Know Your HIV/AIDS Response: Southern Province, Zambia

An Examination of Program Implementers in the Nongovernment Sector

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List of Acronyms

ARV	antiretroviral
ART	antiretroviral therapy
CSO	Central Statistics Office
DATF	District AIDS Task Force
DACA	District AIDS Coordination Advisor
DHS	Demographic and Health Survey
GHI	Global Health Initiative
HIV	human immunodeficiency virus
INESOR	Institute of Economic and Social Research
KYR	Know Your Response
NAC	National HIV/AIDS/STI/TB Council
MSM	men who have sex with men
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
PLWH	people living with HIV
PWID	people who inject drugs
QAS	Questionnaire Appraisal System
STI	sexually transmitted infections
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

Executive Summary

The Know Your HIV-prevention Response study was a situation analysis of HIV-prevention interventions and was conducted in Southern Province Zambia from September to October 2013. The study was implemented jointly by MEASURE Evaluation and the Institute of Economic and Social Research (INESOR) at University of Zambia. The study had five instruments, two of which were the Program Implementer Core Questionnaire and the Program Implementer Modules for Key (and vulnerable) Populations, on which this report is based. The study population included 93 organizations in the nongovernmental organization (NGO) sector and had three primary objectives:

- determine what specific HIV-prevention interventions were being implemented;
- determine by which organizations and in which districts the interventions were being implemented; and
- assess the extent to which the HIV-prevention response matched current HIV-transmission patterns, were focused on geographic areas where HIV was spreading most rapidly, and covered technical recommendations for populations at higher risk of HIV exposure.

Information was collected on six categories of interventions: standard hybrid interventions commonly used; interventions affecting knowledge, attitudes and beliefs and influencing psychological and social risk correlates; harm reduction interventions; biological/biomedical interventions that reduce HIV-infection and transmission risk; interventions for the mitigation of barriers to prevention and negative social outcomes of HIV infection; and interventions for the mitigation of biological outcomes of HIV infection. Data were also collected on interventions targeted at the following key and vulnerable populations: female sex workers; men who have sex with men and transgender; people who inject drugs; young people aged 10-24 years in the general population; emergency settings and refugee/internally displaced population; migrant and mobile populations; pregnant women, infants, and young children; uniformed personnel/services; and incarcerated populations.

The main findings are described below for the NGO sector, with particular attention to geographic gaps in the availability of specific interventions.

<u>Standard Interventions</u>

- Standard interventions (social mobilization; comprehensive sex education; condom social marketing; voluntary counseling and testing [VCT[]) were currently implemented by 90 percent of organizations surveyed.
- No organization surveyed implemented condom social marketing, comprehensive sex/HIV education and social mobilization activities in Pemba.
- No organization surveyed implemented VCT in urban areas of Gwembe and Kazungula.
- The workplace was the least common implementation site for standard interventions in the districts of Choma, Kalomo, Mazabuka, Monze and Namwala.

Interventions Affecting Knowledge, Attitudes and Behavior

- Interventions affecting knowledge, attitudes and behavior and influencing psychological and social risk correlates (mass media campaigns, interpersonal education and persuasion programs including face-to-face dialogue, sex education, education to promote adherence to universal precautions, and prevention counseling) were implemented by 80 percent of organizations surveyed.
- No organization surveyed implemented mass media campaigns or interpersonal education and persuasion programs in Pemba, Siavonga, and Zimba.
- No organization surveyed implemented any interventions affecting knowledge, attitudes and behavior in the past 12 months in urban areas of Kazungula, and to a lesser extent, in urban areas of Gwembe.
- Twenty percent of organizations surveyed implemented interventions affecting knowledge, attitudes and behaviors in worship places.

Harm Reduction Interventions

- Harm reduction interventions (distribution of condoms and condom-compatible lubricants, needle and syringe exchange, provision of equipment for universal precautions, providing safe spaces for vulnerable populations to use prevention services and inject drugs safely, and livelihood alternatives to transactional sex) were implemented by 81 percent of organizations surveyed.
- The most common harm reduction intervention was condom distribution. Few organizations distributed condom-compatible lubricants.
- No organization surveyed distributed condoms in Zimba and in urban areas of Kazungula and Pemba.
- Harm reduction interventions were not implemented by organizations surveyed in schools and at home in Pemba, Siavonga, and Zimba.
- There were five districts in which no organization surveyed reported implementing livelihood alternatives to transactional sex in urban areas: Choma, Gwembe, Kazungula, Pemba and Siavonga.

Biological/Biomedical Interventions

- Biological/biomedical interventions (STI diagnosis and treatment, post-exposure prophylaxis, family planning services, medical male circumcision, ARV prophylaxis for infants born to HIV positive mothers; screening blood products or donated organs for HIV, disinfection of medical equipment; use of gloves and protective clothing, drug treatment including drug substitution therapy, and disinfection of tattoo, body piercing and barber equipment) were implemented by 43 percent of organizations surveyed.
- No organization surveyed promoted or implemented voluntary medical male circumcision in 8 out of 12 districts of Southern Province.
- In Gembe and Mazabuka, antiretroviral prophylaxis for infants born to HIV positive mothers was provided by organizations surveyed in rural but not in urban areas, whereas the reverse was the case in Choma.

Interventions to Mitigate Barriers to Prevention and Negative Social Outcomes of HIV Infection

- Interventions to mitigate barriers to prevention and negative social outcomes of HIV infection (training of service providers and law enforcement, separate accommodation for at-risk population, self-help and solidarity groups, finance and in-kind sustenance support, medical and legal assistance services, counseling, legal, policy and institutional reform) were implemented by 70 percent of organizations surveyed.
- The provision of medical and legal assistance services to people living with HIV and their families was not a common intervention and was provided by 18 percent of organizations surveyed.
- No organization surveyed trained service providers or law enforcement, organized solidarity or support groups or provided financial and/or in-kind support to people living with HIV in the districts of Pemba and Siavonga.
- More organizations surveyed implemented counseling interventions in urban than in rural areas of Livingstone and Choma.

Interventions to Mitigate Biological Outcomes of HIV Infection

- Interventions to mitigate biological outcomes of HIV infection (tuberculosis prevention, diagnosis and treatment; HIV treatment with antiretroviral drugs; HIV-related opportunistic infection prophylaxis and treatment; prevention, diagnosis, and treatment of viral hepatitis; palliative care for people living with HIV) were implemented by 70 percent of organizations surveyed.
- Forty-percent of organizations surveyed provided palliative care but none did so in Pemba and Kazungula.

Gender Integration

- One in every five organizations surveyed did not integrate gender into HIV-prevention activities.
- Over 70 percent of organizations surveyed addressed gender norms and violence against women but only 37 percent addressed cross-generational sex, a major driver of the HIV epidemic in Zambia.

Female Sex Workers

- No organization surveyed targeted HIV-prevention interventions at female sex workers in five districts: Gwembe, Namwala, Pemba, Sinazongwe, and Zimba.
- Only two districts had organizations targeting female sex workers for each of the four WHO recommended priority interventions for this key population. In the districts of Kalomo, Mazabuka, Monze, and Siavonga, there was a lack of STI detection and management services targeted at female sex workers among the organizations surveyed.

People Living With HIV

- No organization surveyed worked in Pemba and Kazungula in the past 12 months to provide recommended interventions to prevent illness and infection in people living with HIV.
- The interventions that were least likely to be provided by NGOs surveyed were palliative care (provided in one district), antiretroviral therapy (provided in three districts), and prevention, diagnosis and treatment of viral hepatitis (provided in three districts).

Young People Aged 10-24 years

- HPV vaccine was provided by only three percent of organization surveyed.
- No organization surveyed implemented HIV-prevention interventions targeted at young people aged 10-24 years in Kazungula and Pemba districts.
- No organization surveyed was involved in designing or establishing youth-friendly facilities and services in Livingstone and Gwembe or in fostering parent and community support for youth-friendly services in Gwembe.

Pregnant Women, Infants, and Young Children

- In four districts – Gwembe, Kazungula, Pemba, and Sinazongwe, No organizations surveyed provided the following interventions for treatment and prevention of HIV in pregnant women, infants, and young children: HIV VCT; STI diagnosis and treatment; family planning/reproductive health care; antiretroviral drugs; infant feeding counseling and support; financial and/or in-kind sustenance support/social welfare; and linkages/referrals to psychosocial support services.

Migrant and Mobile Populations

- No organization surveyed provided HIV-prevention interventions for migrant and mobile populations in the districts of Gwembe, Kazungula, Pemba, Siavonga, and Sinazongwe.
- In Namwala, there was at least one implementing organization for each of the following interventions targeted at migrant and mobile populations: HIV VCT; comprehensive sex/HIV education; condom distribution; harm reduction for people who inject drugs; prevention, diagnosis and treatment of STIs; focused anti-discrimination and anti-stigma activities; medical male circumcision; prevention and response to sexual violence; and community-based outreach.

1. Introduction

According to the Demographic and Health Survey (DHS), Zambia had an adult HIV prevalence rate of 14.3 percent in 2007 (Central Statistical Office [CSO] et al., 2009). In Southern Province, 14.5 percent of adult men and women aged 15-49 years were HIV positive. A district-level comparison of data from the National HIV/AIDS/STI/TB Council (NAC) showed that in 2010, HIV prevalence was highest in Livingstone (25.3 percent) followed by Mazabuka (18.4 percent). Overall, 15.7 percent of adults in the districts of Choma, Monze and Siavonga and 15.2 percent of those in Kalomo and Kazungula were HIV positive. The districts of Gwembe and Namwala had the lowest prevalence of HIV in Southern Province (6.2%). The DHS data also showed that HIV prevalence increased with wealth quintile and level of education (Central Statistical Office (CSO) et al., 2009).

The Zambia Modes of Transmission Study noted that the HIV epidemic in Zambia is generalized and driven by a combination of factors, including multiple and concurrent sexual partners, low and inconsistent condom use, mobility and labor migration, low levels of male circumcision, high risk behaviors among sex workers and in male-to-male sexual relationships, and vertical transmission from mother-to child. Other factors that increase vulnerability to HIV infection included alcohol abuse; gender inequality, gender identities and beliefs about male sexuality; intimate partner violence and sexual coercion; age-disparate relationships and transactional sex; and taboos and barriers regarding couple communication about sex (Zambia NAC, 2009). Underlying many of these factors are social and cultural norms.

The National HIV and AIDS Strategic Framework of 2011-2015 identifies four national priorities for the HIV and AIDS national response: (a) to accelerate and intensify prevention in order to reduce the annual rate of new HIV infections; (b) to accelerate the provision of universal access to comprehensive and quality treatment, care and support to people living with HIV and AIDS, their caregivers and their families, including services for tuberculosis (TB), sexually transmitted infections (STIs) and other opportunistic infections; (c) to mitigate the socio-economic impacts of HIV and AIDS especially among the most vulnerable groups, orphans and vulnerable children, people living with HIV (PLWH) and their care givers/families; and (d) To strengthen the capacity for a well-coordinated and sustainably managed HIV and AIDS multi-sectoral response.

The overall purpose of the Know-Your-HIV-prevention- Response (KYR) tools is to help track the HIV-prevention response. The specific objectives are to:

- determine what specific HIV-prevention interventions are being implemented and what resources are available to implement them;
- determine who is doing what and where; and
- assess the extent to which the HIV-prevention response matches current HIV-transmission patterns, are focused on geographic areas where HIV is spreading

most rapidly, and cover technical recommendations for key populations at higher risk of HIV exposure.

The tool kit addresses three key concepts that are critical for an improved understanding of the HIV-prevention response – location, scale, and needs – and helps provide answers to the following pertinent questions: Who is doing what and where? Who is being reached by HIV-prevention programs? How many are being reached? Are the needs of key populations at higher risk of HIV exposure being met in settings where they are located? Thus the KYR tools permit a gap analysis, geographic mapping of the current HIV-prevention response, and provide information needed at the national and sub-national level to guide the adjustment and prioritization of HIV-prevention programs and interventions, with a view to delivering prevention services to peoples and places where they are most needed.

The HIV-prevention response analysis tools consist of five instruments:

(1) Policy Checklist
(2) Strategic Information Checklist
(3) Program Implementers Core Questionnaire
(4) Program Implementers Modules for Key (and vulnerable) Populations at Higher Risk of HIV Exposure
(5) District Questionnaire
    a. Module 1: Health Facility
    b. Module 2: Government non-Health Sector HIV Prevention Questionnaire

This report focuses on the Program Implementers Core Questionnaire and Program Implementers Modules for Key (and vulnerable) Populations at Higher Risk of HIV Exposure. It is hoped that the data collected will provide evidence to inform the selection and prioritization of prevention interventions that are needed to have an impact on HIV incidence and prevalence.

2. Data and Methods

MEASURE Evaluation conducted a pilot test of the KYR tool kit from September to October, 2013 in Southern Province, Zambia, in collaboration with the Institute of Economic and Social Research at the University of Zambia, and the National HIV/AIDS/STI/TB Council. The study was funded by USAID. The specific objectives of the pilot test were to: (a) identify and eliminate problems in the KYR tools and enable corrective changes or adjustments to be made; (b) permit a thorough test of the logistical arrangements and planned statistical and analytic procedures; and (c) determine whether data collected via the tools yielded information that was needed to assess the extent to which prevention interventions were focused on geographic areas where HIV was spreading most rapidly, and covered technical recommendations for HIV-prevention among populations at higher risk of HIV exposure. An additional objective was to share the results of the pilot test with key stakeholders and data users in order to determine whether the tools provided data needed to answer policy and programmatic questions.

The Program Implementer Core Questionnaire and Program Implementer Modules for Key (and vulnerable) Populations at Higher Risk of HIV Exposure were administered to all HIV-implementing organizations operating in the province based on a list of registered implementers provided by the NAC. A total of 93 Program Implementers in the NGO sector were successfully interviewed. The NAC 2011-2012 data base had identified 111 registered program implementing NGOS in ten districts of Southern Province. It is to be noted that Pemba and Zimba were new districts. At the time the list of registered NGOs was created, Pemba was under Choma District and Zimba was part of Kalomo District. Assuming that all registered organization operating in Choma (a total of 11) also worked in Pemba and all registered organizations operating in Kalomo (a total of 10) also worked in Zimba, the total number of registered NGOs in Southern Province at the time of the study was 132, yielding a response rate of 84.1%. This is a rough approximation as our assumptions were not met, some NGOs on the list could not be located, and the list was also updated.

The Core Questionnaire collected basic information about the implementing organization and for each of the organization's projects that currently conducted HIV-prevention activities, data were collected on the type of HIV-prevention activities implemented in the past 12 months, financial resources expended for HIV prevention activities in the past 12 months, and sources of funding for HIV-prevention activities implemented in the past 12 months. In addition, the Core Questionnaire collected information on the number of people reached with HIV-prevention activities by the organization by district of residence and sex. The structure of the Core Questionnaire was guided by Michael Sweat's (2008) framework for classifying HIV-prevention interventions, published by UNAIDS. Six broad categories of interventions were identified:

1. Standardized hybrid interventions commonly used (e.g., VCT, social mobilization, comprehensive sex education)

2. Interventions affecting knowledge, attitudes and beliefs & influencing psychological & social risk correlates (e.g., mass media campaigns, prevention counseling, etc.)
3. Harm reduction interventions (e.g., condom distribution, needle and syringe exchange etc.)
4. Biological/biomedical interventions that reduce HIV-infection & transmission risk (e.g., post-exposure prophylaxis, male circumcision, etc.)
5. Mitigation of barriers to prevention and negative social outcomes of HIV infection (e.g., training of service providers and law enforcement officers, etc.)
6. Mitigation of biological outcomes of HIV infection (e.g., HIV/tuberculosis (TB) treatment services, opportunistic infection prophylaxis, palliative care, etc.)

The Modules identified which of the following key and vulnerable populations were targeted by the organization in the past 12 months: female sex workers; men who have sex with men and transgender; people who inject drugs; young people aged 10-24 years in the general population; emergency settings and refugee/internally displaced population; migrant and mobile populations; pregnant women, infants, and young children; uniformed personnel/services; and incarcerated populations. For each key and vulnerable population, data were collected on a standard set of HIV-prevention interventions as well as on specific interventions for the group based on PEPFAR and World Health Organization recommendations.

The study methodology consisted of the following stages:

(1) Administering the Questionnaire Appraisal System (QAS) Form to NAC staff: The QAS is a systematic appraisal of survey questions and helps spot potential problems in the wording or structure of the questions that may lead to difficulties in question administration, miscommunication, or other failings. A meeting was organized with NAC staff during which they examined each question in the data collection instruments by considering question characteristics in a step-wise fashion. At each step, a decision was made as to whether the question exhibited features that were likely to cause problems and suggestions were made as to how the questions were to be rephrased.
(2) Cognitive interviewing using the active probing approach: The purpose of cognitive interviewing was to look at question answering from the respondent's perspective. This approach helped the researchers to understand cognitive strategies used to answer a question and the ways in which a question performed across different respondents. This approach helped to highlight question design problems and provided insights into incorrect interpretations of questions, so as to suggest possible revisions to the questions.
(3) Updating of the list of current HIV and AIDS implementing organizations in Southern Province: Using the list provided by the NAC as a starting point, a snowball method was used to ask known implementing partners to direct the research team to other organizations working on HIV/AIDS prevention in the province and/ or district but which were not captured on existing directories/lists.

