A Participatory Evaluation Of VCT Activities of the Zambia VCT Partnership in Chipata, Kabwe, Livingstone, and Lusaka Districts

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Contents

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Acronyms and Abbreviations

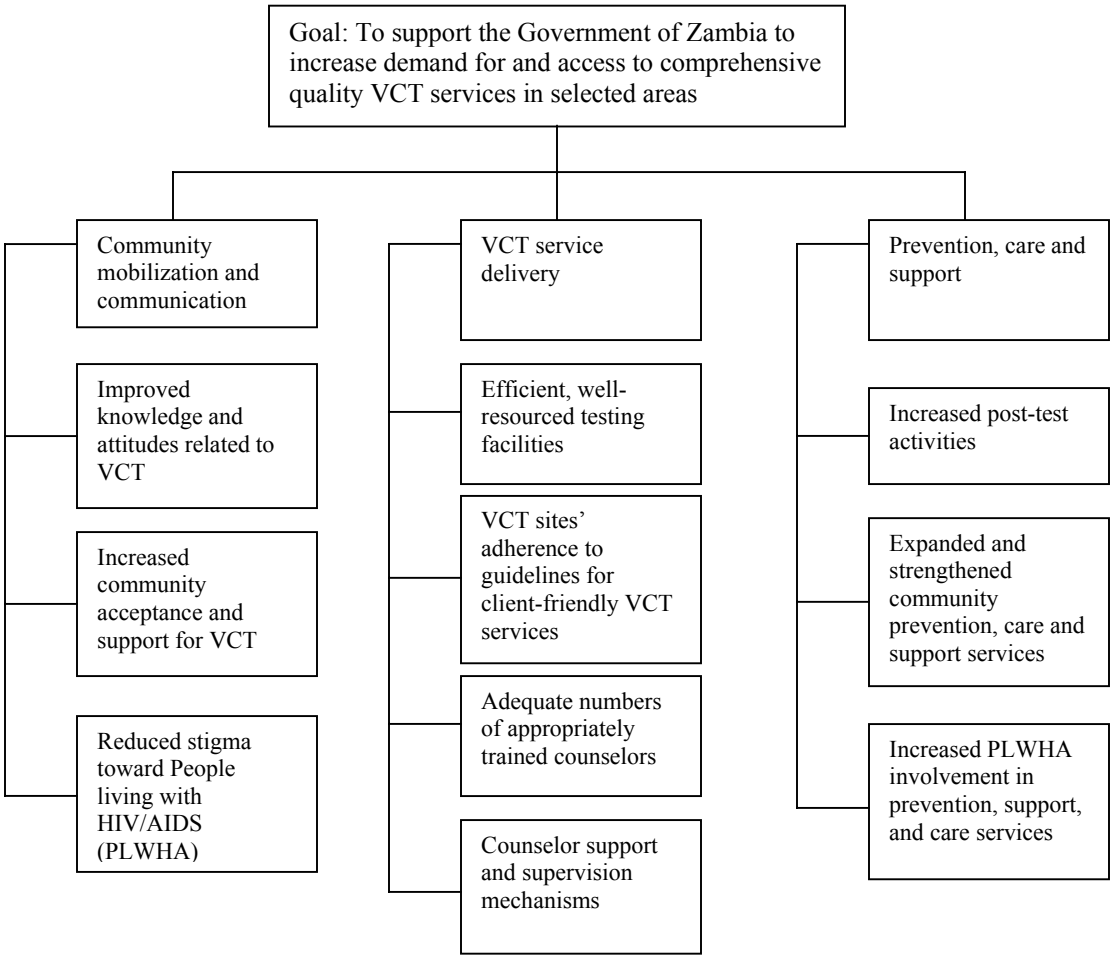
AA	International AIDS Alliance (also referred to as Alliance)
AIDS	Acquired immunodeficiency syndrome
ARVS	Antiretroviral
CBO	Community-based organization
CBOH	Central Board of Health
CTWG	CRIS Technical Working Group
CRIS	Country Response Information System (UNAIDS)
DAPP	Development Aid from People to People
DATF	District AIDS Task Force
DDH	District Director of Health
DHMT	District Health Management Team
FBO	Faith-based organization
HIV	Human immunodeficiency virus
ICRW	International Council for Research on Women
IEC	Information, education, and communication
IGA	Income-generating activity
JICA	Japan International Cooperation Agency
KAFHI	Kabwe Adventist Family Health Institute
KCTT	Kara Counselling and Training Trust
LWF	Lutheran World Federation
MSL	Medical Stores Limited
NAC	National AIDS Council
NGO	Non-governmental organization
NZP+	Network of Zambian People Living with AIDS
PLA	Positive-living advocate
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RPM+	Rational Pharmaceutical Management Plus
SFH	Society for Family Health
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary counseling and testing
ZCC	Zambia Counseling Council
ZIHP	Zambia Integrated Health Program
ZINGO	Zambia Interfaith Non-Governmental Organization
ZVCTS	Zambia Voluntary Counseling and Testing Services

