COMBINED, 2000–2006**

BEHAVIORAL VARIABLES	YEAR OF RESEARCH STUDY (BEHAVIORAL SURVEILLANCE SURVEY)			P VALUE %
	2000 N=377 %	2003 N=580 %	2006 N=738 %	
NUMBER OF FSW <20 YEARS	31.7	29.1	19.1	p=0.001
HAD CONDOM ON HAND AT TIME OF INTERVIEW	23.5	44.2	48.1	p=0.001
USED CONDOM AT LAST TRANSACTIONAL SEX (PAYING PARTNER)	49.6	30.5	78.6	p=0.001
USED CONDOM AT LAST SEX WITH NON-PAYING CLIENT	32.7	30.5	53.5	p=0.001
<b>HISTORY OF SEXUALLY TRANSMITTED INFECTIONS IN LAST 12 MONTHS</b>				
HAD GENITAL ULCERS	32.1	37.2	29.7	p>0.050
HAD GENITAL DISCHARGE	26.7	37.8	28.7	p>0.050



A notable trend among the long distance truck drivers has been their reduction in sexual partners. There was a statistically significant increase in the number reporting not having sex with sex workers or paying for sex in the last 12 months from 68 percent in 2000 to 77 percent in 2006. In addition, there was a significant reduction in those reporting paying for sex with two or more sex partners and a reduction in those reporting a history of STIs.

**CHANGES AND TRENDS IN BEHAVIOR OF LONG DISTANCE TRUCK DRIVERS IN LIVINGSTONE AND CHIRUNDU COMBINED, 2000–2006**

BEHAVIORAL VARIABLES	YEAR OF STUDY			P value
	2000 544 %	2003 587 %	2006 901 %	
<b>LONG DISTANCE TRUCK DRIVERS PAYING FOR SEX (TRANSACTIONAL SEX) IN THE PAST 12 MONTHS</b>				p=0.001
No sex	67.7	82.3	77.1	
1 FSW only	10.3	10.1	13.8	
2 or more FSW	22.0	7.5	9.0	
<b>SEX WITH A REGULAR PARTNER (GIRLFRIEND) IN THE PAST 12 MONTHS</b>				p=0.001
No sex	0.3	62.1	63.8	
1 regular partner	78.7	28.1	31.9	
2 or more regular partners	20.9	9.8	4.4	
<b>SEX WITH NON-REGULAR PARTNERS IN THE PAST 12 MONTHS</b>				p=0.001
No sex	72.8	98.3	93.9	
1 partner	19.6	1.6	4.7	
2 or more partners	7.8	0.2	1.4	
Condom use at last sex with paying partner	93.3	92.7	93.4	p=0.631
Condom use at last sex with non-paying partner	50.1	70.0	61.1	p=0.753
VCT and HIV CT	33.5	37.0	22.0	p=0.002
<b>HISTORY OF SEXUALLY TRANSMITTED INFECTIONS IN THE PAST 12 MONTHS</b>				
Had genital ulcers	5.3	5.6	2.8	p=0.004
Had a genital discharge	6.4	5.7	4.9	p=0.009

## Lessons Learned and Recommendations

- Corridors of Hope managed to achieve regular “opt-in” offers of HIV CT but needed to adopt more routine, opt-out approaches to testing. In addition, the project needed more innovative ways of administering pretest information, such as group discussions to reduce the length of time spent with clients.
- There is a need to take into account the context or issues—economic, social, and cultural—that facilitate or inhibit behavior change. As identified in the qualitative study, important physical and personal barriers continue to impede meaningful behavioral change among FSWs. Some of these factors include the inability of sex workers to enforce the use of condoms due to both economic and physical vulnerability.
- While it is important that sex workers have the knowledge and skills to negotiate condom use, this is not enough. Short-term prevention efforts should target both sides of the commercial sex equation. Women enter into sex work because their family support systems do not exist or have broken down. They are impoverished and perceive sex work as the only option for making a living. Long-term prevention efforts should work on changing the social landscape that deprives women of choices. Furthermore, all prevention efforts need a multisectoral approach recognizing that targeting risk behaviors but not vulnerability may not work.
- FSWs and truck drivers know where to obtain condoms—mostly in traditional places such as health facilities, commercial outlets, and from Corridors of Hope peer educators. However, there appears to be complacency in consistent condom use as evidenced by the small proportions of those with condoms at hand. Peer educators and outreach workers must continue to play key roles as the most convenient behavioral change agents and suppliers of condoms while at the same time coordinating the involvement of other partners in condom distribution and sales and encouraging sex workers to equip themselves with condoms all the time.
- There is increasing recognition of the relationship between substance abuse, such as alcohol abuse, and risky sexual behaviors that predispose people to HIV exposure. Programs like Corridors of Hope should begin to seriously analyze and understand substance use and target it in program interventions.
- Truck drivers are challenging to reach because of the nature of their jobs, which put them on the road for long periods of time. Because of this, it is important to identify priority areas, including systems that support testing and non-discrimination as part of health and safety policies that already exist. Greater impact is achieved by focusing outreach activities through the trucking companies themselves, instead of through drivers directly. When the management of the companies supports activities, employees will be more available and attentive.
- One of the goals of Corridors of Hope’s workplace component was to encourage and help trucking companies develop HIV workplace policies for all employees. This component

needed strengthening. It is important to include management in activities from the beginning, whenever possible. They can even be trained as peer educators.