(4) Testing data collection methodologies to determine which one works best: Districts in Southern Province of Zambia were randomly assigned to one of the following groups: (a) face-to-face interviews whereby the interviewer was to read out all questions to the respondent and fill in the responses provided; and (b) self-administered questionnaire filled out in the presence of an interviewer, whereby the respondent was to complete the questionnaire by him or herself but could ask the interview clarifying questions.
(5) Conducting focus group discussions in order to detect potential problems with the data collection tools and improve them.

The study was approved by the Tulane University Human Research Protection Program Biomedical Institutional Review Board, New Orleans, Louisiana. Local IRB approval was obtained from ERES Converge and authorization to conduct the study, from the Zambia NAC. Interviewers and supervisors received a one-day research ethics training based on the Family Health International 360 Research Ethics Curriculum. The data collection instruments were pretested in Chongwe and Kafue Districts near Lusaka in July 2013.

The data were analyzed using STATA version 12.0. In order to estimate implementation rates for each intervention in a given district by, percentages were calculated based on the total number of organizations that were completely interviewed (i.e., N=93 program implementing organizations for each calculation and cell of a table).

3. Characteristics of Program Implementers

Limited information was collected on the background characteristics of program implementing organizations. As indicated in Table 1, most program implementers received funding for HIV-prevention from non-governmental sources, with slightly more than half (54%) obtaining funding from donors. One in every five program implementers obtained funding for HIV-prevention activities from other non-governmental, faith-based or community-based organizations. Only 3 percent of organizations surveyed received funding from the private commercial sector. Government funding for HIV-prevention was reported by 6 percent of organizations surveyed.

Table 1 Percentage of Organizations Surveyed That Were Currently Implementing HIV-prevention Interventions in Southern Province by Sources of Funding, Zambia 2013

Source of funding	Percent
Government	5.5
Donor	53.9
Private sector	3.3
Insurance	0.0
Clients	1.1
NGO/FBO/CBO	22.0
Other	18.7
N	93

Organizations surveyed were asked to rate the sufficiency (both in terms of quality and quantity) of human and material resources for the implementation of current HIV-prevention activities in Southern Province. Figure 1 shows that there was greater dissatisfaction with the quantity on infrastructure/facilities and equipment than with the quantity of information. More than half of organizations surveyed felt that the quantity of infrastructure was insufficient for current HIV-prevention activities. Between a third and 43 percent of organizations considered the amount of human resources, equipment and supplies to be insufficient for their current HIV-prevention activities. Similarly, there was greater dissatisfaction with the quality of infrastructure/facilities than with the quality of human resources and information. Forty-seven percent of organizations surveyed rated the quality of infrastructure and facilities as being insufficient compared to 30% for equipment and supplies, 19 percent for human resources and 15 percent for information (Figure 2).

There were geographic disparities in the availability of NGOs implementing HIV-prevention activities in Southern Province. As Table 2, shows, 17 percent of organizations surveyed were conducting HIV-prevention activities in Choma and Mazabuka. Roughly 11-13 percent of organizations surveyed were working in Kalomo, Livingstone and Monze compared to 1 percent in Pemba and Zimba.

Figure 1 **Percent of organizations surveyed in Southern Province by level of sufficiency of the quantity of resources for HIV-prevention activities, Zambia 2013.**

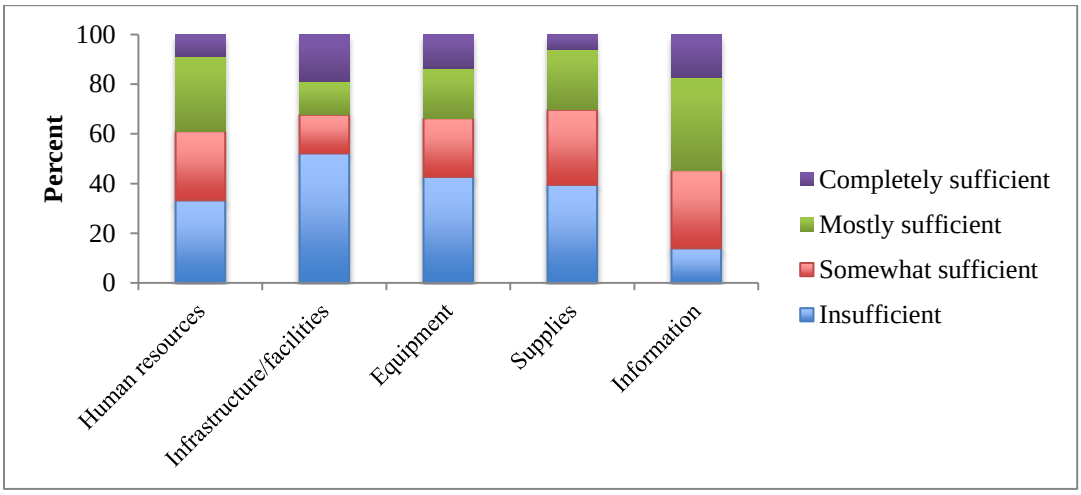


Figure 2 **Percent of organizations surveyed in Southern Province by level of sufficiency of the quality of resources for HIV-prevention activities, Zambia 2013.**

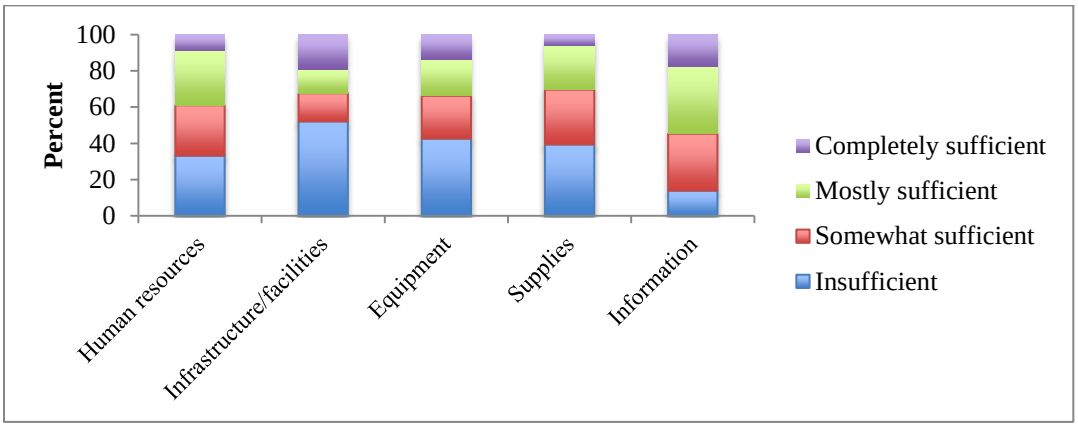


Table 2 **Percentage of Organizations Surveyed in Southern Province that Implemented HIV-prevention Activities by District, Zambia 2013**

District	Percent
Choma	16.5
Gwembe	3.3
Kalomo	12.1
Kazungula	7.7
Livingstone	13.2
Mazabuka	16.5
Monze	11.0
Namwala	6.6
Pemba	1.1
Siavonga	2.1
Sinazongwe	3.3
Zimba	1.1
N	93

Notes: 7 organizations are working in 2 districts each.
13 organizations work at the provincial level

4. Standard Interventions in Common Use

According to Sweat's (2009) framework, standardized hybrid interventions commonly used include voluntary counseling and testing (VCT), condom social marketing, comprehensive sex education, and social mobilization. About 90 percent of organizations surveyed in Southern Province were currently implementing at least one of these interventions. As shown in Figure 3, the interventions most commonly implemented were social mobilization and comprehensive sex education, and were reported by 73 percent of organizations surveyed. More than half of organizations surveyed provided VCT, with three times as many reporting provider-initiated testing services as compared to self-testing. Door-to-door and home-based testing activities were reported as being currently implemented by one in every four organizations surveyed.

As Table 3 shows, there were geographic disparities in the availability of standardized interventions which reflect in part, the distribution of program implementers by district. A number of gaps can be observed. None of the organizations surveyed were implementing condom social marketing, comprehensive sex/HIV education, and social mobilization activities in Pemba. In addition, none of the organizations surveyed were implementing social mobilization activities in Siavonga and condom social marketing interventions in Sinazongwe. Choma had the largest concentration of organizations providing VCT and condom social marketing interventions. Choma, Livingstone and Mazabuka had the largest concentration of organizations providing comprehensive sex/HIV education and social mobilization interventions.

Figure 3 **Percentage of organizations surveyed in Southern province that were currently implementing standard HIV-prevention interventions by type of intervention, Zambia 2013.**

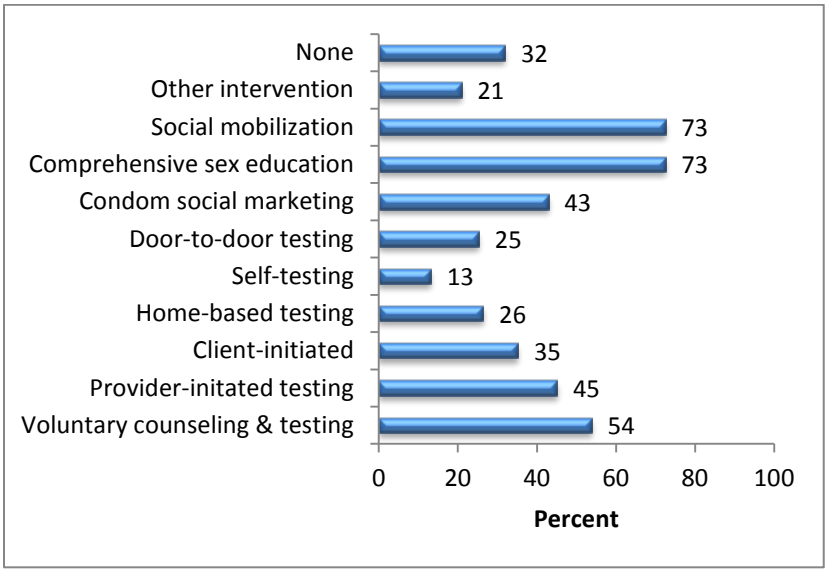


Table 3 **Percentage of Organizations Surveyed in Southern Province that Implemented Standard HIV-prevention Interventions in the Past 12 Months, by District and Type of Intervention, Zambia 2013**

District	Voluntary Counseling and Testing	Condom Social Marketing	Compre-hensive Sex Education	Social Mobili-zation	Other
Choma	13.2	12.1	14.3	16.5	5.5
Gwembe	3.3	2.2	3.3	3.3	0.0
Kalomo	4.4	6.6	6.6	8.8	1.1
Kazungula	1.1	1.1	2.2	2.2	1.1
Livingstone	9.9	6.6	15.4	15.4	1.1
Mazabuka	9.9	7.7	15.4	16.5	2.2
Monze	3.3	5.5	7.7	7.7	1.1
Namwala	5.5	7.7	7.7	6.6	3.3
Pemba	1.1	0.0	0.0	0.0	0.0
Siavonga	1.1	1.1	1.1	0.0	0.0
Sinazongwe	3.3	0.0	2.2	2.2	1.1
Zimba	1.1	1.1	1.1	1.1	1.1

Data on the type of VCT implemented by organizations surveyed are presented in Table 4. While provider-initiated testing was provided or promoted in all districts, no organization surveyed reported implementing client-initiated testing in Kazungula, Pemba, Siavonga, and Sinazongwe. Home-based testing was not implemented by organizations surveyed in Livingston, Pemba, and Siavonga. Few districts reported promoting self-testing, the exceptions being Choma, Mazambuka and Namwala. Door-to-door testing was reported by organizations surveyed for all districts, with the exception of Pemba, Siavonga, and Sinazongwe.

Table 4 **Percentage of Organizations Surveyed in Southern Province that Implemented Voluntary Counseling and Testing in the Past 12 Months by District and Type of Testing, Zambia 2013**

District (N=93)	Provider-initiated Testing	Client-initiated testing	Home-based Testing	Self-Testing	Door-to-Door Testing
Choma	9.9	5.5	5.5	3.3	3.3
Gwembe	1.1	3.3	1.1	0.0	2.2
Kalomo	3.3	3.3	2.2	0.0	3.3
Kazungula	1.1	0.0	1.1	0.0	1.1
Livingstone	7.7	7.7	0.0	0.0	1.1
Mazabuka	6.6	5.5	2.2	3.3	4.4
Monze	3.3	2.2	2.2	0.0	3.3
Namwala	3.3	4.4	4.4	2.2	2.2
Pemba	1.1	0.0	0.0	0.0	0.0
Siavonga	1.1	0.0	0.0	0.0	0.0
Sinazongwe	2.2	0.0	1.1	0.0	2.2
Zimba	1.1	1.1	1.1	0.0	0.0

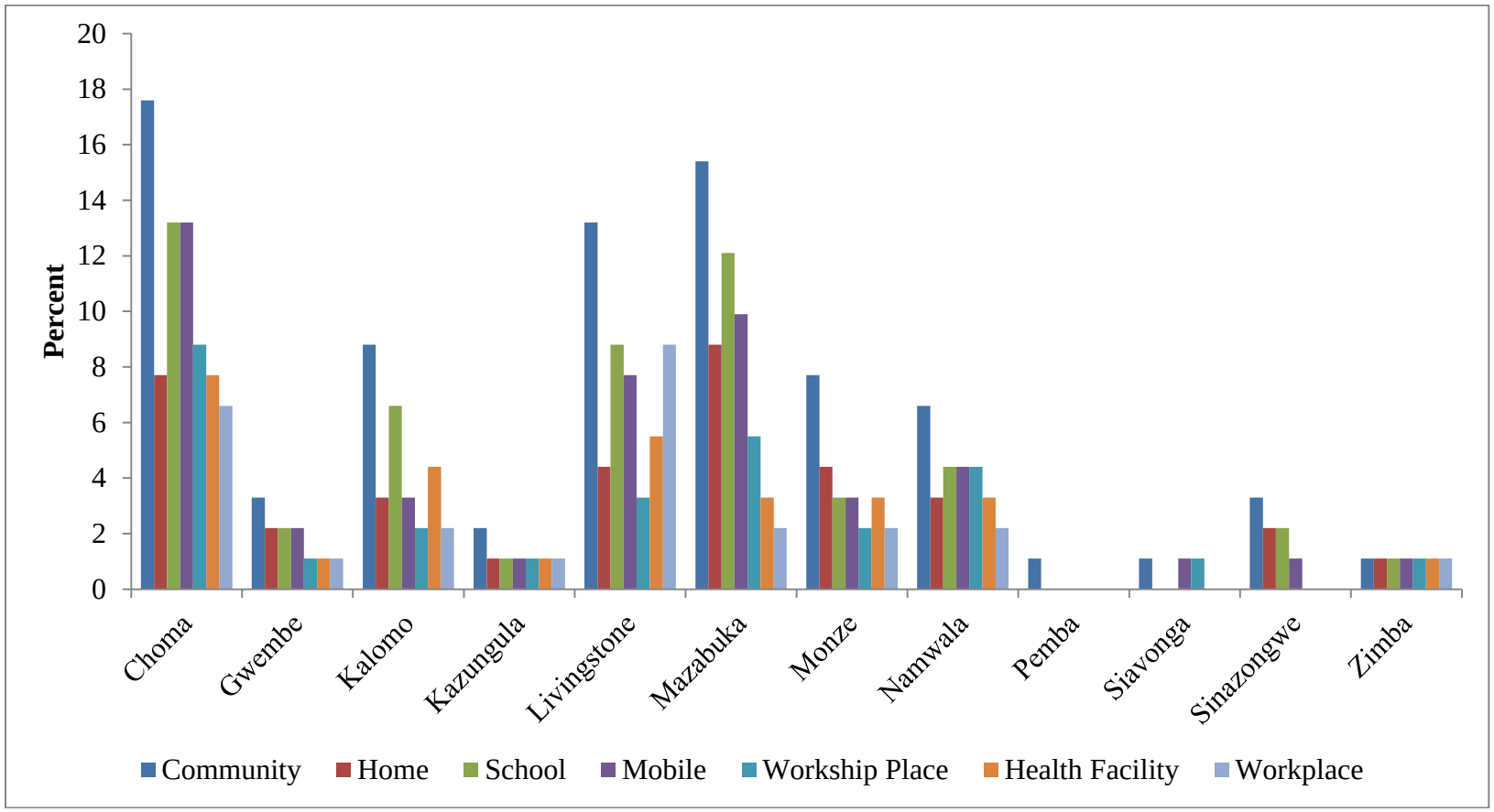
Table 5 provides insights into the availability of standard interventions in rural and urban areas of the districts of Southern Province. None of the NGOs surveyed were implementing VCT in urban areas of Gwembe and Kazungula. As was earlier discussed, no organization surveyed reported implementing condom social marketing interventions in Pemba and Sinazongwe, comprehensive sex/HIV education in Pemba, and social mobilization activities in Pemba and Siavonga. In the other districts, the data reveal gaps in the availability of condom social marketing, comprehensive sex/HIV education and social mobilization interventions in urban areas of Gwembe and Kazungula.