I. Introduction

The Zambia Voluntary Counseling and Testing (VCT) Partnership is an HIV/AIDS program initiative for collaboration between the Government of Zambia, non-governmental organizations (NGOs), District Health Management Teams (DHMT), and three donor partners. The primary objective of the partnership is **to expand access to high-quality voluntary counseling and testing services in the country and to promote the health and social benefits of knowing one's HIV status.** The goals of the partnership are:

- Mobilization of communities for expanded HIV/AIDS work
- VCT promotion through information, education, and communication (IEC)
- High-quality VCT service delivery
- Care and support for people who participate in testing

Figure 1: Zambia VCT Partnership Results Framework



There are currently 54 VCT sites throughout Zambia, most located in government hospitals. The Zambia VCT Partnership members work closely with the National VCT and Care Technical Working Group to ensure confidential, high-quality testing and community mobilization for VCT as a preventive health

service. The National VCT and Care Technical Working Group has the formal mandate to establish guidelines and policies on VCT counseling, VCT service delivery, training, quality assurance, and improved access to HIV/AIDS services and care. The group's goal is to fully support the National HIV/AIDS Strategic Framework and the National HIV/AIDS Secretariat and Council.

Table 1: Core Zambia VCT Partnership Members and Program Focus

Member	Program Focus
Zambia VCT Services	Training, laboratory support, and supervision; reporting and test kits
Society for Family Health (SFH)	VCT promotion and district coordination
Development Aid from People to People	Care and support; social support for counselors
Central Board of Health (CBOH)/ Ministry of Health	Counselor strengthening, service delivery, and confidentiality issues
International AIDS Alliance	Community mobilization
Zambia Counseling Council	National-level professional guidance for counselors; counseling standards; Council Inventory (in 12 districts), and training of counselors
Kara Counselling and Training Trust	Counselor training and supervision of counselors
Chainama College of Health Sciences	Training of counselors
Zambia Integrated Health Program	Health-worker sensitization and service strengthening
North American Aerospace Defense Command (NORAD)	Support to Zambia VCT Services, counselor training, monitoring, and evaluation
Japan International Cooperation Agency (JICA)	Laboratory technical support, test kits, and quality assurance
USAID	Technical and financial support for VCT promotion and community mobilization
District Health Management Teams	Coordination and quality of service delivery
U.S. Department of Defense, U.S. Embassy	Clinic renovations
UNAIDS	Technical support and links to collaborating partners

The Zambia VCT Partnership fully supports the National HIV/AIDS Strategic Framework and the National HIV/AIDS Secretariat and Council. The Zambia VCT Partnership implements its work in several phases. Phase 1 covered the period January 2000 to December 2002. During this phase, activities were carried out in four districts: Lusaka, Livingstone, Kabwe and Chipata. Each member organization in the partnership offer wide range of comprehensive VCT services. Each of the partners also play specific role in the partnership.