- As identified in the qualitative study, outreach workers and peer educators were invaluable to the project. They were able to reach people in the communities, and in bars, nightclubs, and trucking companies and encourage them to come to the drop-in center for services. They were very approachable and dedicated, and had very good relationships with FSWs. Developing a strong outreach program with outreach workers and peer educators was critical to the program's success.
- The DHMTs were key to the long-term sustainability of the centers. Their involvement from the beginning and their capacity to monitor was critical for the centers and the provision of STI and HIV/AIDS services to vulnerable groups.

## **Evaluation of the Syndromic Management Algorithms for Treating STIs in Primary Health Clinics**

implemented by Central Board of Health, MOH

Start Date: December 2002

Estimated Completion: July 2007

Target Population: Medical Personnel Treating STIs

Partners: TDRC, Ndola, and the University Teaching Hospital, Lusaka

### **Program Context**

STIs remain a major health problem in both developed and developing countries. Untreated, they may have serious adverse effects on reproductive and child health. The role of STIs in the transmission of HIV is well recognized.

Traditional approaches to the diagnosis and management of STIs are based on either etiologic data or clinical manifestations. The former is expensive and often results in delayed diagnosis and treatment, while the latter is often incomplete and inaccurate. An STI case management approach that is affordable and acceptable is crucial for the success of STI/HIV prevention strategies, especially in areas where medical specialists and laboratory facilities are not readily available.

The World Health Organization developed a syndromic STI management approach that Zambia adapted for use at the primary care level. This approach uses clinical algorithms based on STI syndromes such as vaginal discharge, urethral discharge, genital ulcer disease, and lower abdominal pain (in women only), together with patient risk behaviors as guides for diagnosis and treatment. In Zambia, algorithms were adapted from WHO generic guidelines and had not been validated with local pathogens. However, the algorithms needed to be validated and compared with existing practices in primary healthcare facilities to confirm their appropriateness and facilitate their adaptation by primary healthcare providers, both in private and government health clinics.

### **Program Strategies and Activities**

Through FHI in 2002, the CDC supported the MOH to evaluate the STI management algorithms being used at the primary healthcare level. The evaluation study was conducted in 11 health clinics in Ndola, 11 clinics in Lusaka, and at the health clinic in Mwachisompola. FHI provided technical support to those carrying out the validation study, whose results would inform the MOH of the revision of the STI management guidelines.

The objectives were to:

- Determine the pathogens responsible for major presenting features of people with STIs, namely genital discharges and genital ulcers.
- Evaluate the sensitivity, specificity, and predictive values of the current STI syndromic algorithms in rural and urban clinics.

- Compare the performance of the current algorithm with alternative algorithms that can be modeled and evaluated using information collected in the evaluation.
- Determine the sensitivity and minimum inhibitory concentrations of *N. gonorrhoea* in the laboratory to various anti-gonococcal agents recommended for use in Zambia.

## **Implementation and Management**

The principal investigator from the MOH was Dr. Rosemary Sunkutu, director of public health and research at the Central Board of Health. FHI's principal investigator was Joseph Kamanga. Coordination in Ndola was done through the TDRC<sup>7</sup> and for Lusaka and Mwachisompola the coordination was done through the UTH at Lusaka.

## **Program Results**

The CDC is spearheading the study on behalf of Ministry of Health. Data collection and entry into the database has been completed. Data cleaning, analysis, and report writing is expected to be completed by July 2007.

## **Outputs**

Staff members were retrained in STI related studies:

- 11 health center “in charges” were trained to manage the study
- 11 nurses were retrained as counselors
- 22 lab technicians were retrained in STI laboratory diagnosis
- 2 individuals were trained in overall supervision of laboratory research
- 22 healthcare providers offered refresher training in STI diagnosis and management
- 6 lab technicians at TDRC were trained in quality assurance and use of state-of-the-art laboratory technology
- The TDRC and UTH laboratories were provided with updated equipment necessary to carry out the studies

## **Lessons Learned and Recommendations**

- This project is not yet finished. The research study to evaluate the algorithms used in a primary healthcare setting was a mammoth undertaking. Several issues were not considered: the capacity of the MOH and local institutions to carry out such work, which included state-of-the-art laboratory investigation through use of Polymerase Chain Reaction (PCR) techniques. The study should have been more focused and relevant to the immediate need of informing policy in terms of a regimen used for managing STIs.

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<sup>7</sup> The TDRC is a leading laboratory based in Ndola. It is recognized by WHO as competent to carry out state of art laboratory work. It has been associated with FHI having carried out laboratory analyses in the biologic behavior surveillance surveys.





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