Figure 4 illustrates the intervention sites aggregated across all standard interventions implemented in a given district. The most common implementation site for standard interventions was the community and in Pemba in which only one NGO worked on HIV-prevention, the community was the only implementation site. The least common implementation site varied by district and was the workplace in Choma, Kalomo, Mazabuke, Monze and Namwala, the worship place (church or mosque) in Livingstone, and mobile outreach in Sinazongwe.

Table 5 **Percentage of Organizations Surveyed in Southern Province that Implemented Standard HIV-Prevention Interventions in the Past 12 Months, by District, Type of Intervention Site and Residence, Zambia 2013**

District (N=93)	Voluntary Counseling and Testing		Condom Social Marketing		Comprehensive Sex Education		Social Mobilization	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Choma	9.9	12.1	8.8	12.1	8.8	13.2	12.1	11.0
Gwembe	3.3	0.0	2.2	0.0	3.3	0.0	3.3	0.0
Kalomo	3.3	3.3	5.5	5.5	5.5	5.5	7.7	5.5
Kazungula	1.1	0.0	1.1	0.0	2.2	0.0	2.2	0.0
Livingstone	5.5	9.9	5.5	6.6	6.6	14.3	6.6	14.3
Mazabuka	5.5	8.8	7.7	3.3	8.8	13.2	11.0	11.0
Monze	3.3	2.2	5.5	3.3	5.5	6.6	6.6	6.6
Namwala	5.5	4.4	6.6	5.5	6.6	5.5	6.6	3.3
Pemba	1.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Siavonga	1.1	1.1	0.0	1.1	1.1	1.1	0.0	0.0
Sinazongwe	3.3	1.1	0.0	0.0	2.2	1.1	2.2	1.1
Zimba	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1

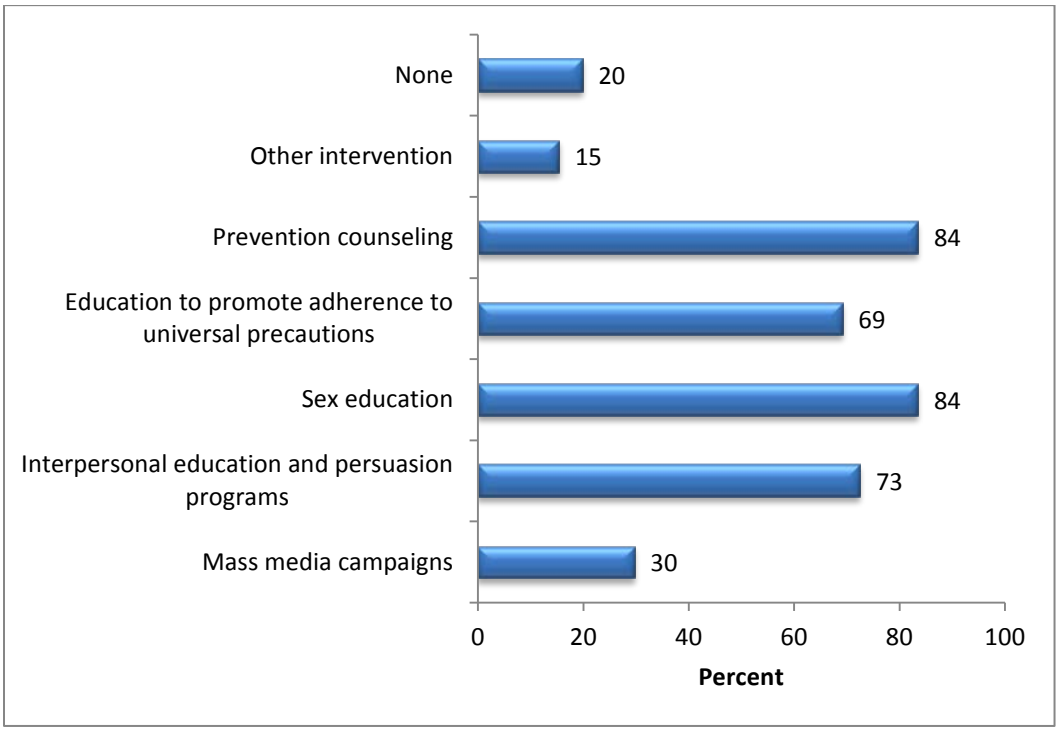
Figure 4 **Percentage of organizations surveyed in Southern Province that implemented standard HIV-prevention interventions in the past 12 months by district and site of intervention, Zambia 2013.**



5. Interventions Affecting Knowledge, Attitudes and Beliefs

Interventions affecting knowledge, attitudes and beliefs and influencing psychological and social risk correlates include mass media campaigns; interpersonal education and persuasion programs, face-to-face dialogue; sex education; education to promote adherence to universal precautions; and prevention counseling. The vast majority of NGOs implemented at least one of these interventions, with the least common being mass media campaigns, which were implemented by 30 percent of organizations surveyed (Figure 5).

Figure 5 **Percentage of organizations surveyed in Southern Province that were currently implementing interventions affecting knowledge, attitudes and beliefs, Zambia 2013.**



The geographic availability of interventions that affect knowledge, attitudes and beliefs in the NGO sector in the past 12 months is shown in Table 6. Three districts stand out: Pemba, Siavonga, and Zimba. None of the organizations surveyed in Southern Province implemented mass media campaigns, interpersonal education and persuasion programs in Pemba, Siavonga, and Zimba. In addition, no organization surveyed in Southern Province implemented sex education and prevention counseling programs in Pemba.

Table 6 **Percentage of Organizations Surveyed in Southern Province that Implemented Interventions Affecting Knowledge, Attitudes and Beliefs and Influencing Psychological and Social Risk Correlates in the Past 12 Months, by District and Type of Intervention, Zambia 2013**

District (N=93)	Mass Media Campaigns	Interpersonal Education and Persuasion Programs	Sex Education	Education to Promote Adherence to Universal Precautions	Prevention Counseling	Other
Choma	3.3	12.1	13.2	9.9	17.6	2.2
Gwembe	1.1	3.3	3.3	2.2	3.3	0.0
Kalomo	1.1	4.4	6.6	7.7	5.5	2.2
Kazungula	1.1	3.3	2.2	1.1	3.3	0.0
Livingstone	5.5	14.3	11.0	6.6	15.4	2.2
Mazabuka	7.7	9.9	13.2	7.7	12.1	0.0
Monze	3.3	8.8	7.7	6.6	8.8	1.1
Namwala	1.1	3.3	6.6	6.6	5.5	0.0
Pemba	0.0	0.0	0.0	1.1	0.0	1.1
Siavonga	0.0	0.0	2.2	1.1	2.2	0.0
Sinazongwe	2.2	2.2	3.3	3.3	3.3	1.1
Zimba	0.0	0.0	1.1	1.1	1.1	0.0

The data also show some rural-urban disparities in intervention coverage (see Table 7). No organization surveyed in Southern Province implemented interventions affecting knowledge, attitudes and beliefs in the past 12 months in urban areas of Kazungula and Gwembe, the only exception in the latter district being prevention counseling. Rural-urban disparities were observed in Choma, Kalomo, and Livingstone, with more of the NGOS surveyed implementing interpersonal education/persuasion programs and sex education programs in urban than in rural areas. Disparities were also seen in the percentage of NGOs surveyed that implemented prevention counseling in Livingstone in the past 12 months (8 percent in rural areas versus 15 percent in urban areas). Also worthy of note is the presence in rural Sinazongwe and absence in urban areas of the district of NGOs implementing mass media campaigns and interpersonal education and persuasion programs.

As Figure 6 shows, the two most common interventions sites for organizations that implemented interventions affecting knowledge attitudes and beliefs in Southern Province in the past 12 months were the community (79 percent) and schools (48 percent). Slightly more than a third of organizations implemented home-based interventions and conducted mobile outreach. Workplace interventions affecting knowledge, attitudes and beliefs were conducted by three in every ten organizations surveyed and 20 percent of organizations surveyed implemented these interventions in worship places.

Figure 6 **Percentage of organizations surveyed in Southern Province that implemented interventions affecting knowledge, attitudes and beliefs in the past 12 months by site of intervention, Zambia 2013.**

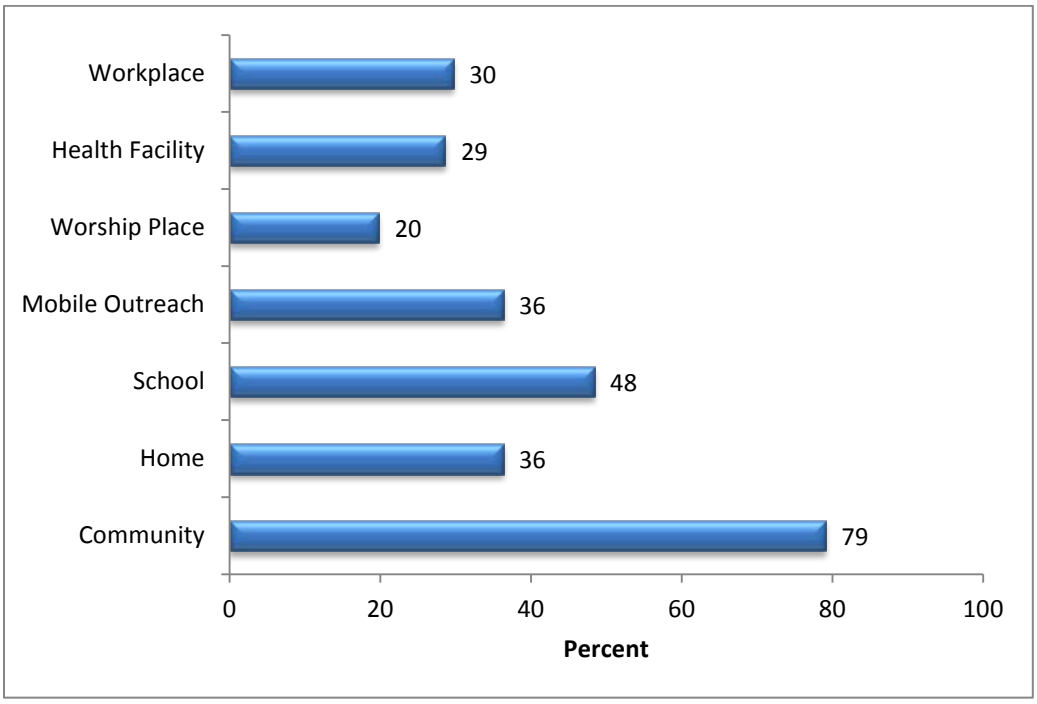


Table 7 **Percentage of Organizations Surveyed in Southern Province that Implemented Interventions Affecting Knowledge, Attitudes and Beliefs and Influencing Psychological and Social Risk Correlates in the Past 12 Months, by District, Type of Intervention and Residence, Zambia 2013**

District (N=91)	Mass Media Campaigns		Interpersonal Education and Persuasion Programs		Comprehensive Sex Education		Education to Promote Adherence to Universal Precautions		Prevention Counseling	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Choma	3.3	3.3	6.6	11.0	9.9	11.0	5.5	8.8	14.3	15.4
Gwembe	1.1	0.0	3.3	0.0	3.3	0.0	2.2	0.0	3.3	1.1
Kalomo	1.1	1.1	4.4	3.3	5.5	4.4	5.5	6.6	4.4	4.4
Kazungula	1.1	0.0	3.3	0.0	2.2	0.0	1.1	0.0	2.2	0.0
Livingstone	2.2	5.5	7.7	12.1	4.4	11.0	4.4	6.6	7.7	15.4
Mazabuka	6.6	5.5	7.7	6.6	6.6	8.8	4.4	4.4	6.6	9.9
Monze	3.3	2.2	5.5	5.5	5.5	6.6	5.5	3.3	7.7	5.5
Namwala	1.1	1.1	3.3	1.1	4.4	3.3	5.5	3.3	3.3	4.4
Pemba	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.0
Siavonga	0.0	0.0	0.0	0.0	0.0	2.2	1.1	1.1	2.2	1.1
Sinazongwe	2.2	0.0	2.2	0.0	3.3	1.1	3.3	1.1	3.3	1.1
Zimba	0.0	0.0	0.0	0.0	1.1	1.1	1.1	1.1	1.1	1.1

However, these estimates hide important differences between districts (see Table 8). None of the organization implementing interventions affecting knowledge, attitudes and beliefs chose homes, schools, worship places, health facilities or workplaces or mobile outreach as their intervention site in Pemba and Zimba. In Siavonga, health facilities and worship places were not sites for interventions affecting knowledge attitudes and beliefs. Workplaces and worship places were the least common intervention sites for organizations implementing interventions affecting knowledge, attitudes and beliefs and were found in only eight of the twelve districts of Southern Province.

6. Harm Reduction Interventions

Harm reduction interventions are defined as interventions that lower the risk of a behavior but do not eliminate the behavior. For the purposes of this study, harm reduction interventions included distribution of condoms and condom-compatible lubricants, needle and syringe exchange, provision of equipment required for universal precautions, providing safe spaces for vulnerable populations to use prevention services and inject drugs safely, and livelihood alternatives to transactional sex. As Figure 7 shows, the most common harm reduction interventions were distribution of condom and condom compatible lubricants, which was implemented by 63 percent of organizations surveyed. It is to be noted, however, that many of the organizations did not distribute condom-compatible lubricants and deleted this aspect of the intervention from the questionnaire. The least common harm reduction interventions were needle and syringe exchange, which probably reflects the fact that injecting drug use is not a key driver of the HIV epidemic in Zambia, and livelihood alternatives to transactional sex.

Figure 7 **Percentage of organizations surveyed in Southern Province that implemented harm reduction interventions in the past 12 months, Zambia 2013.**

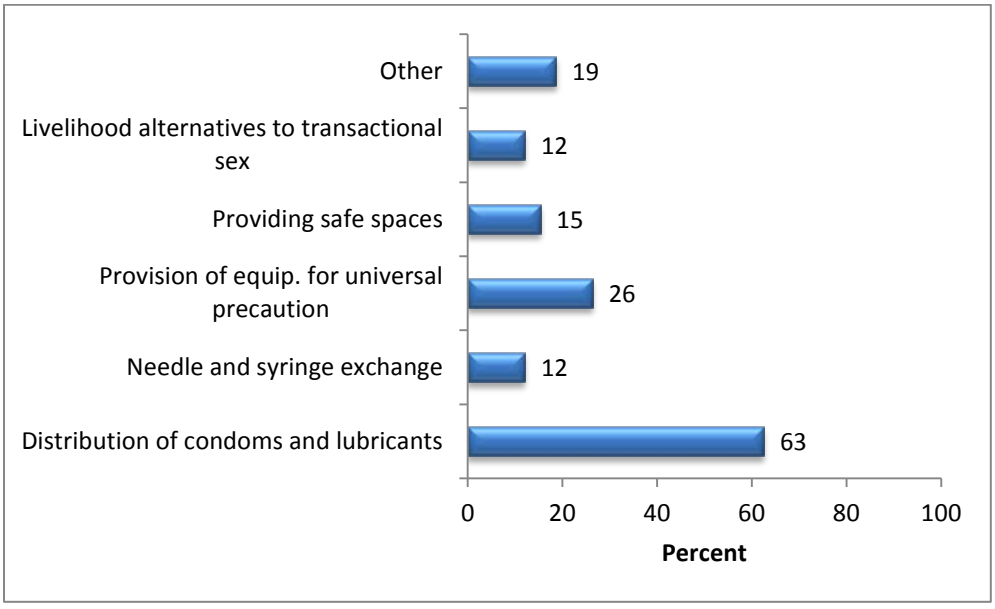


Table 8 **Percentage of Organizations Surveyed in Southern Province that Implemented Interventions Affecting Knowledge, Attitudes and Beliefs and Influencing Psychological and Social Risk Correlates in the Past 12 Months by District and Intervention Site, Southern Province, Know Your HIV-Prevention Response Survey 2013**

District (N=93)	Community	Home	School	Mobile Outreach	Worship Place	Health Facility	Workplace	Other
Choma	13.2	8.8	11.0	7.7	5.5	3.3	5.5	4.4
Gwembe	3.3	2.2	1.1	2.2	1.1	1.1	2.2	0.0
Kalomo	8.8	3.3	5.5	2.2	1.1	3.3	2.2	0.0
Kazungula	2.2	2.2	2.2	1.1	1.1	1.1	1.1	1.1
Livingstone	15.4	4.4	7.7	7.7	0.0	6.6	8.8	5.5
Mazabuka	13.2	5.5	11.0	9.9	6.6	3.3	1.1	2.2
Monze	9.9	4.4	4.4	1.1	3.3	4.4	4.4	1.1
Namwala	5.5	3.3	2.2	3.3	1.1	3.3	4.4	1.1
Pemba	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Siavonga	3.3	1.1	1.1	1.1	2.2	0.0	0.0	0.0
Sinazongwe	3.3	1.1	2.2	1.1	0.0	2.2	0.0	0.0
Zimba	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 9 shows the percentage of organizations surveyed in Southern Province that implemented various types of harm reduction interventions in each district in the past 12 months. There was at least one surveyed organization involved in the distribution of condoms and condom-compatible lubricants in each district, with the exception of Zimba. In each district, needle and syringe exchange was reported as being implemented by at least one organization surveyed, the exceptions being Pemba and Siavonga, which also had no organizations that provided equipment required for universal precautions or safe spaces for vulnerable populations to use preventions services or inject drugs safely. The latter intervention was the least common and was reported as being implemented by organizations surveyed in only half of the districts of Southern Province. No organization surveyed implemented livelihood alternatives to transactional sex in Gwembe, Pemba and Sinazongwe.