This report presents findings on a literature review of VCT in Zambia, and a participatory evaluation of VCT activities supported by the Zambia VCT Partnership in the Phase 1 Districts of Chipata, Livingstone, Kabwe, and Lusaka districts. The evaluation was funded by the United States Agency for International Development (USAID) in Zambia, through the Synergy Project. The objectives of the participatory evaluation were to:

- Evaluate district perspectives on Partnership activities in the Phase 1 Districts
- Analyze information about VCT uptake, VCT service provision, and linkages between VCT and other HIV prevention and care services based on data from the VCT Partnership and other sources
- Review and revise Partnership goals, objectives, strategies, activities, and indicators
- Agree on clarification of roles and responsibilities of current partners and potential inclusion of new partners

The results and lessons learned are used by the Zambia VCT Partnership to improve operations in the delivery of good quality VCT services in selected districts in Zambia, and to develop strategies and VCT activities within the result framework.

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- review and revise Zambia VCT Partnership goals, objectives, strategies, activities, and indicators; and
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The results and lessons learned are used by the Zambia VCT Partnership (the Partnership) to improve operations in the delivery of quality VCT services in selected districts in Zambia, and to develop strategies and VCT activities within the results framework.

II. Methodology

A participatory evaluation methodology was applied. Participatory evaluation is a process of self-assessment, collective knowledge production, and cooperative action in which the stakeholders in a development intervention participate substantively in the identification of the evaluation issues; the design of the evaluation; the collection and analysis of the data; and the action taken as a result of the evaluation findings. This helps build capacity among stakeholders to reflect, analyze, and take action that can lead to the identification of lessons learned, thus resulting in corrective action or improvements in project outcomes. The focus on lessons learned is an essential dimension of participatory evaluations. The process helps to guide projects into the future by giving stakeholders the tools with which to take corrective action.

The first stage in the process was identification of the issues for which the Partnership wanted data collected. With technical support from The Synergy Project, administered by TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc., the Zambia VCT Partnership members identified seven areas of interest for which data were collected through structured interviews with stakeholders in the Phase 1 Districts of Chipata, Kabwe, Livingstone, and Lusaka. These areas were:

- District stakeholders' perceptions of the Partnership
- VCT uptake and utilization
- Referral system
- Support system and its use
- Post-test services
- VCT-site assessment and availability
- Use of IEC

The second step included data collection through face-to-face interviews with VCT focal-point persons on the DHMT, counselors at VCT sites, laboratory technicians in the health facilities, and representatives of focal-point NGOs. Interviews were conducted using a structured questionnaire in the Chipata, Kabwe, Livingstone, and Lusaka Districts October 5–25, 2002.

The third step in this participatory process was a three-day retreat October 29–November 1, 2002, involving core members of the Zambia VCT Partnership. Following their preliminary analysis of the data, these core Partnership members reviewed and discussed the key findings of the interviews; reviewed Partnership achievements; and developed recommendations for future Partnership activities. Representatives of five core partners and one donor agency were in attendance: International HIV/AIDS Alliance; Society for Family Health (SFH); Development Aid from People to People (DAPP); Zambia Voluntary Counseling and Testing Services (ZVCTS); Zambia Counseling Council (ZCC); and USAID/Zambia. The Partnership members identified and deliberated on a number of internal and external issues affecting the Partnership's work; they then made recommendations aimed at strengthening the Partnership's capacity concerning each of the issues identified. Several recommendations were also made on activities in which partners might engage together in the next year to further contribute to the goal of the Partnership.

In addition to the primary data collection using a participatory process, a literature review of HIV/AIDS and VCT in Zambia was conducted. The review provided evidence on VCT knowledge and access in Zambia to inform the Partnership in planned discussions of strategies and approaches to VCT activities.