Geographic gaps in the implementation of harm reduction interventions are further revealed by rural-urban location in Table 10. Condom distribution was reported as being implemented by at least one organization surveyed in the rural and urban areas of each district, with the exception of urban Gwembe, urban Kazungula, urban Pemba and both rural and urban areas of Zimba. In three districts, no organization reported implementing rural needle and syringe exchanges programs: Choma, Pemba, and Siavonga. For this intervention, gaps are also seen in the provision of this intervention in urban areas of three districts: Gwembe, Kazungula, Pemba, and Siavonga. Few organizations surveyed reported that they provided equipment required for universal precautions in the past 12 months. No organization surveyed reported providing this intervention in rural Choma, rural Monze, rural Pemba, rural Siavonga, and rural Zimba. There was also an absence in the sample of organizations that provided equipment required for universal precautions in urban areas of Gwembe, Kazungula, Pemba, Siavonga, and Zimba. In both rural and urban areas, the provision of safe spaces for vulnerable populations to use prevention services and inject drugs safely was the least common intervention offered in the past 12 months by organizations surveyed. Regarding the provision of livelihood alternatives to transactional sex, there were five districts in which no organization surveyed reported implementing this intervention in urban areas: Choma, Gwembe, Kazungula, Pemba and Siavonga.

Among organizations that implemented harm reduction interventions in the past 12 months, the community was the most common implementation site except in Mazabuka. No organization surveyed reported homes and schools as intervention sites in Pemba, Siavonga, and Zimba. In the latter district, the community was the only intervention site. Mobile outreach was reported as a mode of delivering harm reduction interventions in all districts except Sinazongwe and Zimba. Worship places were sites for harm reduction interventions implemented by organizations surveyed except in Gwembe, Kalomo, Livingstone, Pemba, and Zimba. The data also indicated that workplace-based harm reduction interventions were implemented in all districts by organizations surveyed, except in Pemba, Siavonga, Sinazongwe, and Zimba. In three of the latter districts (the exception being Sinazongwe), no organization surveyed reported implementing health facility-based harm reduction interventions (see Table 11).

Table 9 **Percentage of Organizations Surveyed in Southern Province that Implemented Harm Reduction Interventions in the Past 12 Months, by District and Type of Intervention, Zambia 2013**

District (N=93)	Distribution of Condoms and Condom-Compatible Lubricants	Needle and Syringe Exchange	Provision of Equipment Required for Universal Precautions	Providing Safe Spaces for Vulnerable Populations to Use Prevention Services and Inject Drugs Safely	Livelihood Alternatives to Transactional Sex	Other	Any Harm Reduction Interventions
Choma	12.1	2.2	1.1	0.0	2.2	5.5	16.5
Gwembe	2.2	2.2	2.2	0.0	0.0	0.0	3.3
Kalomo	5.5	3.3	1.1	1.1	1.1	1.1	6.6
Kazungula	1.1	3.3	1.1	1.1	1.1	0.0	3.3
Livingstone	11.0	6.6	3.3	0.0	1.1	2.2	17.6
Mazabuka	6.6	5.5	2.2	1.1	6.6	1.1	15.4
Monze	4.4	3.3	1.1	2.2	3.3	2.2	7.7
Namwala	7.7	3.3	2.2	2.2	1.1	2.2	7.7
Pemba	1.1	0.0	0.0	0.0	0.0	0.0	1.1
Siavonga	1.1	0.0	0.0	0.0	1.1	1.1	2.2
Sinazongwe	2.2	2.2	2.2	1.1	0.0	0.0	3.3
Zimba	0.0	1.1	0.0	0.0	1.1	0.0	1.1

Table 10 **Percentage of Organizations Surveyed in Southern Province that Implemented Harm Reduction Interventions in the Past 12 months, by District, Type of Intervention and Residence, Zambia 2013**

District (N=93)	Distribution of Condoms and Condom-Compatible Lubricants		Needle and Syringe Exchange		Provision of Equipment Required for Universal Precautions		Providing Safe Spaces for Vulnerable Populations to Use Prevention Services and Inject Drugs Safely		Livelihood Alternatives to Transactional Sex	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Choma	8.8	12.1	0.0	2.2	0.0	1.1	0.0	0.0	2.2	0.0
Gwembe	2.2	0.0	2.2	0.0	2.2	0.0	0.0	0.0	0.0	0.0
Kalomo	4.4	5.5	3.3	2.2	1.1	1.1	1.1	1.1	1.1	1.1
Kazungula	1.1	0.0	3.3	0.0	1.1	0.0	1.1	0.0	1.1	0.0
Livingstone	5.5	11.0	3.3	3.3	2.2	3.3	0.0	0.0	1.1	3.3
Mazabuka	4.4	4.4	3.3	2.2	1.1	2.2	0.0	1.1	4.4	5.5
Monze	4.4	3.3	3.3	1.1	0.0	1.1	2.2	2.2	3.3	1.1
Namwala	6.6	5.5	3.3	2.2	2.2	2.2	2.2	1.1	1.1	1.1
Pemba	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Siavonga	1.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1
Sinazongwe	2.2	1.1	2.2	1.1	2.2	1.1	1.1	0.0	0.0	0.0
Zimba	0.0	0.0	1.1	1.1	0.0	0.0	0.0	0.0	1.1	1.1

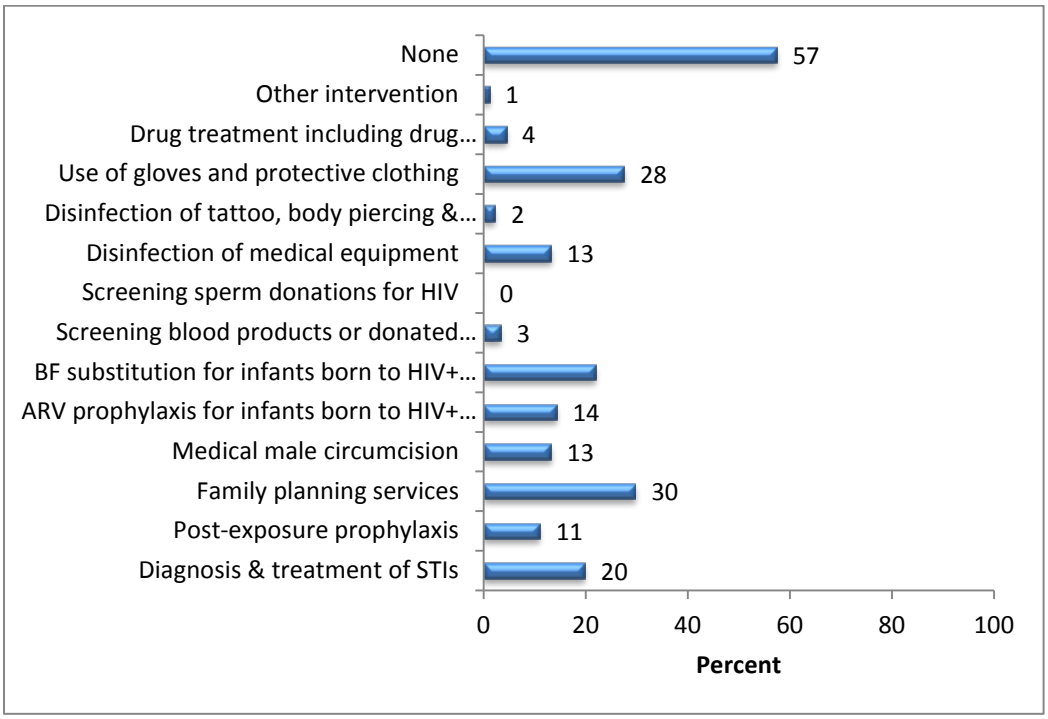
Table 11 Percentage of Organizations Surveyed in Southern Province that Implemented Harm Reduction Interventions in the Past 12 months, by District and Intervention Site, Zambia 2013

District (N=93)	Community	Home	School	Mobile Outreach	Worship Place	Health Facility	Workplace	Other
Choma	14.3	6.6	3.3	8.8	3.3	3.3	7.7	1.1
Gwembe	2.2	2.2	1.1	2.2	0.0	1.1	1.1	0.0
Kalomo	4.4	3.3	3.3	3.3	0.0	3.3	1.1	1.1
Kazungula	1.1	2.2	3.3	1.1	1.1	1.1	1.1	1.1
Livingstone	9.9	5.5	6.6	6.6	0.0	4.4	4.4	5.5
Mazabuka	7.7	8.8	8.8	7.7	3.3	2.2	1.1	5.5
Monze	6.6	1.1	0.0	1.1	2.1	2.2	2.2	0.0
Namwala	6.6	2.2	2.2	3.3	1.1	4.4	4.4	2.2
Pemba	1.1	0.0	0.0	1.1	0.0	0.0	0.0	0.0
Siavonga	1.1	0.0	0.0	1.1	2.2	0.0	0.0	0.0
Sinazongwe	3.3	1.1	2.2	0.0	1.1	1.1	0.0	0.0
Zimba	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0

7. Biological/Biomedical Interventions

Figure 8 shows the percentage of organizations surveyed that were currently implementing biological and biomedical interventions that reduce HIV-infection and transmission risk in Southern Province. This group of interventions was not as common as those that reduce harm or affect knowledge, attitudes and behavior. The most commonly implemented biological/biomedical interventions by organizations surveyed were family planning services, use of gloves and protective clothing during medical procedures and breastfeeding substitution for infants born to HIV+ mothers. One in every five organizations surveyed provided diagnosis and treatment of sexually transmitted infections. Male circumcision was reported as currently implemented by 13 percent of organizations surveyed.

Figure 8 **Percentage of organizations surveyed in Southern province that were currently implementing biological/biomedical interventions that reduce HIV infection and transmission risk, Zambia 2013.**



The geographic availability of selected biomedical/biological interventions is shown in Table 12. No organization surveyed promoted or implemented male circumcision in eight out 12 districts in the past 12 months. In districts in which male circumcision was promoted or offered, organizations surveyed worked provided these services in both rural and urban areas, with the exception of Gwembe in which the service was not found in urban areas (not shown). In addition, none of the organizations surveyed was involved in diagnosis and treatment of sexually transmitted infections, post-exposure prophylaxis, or

provision of family planning services in Pemba, Siavonga, Sinazongwe, and Zimba. In Namwala, the only biological/biomedical intervention offered by organizations surveyed was diagnosis and treatment of sexually transmitted infections. None of the organizations surveyed implemented breastfeeding substitution for HIV positive mothers in Kazungula, Namwala, Pemba and Zimba in the past 12 months. In Gwembe, Mazabuka and Sinazongwe, this intervention was provided only in rural areas by the organizations surveyed.

The data also showed a few rural-urban disparities in the provision of antiretroviral prophylaxis for infants born to HIV+ mothers; breastfeeding substitution for HIV+ mothers and use of gloves and protective clothing during medical procedures in the past 12 months by organizations surveyed (see Table 13). For example, in Gwembe and Mazabuka, antiretroviral prophylaxis for infants born to HIV+ mothers was provided in rural but not in urban areas whereas the reverse was the case in Choma. Breastfeeding substitution for HIV+ mothers was provided in rural but not in urban areas of Gwembe, Mazabuka, and Sinazongwe. Disinfection of tattoo, body piercing and barber equipment was provided by at least one organization surveyed in only three districts: Choma, Mazbuka, and Monze. However, in Choma, this intervention was provided only in urban areas whereas in Mazabuka, it was provided only in rural areas. As Figure 9 shows, the community and mobile outreach were the most common sites for implementation of biological/biomedical intervention but in Choma slightly more implemented these interventions at home than through mobile outreach (not shown).

Figure 9 **Percentage of Organizations Surveyed in Southern Province that Implemented Biological/Biomedical Interventions in the Past 12 Months by Site of Intervention, Zambia 2013**

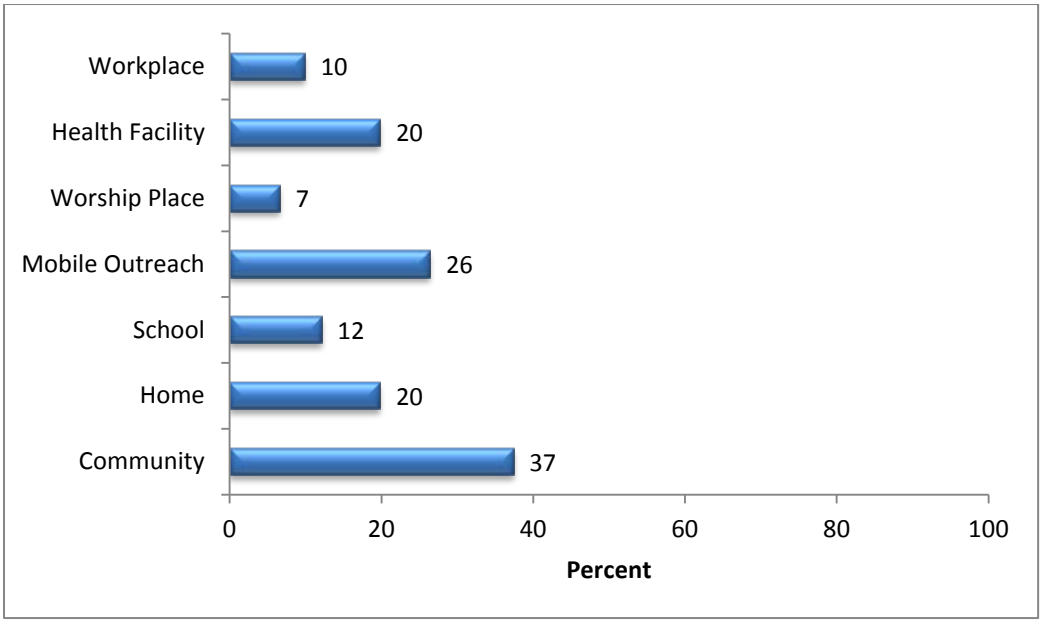


Table 12 Presence of Surveyed Organizations Implementing Selected Biological or Biomedical Interventions in Southern Province by Type of Intervention and District, Zambia 2013

District	STI Diagnosis & Treatment	Post-exposure Prophylaxis	Family Planning	Male Circumcision	ARV Prophylaxis for Infants Born to HIV+ Mothers	Breastfeeding Substitution for HIV+ Mothers
Choma	Yes	Yes	Yes	Yes	Yes	Yes
Gwembe	Yes	Yes	Yes	Yes	Yes	Yes
Kalomo	Yes	Yes	Yes	Yes	No	Yes
Kazungula	Yes	Yes	Yes	No	No	No
Livingstone	Yes	Yes	Yes	No	Yes	Yes
Mazabuka	Yes	Yes	Yes	No	Yes	Yes
Monze	Yes	Yes	Yes	Yes	Yes	Yes
Namwala	Yes	No	No	No	No	No
Pemba	No	No	No	No	No	No
Siavonga	No	No	No	No	No	Yes
Sinazongwe	No	No	No	No	No	Yes
Zimba	No	No	No	No	No	No

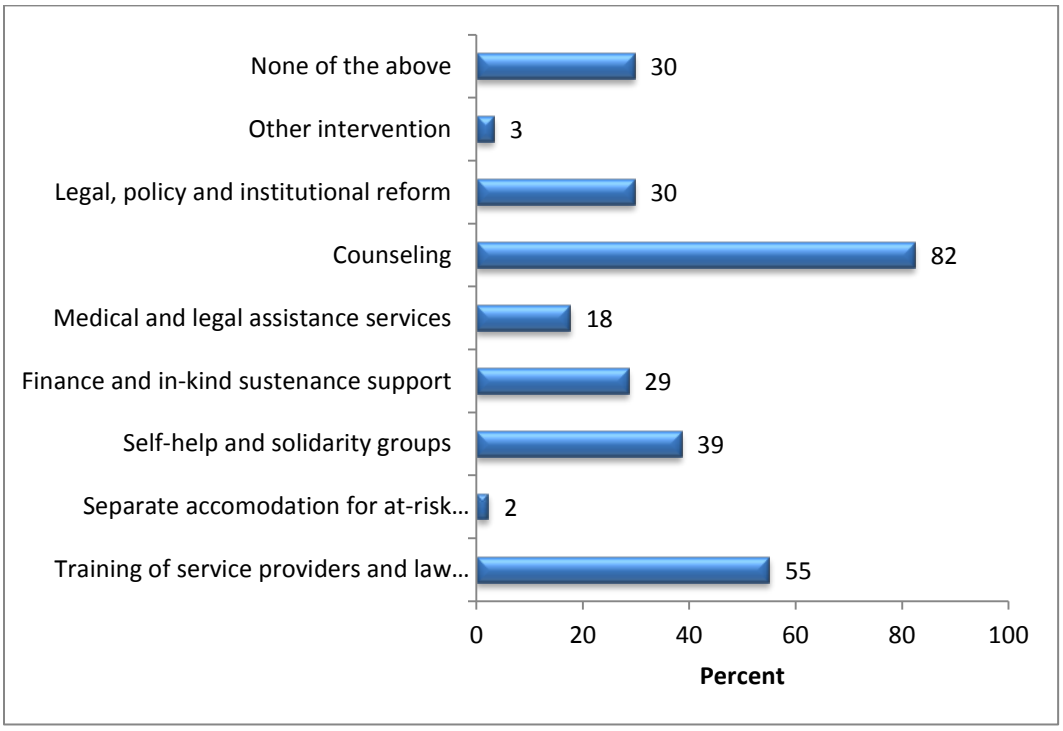
Table 13 Presence of Surveyed Organizations Implementing Selected Biological or Biomedical Interventions in Southern Province by District and Place of Residence, Zambia 2013

District	Antiretroviral Prophylaxis for Infants Born to HIV+ Mothers		Breastfeeding Substitution for HIV+ Mothers		Disinfection of Tattoo, Body Piercing and Barber Equipment	
	Rural	Urban	Rural	Urban	Rural	Urban
Choma	No	Yes	Yes	Yes	No	Yes
Gwembe	Yes	No	Yes	No	No	No
Kalomo	No	No	Yes	Yes	No	No
Kazungula	No	No	No	No	No	No
Livingstone	Yes	Yes	Yes	Yes	No	No
Mazabuka	Yes	No	Yes	No	Yes	No
Monze	Yes	Yes	Yes	Yes	Yes	Yes
Namwala	Yes	Yes	No	No	No	No
Pemba	No	No	No	No	No	No
Siavonga	No	No	Yes	Yes	No	No
Sinazongwe	No	No	Yes	No	No	No
Zimba	No	No	No	No	No	No

8. Interventions to Mitigate Barriers to Prevention and Negative Social Outcomes of HIV Infection

This group of interventions typically includes training of service providers and law enforcement; separate accommodation to protect at-risk population; self-help and solidarity groups; financial and in-kind sustenance support; medical and legal assistance services; counseling; legal, policy and institutional reform to protect human rights of vulnerable groups and people living with HIV (PLWH). The vast majority of organizations (82 percent) implemented counseling in the past 12 months. More than half of the organizations surveyed trained service providers and law enforcement and three in every ten worked on legal, policy and institutional reform. Medical and legal assistance services and separate accommodation to protect at-risk populations were fairly uncommon interventions and were implemented by 18 percent and 2 percent of organizations, respectively (see Figure 10).

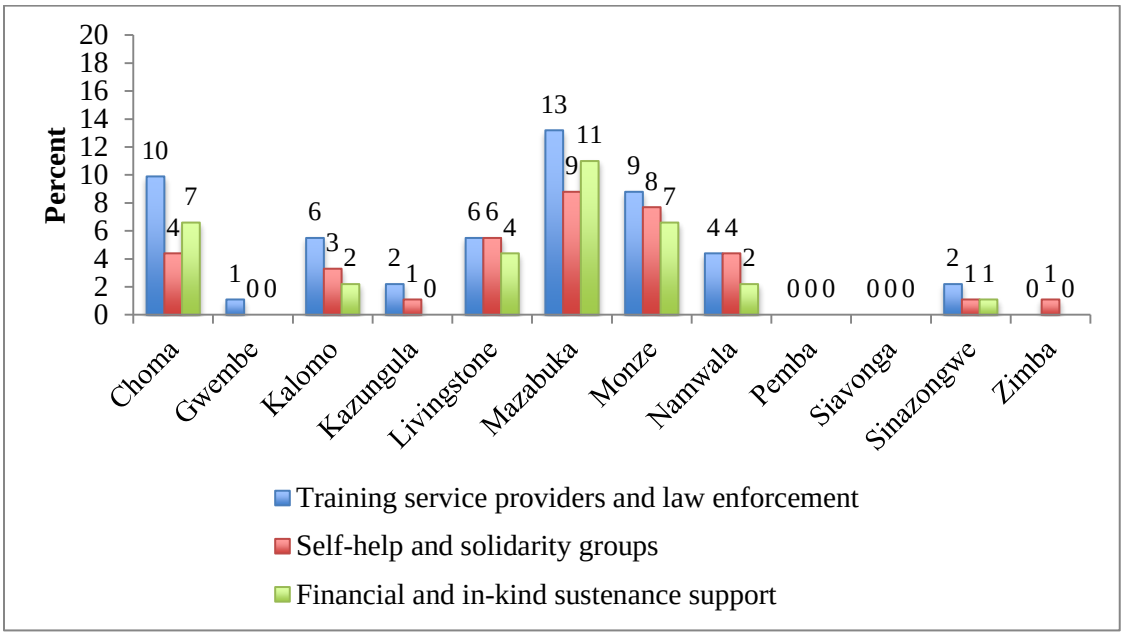
Figure 10 **Percentage of organizations surveyed in Southern province that were currently implementing interventions to mitigate barriers to prevention and negative social outcomes of HIV infection and transmission risk, Zambia 2013.**



The data above mask geographic variations in the provision of interventions to mitigate barriers to prevention and negative social outcomes of HIV infection. As Figure 11 shows, no organizations surveyed trained service providers and law enforcement, organized solidarity groups, or provided financial and in-kind support to PLWH in

Pemba and Siavonga. With the additional exception of Gwembe, at least one organization surveyed promoted self-help and solidarity groups in each district. No organization surveyed reported training service providers and law enforcement in Zimba. In addition to Pemba and Siavonga, there were three districts in which no organization surveyed reported providing financial and in-kind sustenance support: Gwembe, Kazungula and Zimba. It is worth noting that none of the organizations surveyed reported implementing any of the interventions presented in this section to mitigate barriers to prevention and negative social outcomes of HIV infection, not even counseling, in Pemba (not shown).

Figure 11 **Percentage of organizations surveyed in Southern Province that implemented selected interventions to mitigate barriers to prevention and negative social outcomes of HIV infection in the past 12 months by district, Zambia 2013.**



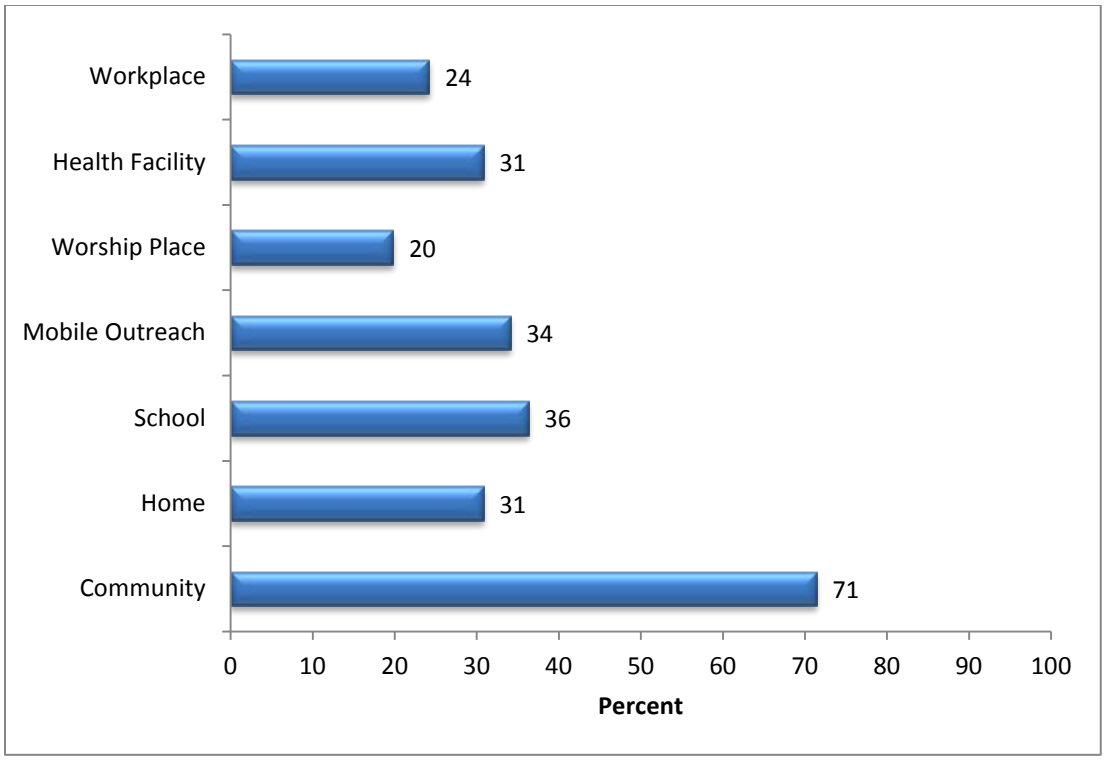
There were some rural-urban variations in the implementation of interventions to mitigate barriers to prevention and negative social outcomes of HIV infection in the past 12 months (see Table 14). For example, training of service providers and law enforcement, counseling, and legal/policy/institutional reform interventions were implemented by at least one organization surveyed in rural areas of Gwembe and Kazungula, but not in urban areas of those districts. In addition, medical and legal assistance services were not provided by organizations surveyed in urban areas of Gwembe and Sinazongwe and in rural areas of Choma and Namwala. Some rural-urban disparities are also seen in the percentage of organizations surveyed that were implementing a given intervention, the most noteworthy being training of service providers and law enforcement in Choma and counseling in Livingstone. For example, 8 percent of organizations surveyed implemented counseling interventions in rural Livingstone compared to 13 percent in urban areas of the district. In Choma and Livingstone, there was a clear urban advantage.

Table 14. Percentage of Organizations Surveyed in Southern Province that Implemented Interventions to Mitigate Barriers to Prevention and Negative Social Outcomes of HIV Infection in the Past 12 Months, by District, Type of Intervention and Residence, Zambia 2013

District (N=93)	Training of Service Providers and Law Enforcement		Counseling		Legal, Policy and Institutional Reform to Protect Human Rights of Vulnerable Groups and HIV+ People		Financial and In-kind Sustenance Support		Medical and Legal Assistance Services	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Choma	3.3	9.9	11.0	13.2	1.1	4.4	3.3	5.5	0.0	1.1
Gwembe	1.1	0.0	2.2	0.0	1.1	0.0	0.0	0.0	1.1	0.0
Kalomo	3.3	5.5	4.4	5.5	1.1	2.2	1.1	2.2	1.1	1.1
Kazungula	2.2	0.0	1.1	0.0	1.1	0.0	0.0	0.0	0.0	0.0
Livingstone	2.2	5.5	7.7	13.2	5.5	6.6	1.1	4.4	1.1	3.3
Mazabuka	7.7	8.8	8.8	8.8	5.5	4.4	7.7	7.7	4.4	4.4
Monze	5.5	5.5	4.4	4.4	3.3	3.3	4.4	5.5	3.3	1.1
Namwala	4.4	2.2	5.5	3.3	1.1	0.0	1.1	1.1	0.0	1.1
Pemba	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Siavonga	0.0	0.0	2.2	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Sinazongwe	2.2	1.1	1.1	1.1	0.0	0.0	1.1	0.0	1.1	0.0
Zimba	0.0	0.0	1.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0

Most organizations surveyed (71 percent) delivered interventions aimed at mitigating barriers to prevention and negative social outcomes of HIV infection at the community level (see Figure 12). However, approximately a third implemented these interventions at home, in schools and through mobile outreach and at least one organization reported each site shown for the implementation of this category of HIV-prevention interventions in Choma, Kazungula, Livingstone, Mazabuka, Monze, Namawala and Zimba. No mobile outreach was reported in Gwmebe , no worship place interventions in Kalomo and Sinazongwe, and no health facility and workplace interventions in Siavonga (not shown).

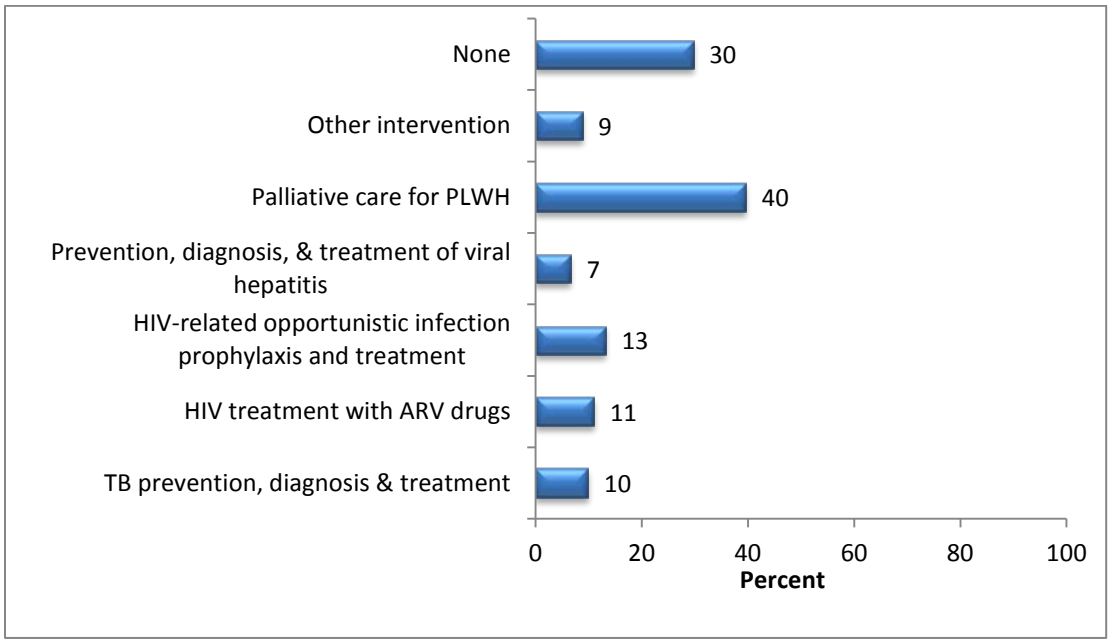
Figure 12 **Percentage of organizations surveyed in Southern Province that implemented interventions aimed at mitigating barriers to prevention and negative social outcomes of HIV infection in the past 12 months by site of intervention, Zambia 2013.**



9. Interventions to Mitigate Biological Outcomes of HIV Infection

Interventions to mitigate biological outcomes of HIV infection include: (a) TB prevention, diagnosis and treatment services; (b) HIV treatment with antiretroviral (ARV) drugs ; (c) HIV-related opportunistic infection prophylaxis and treatment; (d) prevention, diagnosis and treatment of viral hepatitis (allowing access to antiretroviral treatment); and (e) palliative care for PLWH. The most common of these interventions was palliative care for PLWH, which was implemented by 40 percent of organizations surveyed (Figure 13). Each of the other interventions was implemented by less than 15 percent of organizations surveyed.

Figure 13 Percentage of organizations surveyed in Southern province that were currently implementing interventions to mitigate biological outcomes of HIV infection, Zambia 2013.