III. HIV/AIDS and Voluntary Counseling and Testing in Zambia: A Review of the Literature

This brief review of literature on HIV/AIDS and VCT in Zambia is intended to provide insights to the Zambia VCT Partnership for reviewing its strategies and the first phase of activities from January 2000 to December 2002, and to inform the planning of activities for the next phase. Therefore, the literature is reviewed in the context of the Zambia VCT Partnership, highlighting key points with implications for the VCT activities and strategy of the Partnership. The review focused on the following areas:

- an overview of HIV/AIDS in Zambia
- knowledge, attitudes, and beliefs about VCT in Zambia
- different models of VCT
- VCT utilization in Zambia

A. Overview of HIV/AIDS in Zambia

Orobaton et al. (2001) described HIV/AIDS in Zambia as "an embodiment of dynamic complexity"; and therefore recommended responses, which "share properties similar to that of systems thinking" (Senge, 1994) in order to have "best prospects for producing tangible and long lasting results". It is these tangible and long lasting results that have motivated the Zambia VCT Partnership and continue to guide their actions and the principles they represent.

Since it was first diagnosed in Zambia in 1984, HIV/AIDS has become an enormous health, social, security, and economic problem in the country. With a population of 10.3 million, an estimated 20 percent of adults aged between 15 and 49 years are infected with HIV, with about one million (including children below 15 years) already in the AIDS stage. Between 1984 and 1999, cumulative AIDS death is estimated to be 650,000 persons; with a population of about 520,000 orphans left behind. Projections from the Central Board of Health/Ministry of Health (1999) indicate that if HIV prevalence continues to gradually drop, the number of those with HIV infection in the population (including children) will be about 1,260,000. According to the Ministry of Finance and Planning Analysis:

> *Although the epidemic is showing signs of stabilization in the urban areas, the rates continue to rise in some rural areas. Currently about 20 percent of the adult population aged 15 to 49 are living with HIV…. It is estimated that about $200 per AIDS patient per day is needed for hospitalization. This is against the current per capita expenditure on health by the government of approximately $3 per year. …There are, however, some hopeful indications. The prevalence of HIV positive tests in 15–19 year-old youths has dropped over most of the country between 1994 and 1998"* (Ministry of Finance and National Planning, 2002, p.109).

The Central Board of Health/Ministry of Health provides area- and sector-specific social and economic impacts of HIV/AIDS in Zambia. The apparent symbiotic relationship between HIV/AIDS and poverty can be clearly identified from this brief account. Among the negative economic impacts on the economy identified by the report were reduced quality of education, an overburdened health sector, a diminishing labor force, and low agricultural productivity. A serious health impact of HIV/AIDS with which the nation is already grappling is the increase in tuberculosis (TB) cases resulting from weakened immunity of HIV/AIDS-infected individuals. The current average rate of TB infection is more than 500 per 100,000 population. During the period 1964 to 1984, before the advent of HIV/AIDS, the average rate of

TB infection remained stable at about 100 per 100,000 population. The report further asserts that women and children are among the most vulnerable groups because of their biological and cultural pre-disposure and dependency. HIV/AIDS has also placed child survival under serious threat. For example, mortality of children under 5 years of age has increased from 1 per 1,000 in 1984, to 26 per 1,000 in 1999 (Central Board of Health/Ministry of Health, 1999: 32-51).

B. HIV/AIDS Prevalence in Zambia

HIV-infection rates and prevalence are influenced by a combination of social, economic, cultural, and demographic factors. As indicated, the Central Board of Health/Ministry of Health (1999 a) estimates the average national HIV-prevalence rate among the adult population between 15 and 49 years of age at 19.7 percent.

Prevalence is highest in the urban areas where, in some locations such as Lusaka and Ndola, prevalence has been between 27 percent and 30 percent. The four provinces with the highest prevalence rates are Lusaka, Luangwa, Kitwe, and Ndola. With the exception of Luangwa, these districts are predominantly urban. Rural populations have an average prevalence of 13.5 percent; but ranges from as low as 4 percent to highs of more than 20 percent. In urban areas, prevalence ranged between 27 and 28 percent (Central Board of Health/Ministry of Health, 1999b).

Table 2: Four Districts with the Highest HIV Prevalence Rates

DISTRICT (Province)	AVERAGE PREVALENCE RATE (Percent)
Lusaka (Lusaka)	29.5
Luangwa (Lusaka)	28.7
Kitwe (Copperbelt)	28.7
Ndola (Copperbelt)	28.4

(Ministry of Finance and National Planning, 2002)

The preliminary report of the Zambia Demographic and Health Survey (ZDHS) 2001-2002 indicates that among adults aged 15–49 years, the national HIV-prevalence average rate is 15.6 percent (Central Statistics Office/Ministry of Health, 2002). Further, the report indicates a considerably lower HIV-prevalence rate in all provinces, compared to rates reported by the Central Statistics Office/Ministry of Health, (1999b) and shown in Table 3.

Nonetheless, the general trend and prevalence pattern remain the same as for that depicted in the CBOH/MOH (1999b) report, i.e., urban areas have higher prevalence rates than do rural areas. Average HIV-prevalence rates for urban and rural areas are 23.1 percent and 10.8 percent, respectively. Copperbelt, Lusaka, and Southern provinces have HIV-prevalence rates above national average, while the other six provinces' rates are below the national average. These rates compare favorably with the figures from the previous three-year period of 27 percent and 13.6 percent for urban and rural areas, respectively. Also encouraging is the remarkable reduction in the prevalence rates for the age group 15–24 years. The vulnerable situation of women regarding HIV infection still persists, however: Average prevalence for women is 17.8 percent, compared to 12.9 percent for men.

The HIV/AIDS-prevalence rate remains high in Zambia, and is also among the highest in the region and the world. This may be the case for some time to come if HIV/AIDS programs and solutions do not

adequately address socioeconomic factors that contribute to the gravity of the epidemic in Zambia. According to the available literature these factors include:

- Low use of condoms
- Low levels of sexual abstinence
- Prevalence of multiple sexual relationships
- Sexually transmitted diseases
- Gender perceptions; and the low status of women, which inhibits the exercise of their rights to refuse unsafe sex and to make safe and appropriate reproductive choices
- Poverty; poor overall health of the population; and poor availability of and access to appropriate health and social services
- Urbanization
- Mobility (e.g., cases of migrant workers, uniformed personnel, refugees, cross-border traders, truckers)
- Socio-cultural beliefs and traditional practices (e.g., dry sex, sexual initiations, sexual cleansing, and spouse inheritance)
- Early sexual debut and a high level of sexual activity of the population
- High and increasing rates of mother-to-child- transmission
- Prison confinement
- Stigma, silence, and discrimination
  (Ndubani, 2001a; 2001b; 2001c; 2001d; Society for Family Health, 2002; CSO/MOH, 2000; Family Health International, 2000a; 2000b)

Table 3: HIV Prevalence among Adults aged 15–49 by Background Characteristics

Background Characteristics	WOMEN Percent HIV+	WOMEN Number Tested	MEN Percent HIV+	MEN Number Tested	TOTAL Percent HIV+	TOTAL Number Tested
Age						
15–19	6.6	498	1.9	366	4.6	864
20–24	16.3	443	4.4	309	11.4	752
25–29	25.1	363	15.0	318	20.4	681
30–34	29.4	274	20.5	260	25.1	534
35–39	22.6	210	22.4	227	22.5	437
40–44	17.3	154	20.5	153	18.9	307
45–49	13.6	131	20.2	101	16.5	232
Residence						
Urban	26.3	808	19.2	676	23.1	1,484
Rural	12.4	1,265	8.9	1,058	10.8	2,323
Province						
Central	16.8	171	13.4	135	15.3	306
Copperbelt	22.1	423	17.3	352	19.9	775
Eastern	16.1	252	11.0	219	13.7	471
Luapula	13.3	167	8.6	133	11.2	299
Lusaka	25.0	296	18.7	263	22.0	559
Northern	10.0	283	6.2	234	8.3	517
Northwestern	8.8	92	9.5	75	9.2	166
Southern	20.2	220	14.6	188	17.6	408
Western	16.9	169	8.3	136	13.1	306
TOTAL	17.8	2,073	12.9	1,734	15.6	3,807