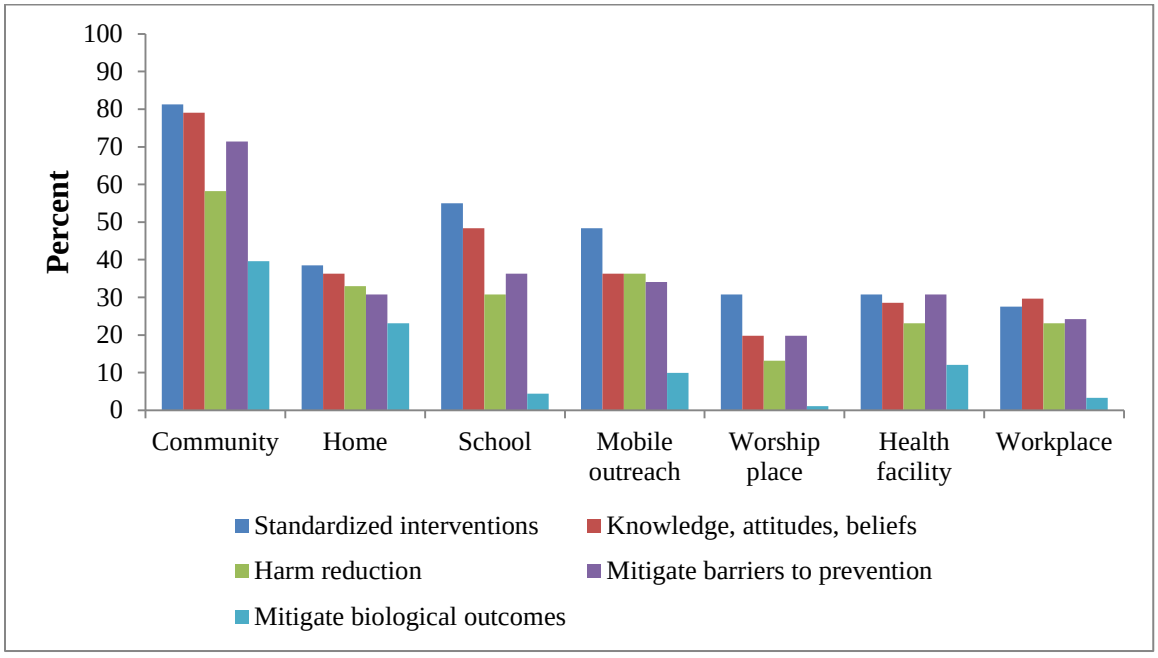
As Table 15 shows, none of the interventions to mitigate biological outcomes of HIV infection was implemented in Kazungula and Pemba by organizations surveyed. In Gwembe, Kalomo and Livingstone, four of the five interventions shown were implemented by at least one organization surveyed but the districts differed in terms of which intervention was not provided. In Gwembe, no organization surveyed implemented interventions to prevent, diagnose and treat viral hepatitis. In Kalomo, it was HIV-related opportunistic infection prophylaxis and treatment that was not provided by any of the organizations surveyed. None of the organizations surveyed reported implementing tuberculosis prevention, diagnosis and treatment services in Livingstone. It is also noted that only one of the interventions shown in Table 15, palliative care, was implemented in Monze, Sinazongwe and Zimba by organizations surveyed.

Table 15 Presence of Organizations Surveyed in Southern Province that Implemented Selected Interventions to Mitigate Biological Outcomes of HIV Infection in the Past 12 Months by Type of Intervention and District, Zambia 2013

District	Tuberculosis Prevention, Diagnosis & Treatment	HIV Treatment with Antiretroviral Drugs	HIV-related Opportunistic Infection Prophylaxis and Treatment	Prevention, Diagnosis and Treatment of Viral Hepatitis	Palliative Care for People Living with HIV
Choma	No	Yes	No	No	Yes
Gwembe	Yes	Yes	Yes	No	Yes
Kalomo	Yes	Yes	No	Yes	Yes
Kazungula	No	No	No	No	No
Livingstone	No	Yes	Yes	Yes	Yes
Mazabuka	Yes	No	Yes	No	Yes
Monze	No	No	No	No	Yes
Namwala	No	No	No	Yes	Yes
Pemba	No	No	No	No	No
Siavonga	No	No	Yes	No	Yes
Sinazongwe	No	No	No	No	Yes
Zimba	No	No	No	No	Yes

Figure 14 presents the percentage of organizations surveyed that implemented HIV-prevention interventions in Southern Province in the past 12 months by type and site of intervention and permits a comparison with categories of interventions discussed previously. Forty percent of organizations implemented community-based interventions to mitigate biological outcomes of HIV infection, roughly half the percentage that implemented community-based standard interventions. Less than 10 percent of organizations surveyed implemented interventions to mitigate biological outcomes of HIV infection in schools, worship place and workplaces or through mobile outreach. At every site shown, fewer organizations surveyed implemented interventions to mitigate biological outcomes of HIV infection as compared to other types of HIV-prevention interventions.

Figure 14 **Percentage of organizations surveyed in Southern Province that implemented HIV-prevention interventions in the past 12 months by type and site of intervention, Zambia 2013.**



10. Gender Integration

All program implementers working in a given district were asked questions to assess the extent to which their HIV-prevention activities in the district included strategies to address gender issues and the type of gender issues addressed. Program implementers were also requested to provide a brief description of the activities implemented to address the specified gender issues. As Table 16 shows, one in every five organizations did not integrate gender issues into their HIV-prevention activities and about 46 percent integrated "most or all" gender issues. At least two out of three organizations surveyed addressed gender norms, violence against women, and gender-related barriers in access to and utilization of HIV/AIDS services. Half as many organizations addressed cross-generational sex, which has been identified as one of the key drivers of HIV transmission in Zambia.

A review of the various activities conducted by program implementers to address gender issues in HIV-prevention projects in Southern Province suggests that there is a continuum of approaches (see Table 17). Approaches range from those addressing gender inequalities and discrimination, gender norms and gender-based violence to those that recognize women's lack of income, a general denial or lack of awareness of women's rights, and the specific vulnerabilities of adolescents and youth. Some organizations built the capacity of their own staff in gender mainstreaming and gender norms. Other activities focused on empowering women by improving girls' access to information about their rights in Choma, Kazungula, and Livingstone. In Choma, this also included disseminating information about the GBV Act of 2011. In one district, gender integration also included promoting male involvement in reproductive health. Many of the activities described could be classified as social and behavioral change communication delivered through both community-based informants and networks as in Gwembe and media channels such as radio as in Livingstone and Mazabuka.

While gender-sensitization activities were conducted in all districts (no information was provided for Zimba), some organizations' efforts tended to target specific population subgroups. For example, in Monze, teachers and parents were sensitized about the importance of educating both boys and girls. In Namwala, traditional leaders such as village headmen and religious leaders were sensitized about the dangers of early marriage. Drivers, policemen, call boys, and scouts were also some of the target groups for gender sensitization efforts. Activities addressing gender-based violence varied from campaigns against gender-based violence in Mazabuka to counseling of perpetrators in Choma. Some program activities focused on increasing women's access to income, education, and resources. These included girl support and women's livelihood programs in Sinazongwe. A few specified activities (in Mazabuka, Monze and Sinazongwe) focused on ensuring the involvement of both men and women in caregiver training and in advocacy to discourage gender discrimination and promote gender equity (see Table 17).

Table 16 **Percentage of Organizations Surveyed that Integrated Gender Issues into District-Level HIV-prevention Activities by Level of Integration and Type of Gender Issue Addressed, Southern Province, Zambia 2013**

Variable	Percent
Level of integration	
Did not integrate gender	19.2
Some key gender issues addressed	34.6
Most key gender issues addressed	32.1
All key gender issues addressed	14.1
Total	100.0
Key issue addressed	
Gender norms	70.5
Violence against women	73.1
Cross-generational sex	37.2
Gender-related barriers in access to and utilization of HIV/AIDS services	68.0
Gender differentials in care giving for HIV-infected and affected people	48.7
Gender differentials in access to education and economic security	38.5
Other	6.4
N	78

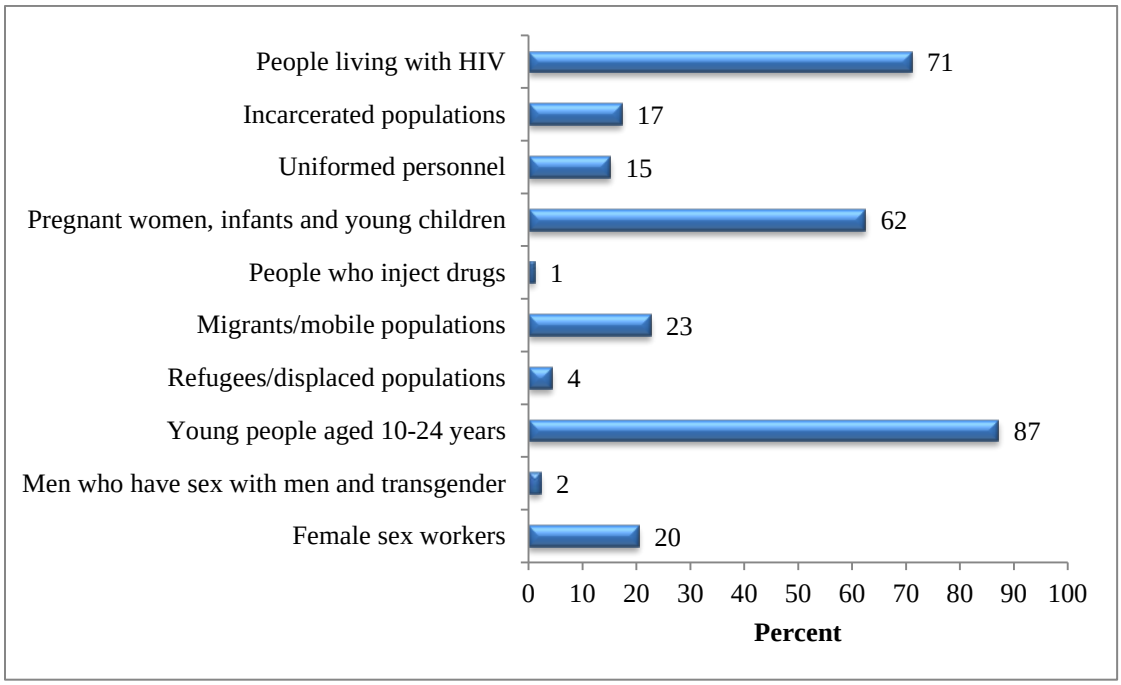
Table 17 Activities Implemented by Organizations Surveyed in Southern Province to Integrate Gender Issues into HIV-prevention Interventions, by District, Zambia 2013

District	Gender-integration Activities
Choma	• Counseling to perpetrators of gender-based violence • Dissemination of ARH and GBV Act 2011 • Talking to girls in schools about their rights • Continued sensitization against gender-based violence • The project involved traditional leaders like village headmen, religious leaders to discuss gender issues using small group discussions with women, men, girls and boys. • Promotion of male involvement in reproductive health.
Gwembe	• We involve all stakeholders of the community that is the men, women boys, girls and leaders in sensitizing them on the aspects of gender issues.
Kazungula	• Talking to girls in schools about their rights • Held several social mobilization, interactions to address gender issues • Sensitization
Livingstone	• Community awareness sensitization against gender-based violence • Face to face meetings with stakeholders like drivers, police, call boys etc. • Our LPCB partner trained our staff in gender norms • Participated in workshops and gender mainstreaming • Workshops in community. Priority in girls' education. • 9 Scouts are sensitized on a weekly basis regarding gender issues • Talking to girls in schools about their rights • Workshops, radio and community meetings • Community awareness-raising with other partners on gender issues among the disabled
Mazabuka	• Campaign against gender based violence in the district with other organizations e.g. PAFF • Involved all stakeholders both male and female of different background to discuss issues and discourage gender discrimination • Radio, school, churches, outreach programs • We sensitize the community on gender-based violence
Monze	• Provided financial resources • Sensitization to teachers on education for both girls and boys. We have talked about children's rights. Sensitization of parents/headmen about the importance of education of boys and girls • Through sensitization, we taught the community through meetings on issues of advocacy for gender equity and gender balance • We had an education talk during meetings on violence against women • We have gender clubs and we hold public company sensitization
Namwala	• Community sensitization on equality in working • Meeting with traditional leaders to educate them on dangers of early marriages and its impact. • We organized meetings with traditional leaders, district stakeholders. We also had group discussions with community leaders
Pemba	• Provided financial resources
Siavonga	• Provided financial resources • Through continuous meetings and collaborations • Workshop and family discussions
Sinazongwe	• Conducted small group discussions in schools and communities • Provided financial resources • Balance support on training male and female caregivers. Girl child support program and women livelihood support programs.
Zimba	Not stated

11. Key and Vulnerable Populations

Organizations were asked to complete a module indicating which key and vulnerable populations were targeted for HIV-prevention activities in the past 12 months. For each key population group, a matrix was provided on which the organization indicated which of the specified activities and services were performed or provided for the key/vulnerable population during the reference period. As Figure 15 indicates, the HIV-prevention-specific needs of young people aged 10-24 years, people living with HIV, and pregnant women, infants and young children were targeted by 87 percent, 71 percent and 62 percent of organizations surveyed in Southern Province. Roughly one in every five organizations surveyed targeted HIV-prevention interventions at migrants/mobile populations and female sex workers. Fewer than three organizations surveyed targeted people who inject drugs (PWID) and men who have sex with men (MSM) and transgender. It is to be noted that injecting drug use and same-sex relationships are not key drivers of HIV transmission in Zambia and are criminalized.

Figure 15 Percentage of organizations surveyed in Southern Province that targeted HIV-prevention activities at specific key populations in the past 12 months, Zambia 2013.

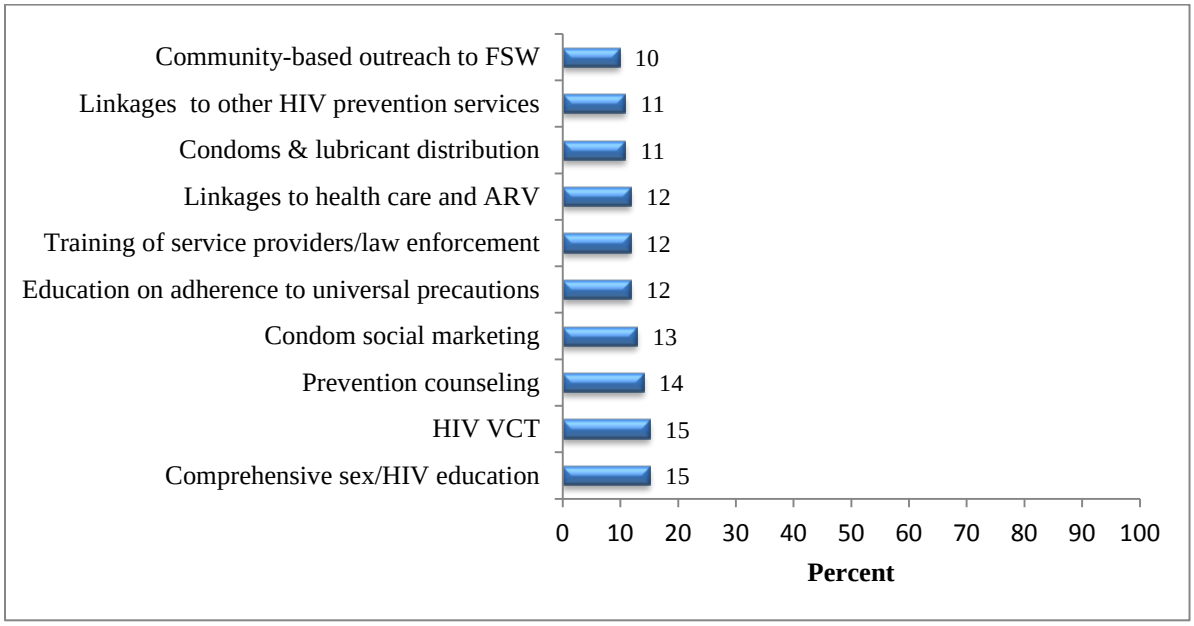


11.1 Female Sex Workers

Figure 16 shows the ten most common interventions targeted at female sex workers in the past 12 months by organizations surveyed. These interventions included comprehensive sex/HIV education; HIV voluntary counseling and testing; prevention counseling; condom social marketing; education on adherence to universal precautions; training of service providers and law enforcement; linkages to health care and antiretroviral drugs; distribution of condoms and condom-compatible lubricants; linkages to other HIV-prevention services; and community-based

outreach to female sex workers. A total of 35 possible interventions were included in the female sex worker module. As in previous tabulations, calculations are based on the total number of organizations surveyed in Southern Province (N=93).

Figure 16 Percentage of organizations surveyed in Southern Province that provided the ten most common interventions targeted at female sex workers in the past 12 months, Zambia 2013.



As Table 18 shows, no organization surveyed targeted HIV-prevention interventions at female sex workers in five out of twelve districts of Southern Province: Gwembe, Namwala, Pemba, Sinazongwe, and Zimba. The maximum number of interventions targeted at female sex workers by a single organization varied widely by district and ranged from 28 in Livingstone to 8 in Mazabuka. The data suggest that Choma and Livingstone were more likely than the other districts to have at least one organization in the non-government sector offering a comprehensive package of HIV-prevention services for female sex workers.

According to the World Health Organization, priority interventions for sex workers must include condom distribution (including condom-compatible lubricants); STI detection and management, information, education, and communication; and voluntary counseling and testing for HIV (WHO, 2010). Table 19 shows the availability of at least one organization implementing a given priority intervention in each district of Southern Province. The absence in five districts of any organizations targeting female sex workers with HIV-prevention interventions had been noted earlier. Only Choma and Livingstone districts can be described as having at least one implementing organization targeting female sex workers for each of the four recommended interventions. In the remaining districts (Kalomo, Mazabuka, Monze, and Siavonga), there is a lack of STI detection and management services targeted at female sex workers, a noticeable gap in the provision of priority HIV-prevention interventions for this key population group.

Table 18 **Maximum Number of HIV-prevention Intervention Targeted at a Given Key Population in Southern Province by a Single Program Implementing Organization in the Past 12 Months, by District and Key Population Group, Zambia 2013**

District (N=93)	Female Sex Workers	People Living with HIV	Young People Aged 10-24 years	Pregnant Women, Infants, and Young Children	Migrants/ Mobile Populations
Choma	21	34	27	25	18
Gwembe	0	0	22	1	0
Kalomo	17	26	22	21	20
Kazungula	7	3	0	3	0
Livingstone	28	43	37	38	26
Mazabuka	8	23	24	23	22
Monze	11	24	21	13	14
Namwala	0	26	23	20	23
Pemba	0	0	0	0	0
Siavonga	9	10	8	18	0
Sinazongwe	0	1	22	18	0
Zimba	0	25	22	18	19
Maximum number of interventions	35	43	39	39	36

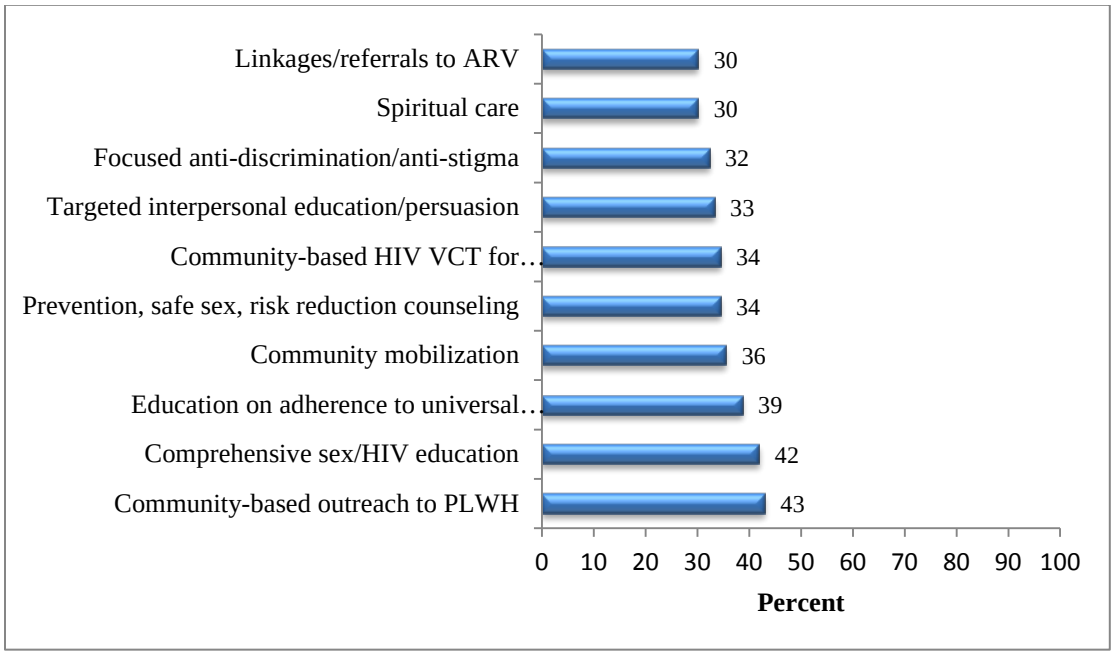
Table 19 Availability of at Least One Organization Providing WHO Priority HIV-prevention Interventions for Female Sex Workers in the Past 12 Months by District, Southern Province, Zambia 2013

District	Condom Distribution	STI Detection and Management	Information, Education, and Communication	Voluntary Counseling and Testing
Choma	Yes	Yes	Yes	Yes
Gwembe	No	No	No	No
Kalomo	Yes	No	Yes	Yes
Kazungula	Yes	No	Yes	Yes
Livingstone	Yes	Yes	Yes	Yes
Mazabuka	Yes	No	Yes	Yes
Monze	Yes	No	Yes	Yes
Namwala	No	No	No	No
Pemba	No	No	No	No
Siavonga	Yes	No	Yes	Yes
Sinazongwe	No	No	No	No
Zimba	No	No	No	No

11.2 People Living with HIV

Data from the PLWH module showed that the ten most common interventions for this group in the past 12 months included linkages and referrals to ARVs; spiritual care; focused anti-discrimination and anti-stigma activities; targeted interpersonal education/persuasion programs; community-based HIV/VCT for families and partners; prevention, safer sex, and risk reduction counseling; community mobilization; education on adherence to universal precautions; comprehensive sex/HIV education; and community-based outreach to PLWH (see Figure 17). Each of these interventions was offered by at least three in every ten organizations surveyed.

Figure 17 **Percentage of organizations surveyed in Southern Province that provided the ten most common interventions targeted at people living with HIV in the past 12 months, Zambia 2013.**



As Table 18 had shown, no organization surveyed targeted HIV-prevention interventions at people living with HIV in Gwembe and Pemba. The maximum number of interventions targeted at PLWH by a single organization varied widely by district and ranged from 43 in Livingstone (the maximum number of interventions included in the PLWH module) to 1 in Sinazongwe, making Livingstone more likely than the other districts of the Province to have at least one organization in the non-government sector offering a comprehensive package of HIV-prevention services for PLWH. Choma was second place, with the maximum number of interventions provided by a single organization surveyed being 34.

Table 20 examines geographic differentials in the availability of at least one organization surveyed in the NGO sector (among those surveyed) providing recommended treatment and care interventions for PLWH (ART, management of opportunistic infections and co-morbidities, palliative care, and TB prevention, diagnosis and treatment). The table also shows the availability of at least one organization in the NGO sector providing recommended interventions to prevent illness in PLWH (vaccinations, nutritional care and support, providing safe water, sanitation and hygiene, and preventing malaria) in each district. Other interventions shown that aim to prevent illness and infection in PLWH include education to promote adherence to universal precautions and STI diagnosis and treatment. No organization surveyed in Southern Province was working in the districts of Gwembe, Kazungula, Pemba and Sinazongwe to provide interventions to prevent illness and infection in PLWH. For each of the interventions shown, Livingstone had at least one organization providing the intervention, followed closely by Choma and Mazabuka, which lacked organizations providing palliative care in those districts among those surveyed. Monze and Kalomo districts had similar gaps in the NGO sector in interventions to prevent illness and infection in PLWH. Both districts lacked organizations

surveyed that provided ART; palliative care; prevention, diagnosis and treatment of viral hepatitis; malaria prevention and treatment; and STI prevention, diagnosis and treatment.

In addition, none of the organizations surveyed provided opportunistic infection prevention and treatment in Monze. In Zimba, only three of the recommended interventions were provided by NGOs surveyed: malaria prevention and treatment; STI prevention, diagnosis and treatment; and education to promote adherence to universal precautions. The interventions that were least likely to be provided by NGOs surveyed included palliative care (provided in only one district), antiretroviral therapy, provided in 3 districts) and prevention, diagnosis, and treatment of viral hepatitis (provided in three districts).

Table 21 presents interventions that address a second dimension of positive prevention – prevention of HIV transmission to other people. The interventions considered here are prevention counseling, partner/family HIV testing programs, family planning education and counseling, programs for the prevention of mother to child transmission, needle/syringe exchange programs, condom distribution, and mass media programs. The data suggest that there were fewer geographic disparities in the availability of interventions for preventing HIV transmission to others as compared to interventions aimed at illness prevention, treatment and care for people living with HIV. For each intervention shown in Table 21, five districts had at least one NGO providing the intervention: Choma, Livingstone, Mazabuka, Monze and Namwala. Pemba was the only district that had no NGO surveyed providing any of the interventions aimed at preventing HIV transmission to others. NGOs implementing PMTCT and mass media programs were absent in Gwembe (among program implementers interviewed). The intervention that was least likely to be offered (as measured by the number of districts in which the intervention was not implemented by organizations surveyed) was family planning and reproductive health care.

11.3 Young People Aged 10-24 Years

At least half of the organizations surveyed provided prevention counseling, comprehensive sex/HIV education and community-based outreach to young people in the past 12 months (see Figure 18). Between 30-40 percent of organizations surveyed provided VCT, training for service providers and law enforcement, and interventions to prevent and respond to sexual violence among youth. Advocacy interventions targeted at young people's needs were implemented by 45 percent of organizations surveyed and a slightly lower percentage assessed the risks, needs, and vulnerability of youth during the past 12 months. Of all the interventions listed on the Young People's Module, the least common were separate accommodation to protect at-risk youth (2%); hepatitis prevention, diagnosis and treatment (2%); drug treatment and drug substitution therapy (3%); and HPV vaccination (3%) (not shown).

Figure 18 **Percentage of organizations surveyed in Southern Province that provided the 15 most common interventions targeted at young people aged 10-24 years in the past 12 months, Zambia 2013.**

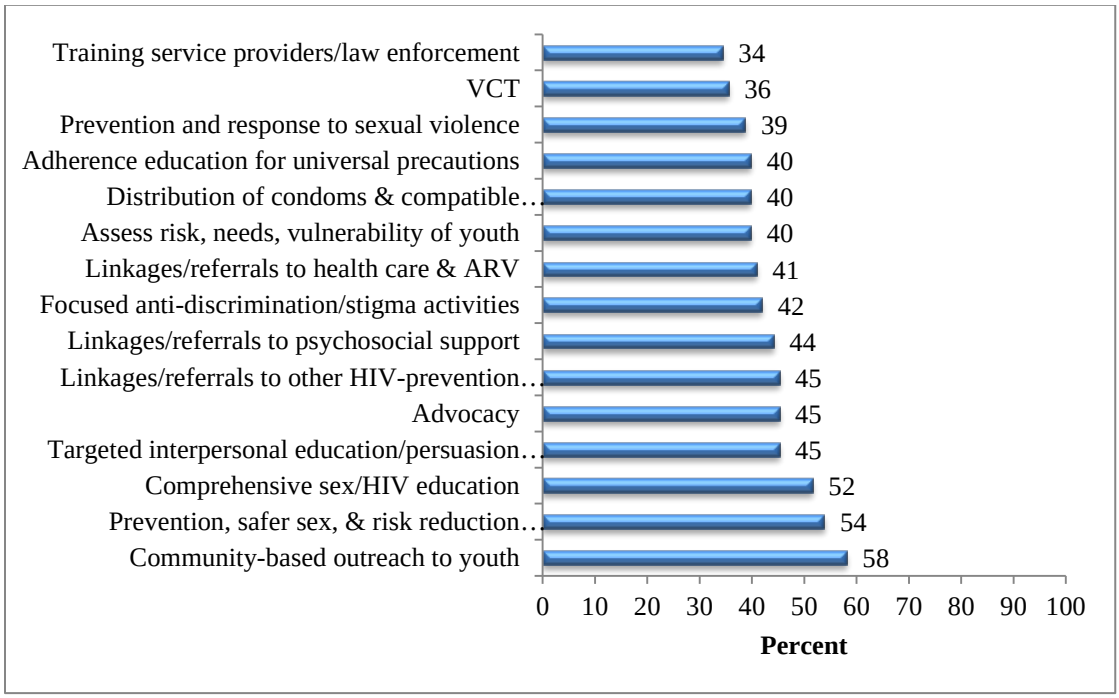


Table 20 Availability of at Least One Organization Surveyed in Southern Province that Provided WHO Priority Interventions for Illness Prevention, Treatment and Care in People Living with HIV, by District, Zambia 2013

District (N=93)	Antiretroviral Therapy	Opportun-istic Infection Prophylaxis and Treatment	Palliative Care	Tuberculosis Prevention, Diagnosis and Treatment	Prevention, Diagnosis, Treatment of Viral Hepatitis	Interventions to Improve Quality of Drinking Water and Hygienic Practices	Malaria Prevention and Treatment	Food Security of HIV-affected Households; Nutritional Care and Support	Prevention, Diagnosis and Treatment of SexuallyTrans mitted Infections	Education to Promote Adherence to Universal Precautions
Choma	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gwembe	No	No	No	No	No	No	No	No	No	No
Kalomo	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Kazungula	No	No	No	No	No	No	No	No	No	No
Livingstone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mazabuka	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Monze	No	No	No	Yes	No	Yes	No	Yes	No	Yes
Namwala	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes
Pemba	No	No	No	No	No	No	No	No	No	No
Siavonga	No	No	No	No	No	No	No	No	Yes	Yes
Sinazongwe	No	No	No	No	No	No	No	No	No	No
Zimba	No	No	No	No	No	No	Yes	No	Yes	Yes

Table 21 Availability of at Least One Organization Surveyed in Southern Province that Provided Positive Prevention Interventions to Prevent HIV Transmission to Other People, by Ddistrict, Zambia 2013

District (N=93)	Prevention, Safer Sex, Risk Reduction Counseling, and Sero-discordant Couple Counseling	Community-based HIV VCT for partners and families of PLWH	Provider-initiated Counseling and Testing for partners and families of PLWH	Family Planning and Reproductive HealthCare	Programs for Prevention of Mother-to-Child Transmission	Distribution of Condoms and Condom-Compatible Lubricants	Mass Media Programs
Choma	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gwembe	No	No	No	No	Yes	No	Yes
Kalomo	Yes	Yes	Yes	No	Yes	Yes	Yes
Kazungula	No	No	Yes	No	Yes	No	Yes
Livingstone	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mazabuka	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Monze	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Namwala	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pemba	No	No	No	No	No	No	No
Siavonga	No	Yes	No	No	Yes	No	No
Sinazongwe	No	Yes	No	No	Yes	No	Yes
Zimba	Yes	Yes	Yes	No	Yes	Yes	No

As Table 18 had shown, no organization surveyed was implementing HIV-prevention interventions targeted at young people aged 10-24 years in Kazungula and Pemba districts. The maximum number of interventions provided for young people by a single organization varied widely by district, from 37 in Livingstone to 8 in Siavonga. Key interventions for prevention in young people include HIV testing and counseling; youth friendly services, fostering parent and community support for youth-friendly services; information and counseling, condom distribution; harm reduction for people who inject drugs; STI diagnosis and treatment; male circumcision; access to HIV treatment and services; and HPV vaccination (see WHO, 2000 on priority interventions).

The availability of at least one organization implementing a given key intervention for HIV prevention in young people in the past 12 months is shown in Table 21 for each district. These data were derived from the Young People's Module. An organization was considered to provide information and counseling for young people if at least one of the following interventions was implemented: comprehensive sex/HIV education; targeted interpersonal education and persuasion programs, face-to-face interactive dialogue; and prevention, safer sex and risk reduction counseling. An organization was considered to provide harm reduction for young people who inject drugs if it reported in the young people's module that it provided needle and syringe exchange or drug treatment including drug substitution therapy. An organization was considered to provide access to HIV treatment and services if it implemented at least one of the following interventions for youth: provision of antiretroviral drugs, palliative care for HIV+ youth, linkages/referrals to psychosocial support services, linkages/referrals to health care and antiretroviral treatment, or linkages/referrals to other HIV-prevention services.

Mazabuka was the only district in which there was at least one implementing organization in the past 12 months for each of the key interventions for HIV prevention in young people aged 10-24 years (see Table 21). Choma and Livingstone lacked NGOs providing HPV vaccination and designing or establishing youth-friendly facilities and services, respectively, among those surveyed. In Kalomo and Monze, there was an absence of NGOs providing harm reduction for youth who inject drugs; prevention, diagnosis and treatment of STIs; and HPV vaccination. NGOs providing HPV vaccinations were absent in all but two districts. It is also observed that no organization surveyed was involved in designing/establishing youth-friendly facilities and services, or fostering parent and community support for youth-friendly services in Gwembe.

11.4 Pregnant Women, Infants and Young Children

WHO recommendations for a comprehensive approach to preventing HIV in infants and young children consist of four elements: (1) primary prevention of HIV transmission; (2) prevention of unintended pregnancies among women living with HIV; (3) prevention of HIV transmission from women living with HIV to their children; and (4) provision of treatment, care and support for women living with HIV, and their children and families. Each of these elements consists of a package of interventions, not all of which were included in the relevant module. Figure 19 shows the 15 most common interventions implemented by organizations surveyed in order to meet the HIV-prevention needs of pregnant women, infants, and children. The most common interventions were comprehensive sex/HIV education and community-based outreach. Of the 15

most common interventions, only one is recommended by WHO for treatment and prevention of HIV in pregnant women, infants and young children – family planning and reproductive health care – which was implemented in the past 12 months by one in every four organizations surveyed. Only one recommended intervention for primary prevention of HIV transmission was included among the 15 most common interventions implemented by organizations surveyed – safer sex and risk reduction counseling, which was implemented by 34 percent of the sample.

Figure 19 Percentage of organizations surveyed in Southern Province that implemented the 15 most common HIV-prevention interventions targeted at pregnant women, infants and young children in the past 12 months, Zambia 2013.

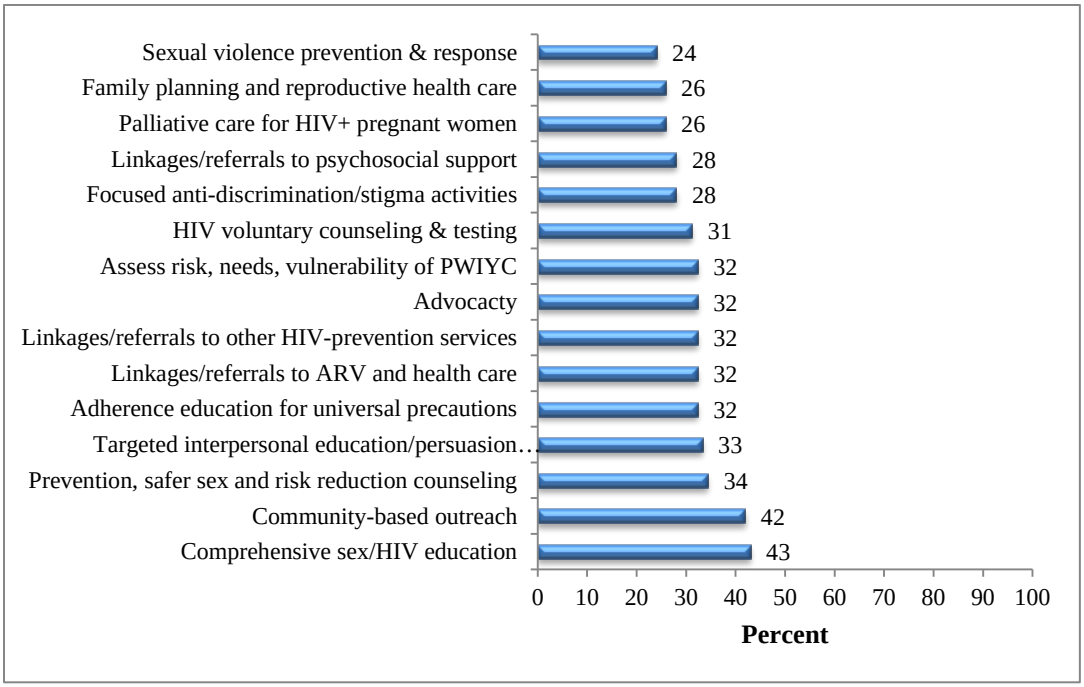


Table 23 examines geographic differentials in some of the WHO priority interventions for treatment and prevention of HIV in pregnant women, infants, and young children. Included in the table are some of the interventions for the prevention of sexual transmission of HIV, such as, promoting condom use, detecting and managing STIs, and safer sex/risk reduction counseling. Other interventions that fall in this category, such as prevention among people living with HIV and interventions targeting sex workers and young people, have been covered in previous sections. Data on provision of non-occupational post-exposure prophylaxis and provision of an essential package of services during child birth (including assistance of a skilled attendant at delivery) were not collected in the module for pregnant women, infants, and young children. Table 23 includes recommended interventions for the prevention of HIV transmission from women living with HIV to their children –family planning counseling and contraception, antiretroviral drugs (treatment for life and prophylaxis to reduce transmission), infant feeding counseling and support—and interventions aimed at treatment, care and support of pregnant women living with HIV and their families and children (tuberculosis screening and treatment, nutritional and psychosocial support, and virilogical tests for infants).

Table 22 Availability of at Least One Organization Surveyed in Southern Province that Provided Key Interventions for HIV Prevention in Young People Aged 10-24 Years, by District, Zambia 2013

District (N=93)	Design/Establishment of Youth-friendly Facilities and Services	Fostering Parent and Community Support for Youth-friendly services	Providing Information and Counseling	Distribution of Condoms and Condom-Compatible Lubricants	Harm Reduction for Injecting Drug Users	Prevention, Diagnosis and Treatment of Sexually Transmitted Infections	Medical Male Circumcision	HIV Voluntary Counseling and Testing	Access to HIV Treatment and Services	HPV Vaccination	Training for Service Providers/Law Enforcement
Choma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Gwembe	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Kalomo	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes
Kazungula	No	No	No	No	No	No	No	No	No	No	No
Livingstone	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mazabuka	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Monze	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes
Namwala	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Pemba	No	No	No	No	No	No	No	No	No	No	No
Siavonga	No	No	No	No	No	No	No	No	Yes	No	Yes
Sinazongwe	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
Zimba	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No

In four districts – Gwembe, Kazungula, Pemba, and Sinazongwe – none of the interventions shown for treatment and prevention of HIV in pregnant women, infants and young children were implemented by organizations surveyed. For each intervention shown, Livingstone was the only district with at least one organization providing the intervention in the past 12 months. Observed gaps in intervention coverage varied by district (see Table 23).

None of the NGOs surveyed in Southern Province provided ARV drugs in Mazabuka, whereas in Choma, none provided STI diagnosis and treatment services or virilogical/ serological tests for HIV-exposed infants. In Namwala, three of the interventions shown in Table 23 were not provided in the NGO sector by organizations surveyed: antiretroviral drugs, infant feeding counseling and support, and tuberculosis prevention, diagnosis, and treatment. Although Zimba had at least one implementing organization for two of the interventions shown, none were recommended for the prevention of HIV in infants and young children. The least common interventions provided by organizations surveyed in the NGO sector were STI diagnosis and treatment, antiretroviral drugs, virilogical/serological tests for HIV-exposed infants, and tuberculosis prevention, diagnosis and treatment.

11.5 Migrant and Mobile Populations

The study's definition of migrants and mobile populations was restricted to non-refugee/non-emergency mobile populations and included truckers, migrants, seasonal workers, and street youth. Although sex workers are also mobile populations, they were covered in a separate module, the results of which were presented in section 11.1 of this report. It is difficult to define a comprehensive HIV-prevention package for migrant and mobile populations that differs from the prevention package for the general population since migrant and mobile populations should have access to services and levels of care equivalent to those provided to surrounding populations. In highlighting priority interventions for migrants and mobile populations, this section focuses on interventions to provide information and education about prevention of HIV and other sexually transmitted infections (STIs); HIV VCT; condoms and condom-compatible lubricants; focused anti-discrimination and anti-stigma activities; STI diagnosis and treatment; and community-based outreach to mobile and migrant populations; and on interventions to prevent and respond to sexual violence.

Figure 20 suggests that behavior change communication programs were the most prevalent interventions and were implemented by 15-18 percent of organizations for migrant and mobile populations. Roughly one in every ten organizations surveyed worked on increasing this key population's access HIV-prevention and treatment services through linkages and referrals. A similar proportion of organizations surveyed implemented advocacy activities and focus anti-discrimination and anti-stigma activities for migrant and mobile populations, in accordance with the principle that access to health services should be based on the principles of equitable and equal access, without discrimination that could lead to the exclusion of vulnerable populations.

Table 23 Availability of at Least One Organization Surveyed in Southern Province that Provided Key Interventions for HIV Prevention in Pregnant Women, Infants and Young Children, by District, Zambia 2013

District (N=93)	HIV Voluntary Counseling and Testing	STI Diagnosis and Treatment	Family Planning and Reproductive Health Care	Anti-retroviral Drugs	Infant Feeding Counseling and Support	Survival Interventions for HIV-Exposed/ Infected Infants	Virilogical/ Serological Tests for HIV-exposed Infants	Financial/In-kind Sustenance Support/Social Welfare	Linkages/ Referrals to Psychosocial Support Services	Tuberculosis Prevention, Diagnosis, and Treatment
Choma	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Gwembe	No	No	No	No	No	No	No	No	No	No
Kalomo	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No
Kazungula	No	No	No	No	No	No	No	No	No	No
Livingstone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mazabuka	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Monze	Yes	No	Yes	No	No	No	No	No	Yes	No
Namwala	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No
Pemba	No	No	No	No	No	No	No	No	No	No
Siavonga	Yes	No	Yes	No	Yes	No	No	No	Yes	No
Sinazongwe	No	No	No	No	No	No	No	No	No	No
Zimba	Yes	No	No	No	No	No	No	No	Yes	No

Figure 20 **Percentage of organizations surveyed in Southern Province that implemented the 10 most common HIV-prevention interventions targeted at migrants and mobile populations in the past 12 months, Zambia 2013.**

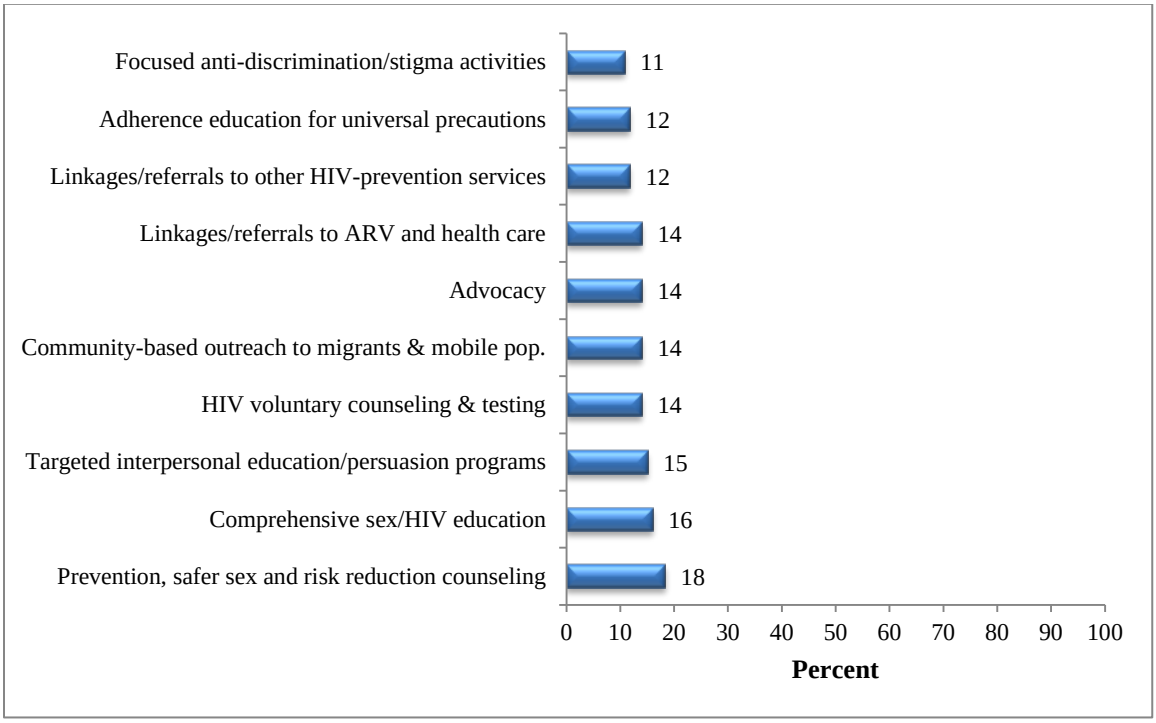


Table 24 presents geographic differentials in the availability of some of the components of a comprehensive package of HIV-prevention services for the prevention of HIV in migrant and mobile populations in the past 12 months. As was shown previously (in Table 18), no organization in the sample provided HIV-prevention interventions for migrant and mobile populations in the districts of Gwembe, Kazungula, Pemba, Siavonga, and Sinazongwe. Of the remaining districts, only Choma and Namwala provided each intervention for migrant and mobile populations through at least one NGO surveyed in Southern Province. Each of the interventions shown was provided for migrants and mobile populations in Livingstone by at least one NGO surveyed, with the exception of medical male circumcision, which together with sexual violence prevention and response, was also not provided in Kalomo and Mazabuka.

Table 24 Availability of at Least One Organization Surveyed in Southern Province that Provided Selected Interventions for HIV Prevention in Migrant and Mobile Populations, by District, Zambia 2013

District (N=93)	HIV Voluntary Counseling and Testing	Compre-hensive Sex/HIV Education	Distribution of Condoms and Condom-Compatible Lubricants	Harm Reduction for People Who Inject Drugs	Prevention, Diagnosis and Treatment of Sexually Transmitted Infections	Focused Anti-Discrimin-ation and Anti-Stigma Activities	Medical Male Circum-cision	Prevention and Response to Sexual Violence	Community-based Outreach to Migrants and Mobile Populations
Choma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gwembe	No	No	No	No	No	No	No	No	No
Kalomo	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Kazungula	No	No	No	No	No	No	No	No	No
Livingstone	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Mazabuka	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Monze	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
Namwala	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pemba	No	No	No	No	No	No	No	No	No
Siavonga	No	No	No	No	No	No	No	No	No
Sinazongwe	No	No	No	No	No	No	No	No	No
Zimba	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes

12. Implementation Challenges

In the Program Implementer Core Questionnaire, organizations were asked to describe how social, political and economic factors, at either the local or national level, facilitated the organization or respondent's ability to implement HIV-prevention interventions in Southern Province. Social factors considered included religious practices or beliefs, gender norms, cultural practices, ethnic affiliations, or social status. Among social factors, gender norms, cultural practices, and social status were reported by three in every ten organizations as hindering organizations' ability to implement HIV-prevention activities (see Table 25). In discussing how gender norms facilitated HIV transmission in Southern Province, respondents made numerous references to women's lack of power and control over decisions about sexual activity, condom use, and utilization of HIV-testing and ART services. For example: "*In our society, the role of women is to be submissive and provide sex to a man. Women have no say in the use of condoms. This puts women at a great risk of contracting HIV and makes our prevention measures difficult.*" References were also made to the lower involvement of men in all HIV-prevention activities, including HIV testing and the utilization of ART services, and the difficulty of mobilizing groups of the opposite sex around HIV prevention.

Changes in leadership and the policy environment were considered the most constraining political factors with regard to HIV-prevention and were reported by approximately 20 percent of organizations surveyed. International agreements and political orientation were considered as the least constraining factors and were mentioned by only 7 percent of organizations surveyed.

Insights into how the policy environment constrained HIV-prevention activities were obtained from the open-ended responses to the question asking respondents to describe the effect of a particular factor. One respondent stated that there was clear guidance from the NAC about how to go about HIV prevention, which led to the harmonization of program implementation approaches. However, another mentioned that "*separation of health into Ministry of Health and Ministry of Community development is making our job difficult because of bureaucracies and dealing with two ministries*." One respondent stated that organizations do not receive copies of relevant policies, which hindered policy application to HIV-prevention work, while many others pointed to the lack of implementation of existing policies: for example, "*On paper, the disabled are covered but at the implementation level, the policy is dormant.*" The NGO act and decentralization policies were perceived by some program implementers to cause delays in program implementation but the processes/components that led to implementation delays were not specified, although it was mentioned that not all organizations may meet the requirements to "operate". Policies against condom distribution in schools and prisons were also considered by some organizations to hinder HIV-prevention activities.

Of all factors considered, unemployment, migration and poverty were considered to be the most important constraints to the implementation of HIV-prevention activities in Southern Province and were reported by 48 percent, 42 percent, and 42 percent of

organizations surveyed, respectively. Migration was considered a key driver of the HIV epidemic by many of the organizations surveyed which pointed to the multiple sexual partnerships, unprotected sex, and transactional sex in areas affected by in-migration: for example, "*Migration hinders in the sense that these migrants are either in transit or will stay in an areas for a short period. They are coming from places where they have spouses and will try to have a short-term relationship.*" Many respondents described the difficulty of following-up clients who may "leave without transfer letters"; the loss of human resources, which made it difficult to achieve HIV-prevention goals; the loss of trained caregivers for PLWH; and challenges with social mobilization and sensitization activities due to high turnover in the target population: for example, "*A lot of people who come to Namwala to do business do not stay long. So whenever you do the sensitization, you meet different people.*" One respondent also felt that the influx of migrants from rural to urban areas has contributed to the neglect of rural areas in the implementation of HIV-prevention programs while another felt that migrants impinged on the meagre resources available in a given locality for HIV-prevention.

Table 25 Percentage of Organizations Surveyed in Southern Province that Considered the Social, Political and Economic Context to Hinder Their Ability to Implement HIV-prevention Activities, Zambia 2013

Type of Factor	Percent
Social	
Religious practices or beliefs	15.4
Gender norms	30.8
Cultural practices	37.4
Ethnic affiliations	18.7
Social status	31.9
Other	0.0
Political	
Changes in political leadership	20.9
Decentralization	13.2
Policy environment	20.0
International agreements, programs, priorities	6.7
Prioritization of poverty alleviation on policy agenda	8.9
Political orientation	6.6
Other	1.1
Economic	
Unemployment	48.4
Migration	41.8
Poverty	41.8
Global assistance mechanisms, donor priorities	18.7
Currency exchange rates	24.4
Other	0.0
N	93

13. Study Limitations

The Program Implementer Core Questionnaire and Modules permitted the identification of gaps in the availability of HIV-prevention activities. However, they had a number of limitations. The questionnaires were quite lengthy and could not be easily self-administered or interviewer-administered in paper format. The questionnaires simply asked implementers whether or not a specific service for a specific target population was in place and no quantifiable data were available about the quality of HIV-prevention services or the intensity with which interventions were being delivered by the NGO sector and over which periods of time. The reference period used was 12 months. The data also do not permit the assessment of the allocative efficiency of HIV-prevention programs. In spite of these limitations, the study permitted us to know which interventions were being implemented by the NGO sector and for which key and vulnerable populations, contributing to new knowledge in Zambia about geographic gaps in the availability of HIV-prevention interventions in the NGO sector.

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