(Zambia Demographic and Health Survey 2001-02, Central Statistics Office/Ministry of Health, 2002)

C. Knowledge, Attitudes, and Beliefs about VCT in Zambia

A broad range of available documentation and literature exists on knowledge, awareness, beliefs, perceptions, and attitudes regarding VCT in Zambia. The following documents were reviewed and the key points summarized in this section:

- *Zambia Sexual Behavior Survey 2000* (Central Statistics Office/Ministry of Health, 2000)
- *SFH Formative Qualitative Research for Voluntary Counseling and Testing (VCT) Communication in Zambia* (Society for Family Health, 2002)
- *International AIDS Alliance) 2001 Qualitative and Quantitative Baseline Surveys for Chipata, Kabwe, Livingstone and Lusaka* (Ndubani, 2001a; 2001b; 2001c; 2001d)
- *SFH Multiround Survey of Youth, Round I 2002* (Society for Family Health, 2002)
- *AIDS Alliance – The Involvement of People Living with HIV/AIDS (PLWHA) in the Delivery of Community-Based Prevention, Care and Support Services in Zambia* (International HIV/AIDS Alliance, 2002)
- ZVCTS reports (ZVCTS, 2001; 2002)

In general, awareness of HIV/AIDS is high in Zambia. It is estimated that more than 80 percent of the population has heard about HIV/AIDS; knows that AIDS is fatal and cannot be cured; and that it can be

transmitted from mother to child (Central Statistics Office/Ministry of Health, 1996). Knowledge and awareness about VCT, however, is still low (Ndubani, 2001). Rural populations are least likely to be aware of VCT, based on the inadequacy or absence of VCT services and/or VCT-related IEC.

Knowledge and awareness of VCT primarily refer to the ability to know one's sero-status, and to locations where VCT services are offered. Awareness is limited to a few well-known sites or service providers (Society for Family Health, 2002; Ndubani, 2001a). Awareness and knowledge of VCT, what it offers apart from sero status, and updated knowledge about new VCT sites are still limited.

Awareness of how to access VCT and who is eligible to access VCT is also still inadequate. The literature indicates that some survey respondents believed that VCT could only be accessed on doctors' or health providers' instructions. Almost all the reviewed literature indicates that respondents generally think that only the sick should get VCT. Although men are more likely to use VCT services, the literature suggests that men think that VCT is for people who are promiscuous.

Misconceptions regarding VCT persist, and they influence individuals' attitudes toward VCT. Almost all the literature indicates that the most frequent reasons for seeking VCT are concerns related to chronic or recurrent illness; and past risky sexual behavior on the part of the individual or one's present or past sexual partners. Other motives include the need to allay fears and suspicion of being HIV positive; intentions to have a child or marry; to go for further studies and planning one's life.

Nearly all the examined literature acknowledged a fear of HIV. Since no cure exists for HIV, being HIV positive is perceived as a death sentence, thus creating tension, stress, fear, and helplessness. For this reason, many individuals do not want to access VCT because they do not want to know their sero status.

Stigmatization of and discrimination against people living with HIV/AIDS (PLWHA) have a negative effect on VCT uptake. Ndubani (2001d) and International HIV/AIDS Alliance (2002) cite examples of even VCT service providers who unintentionally (perhaps unknowingly) behave and act in a discriminatory and stigmatizing manner toward those who test HIV-positive.

Survey findings have established that many individuals would have preferred counseling by peers. Connected to this is the expressed wish of community members and PLWHAs to be involved in local VCT activities. They wish to have opportunities to select or recommend persons from their communities to be trained as counselors and provide VCT services.

D. Models of VCT

There is no universal model for delivering VCT services. In Zambia, one or several models may be needed to address specific needs of a particular community, including the demographic and socioeconomic factors of the community. Factors influencing the type of model used include HIV sero-prevalence; stage of the epidemic; societal attitudes; and acceptance and support for PLWHAs. Others include existing resources for VCT; political and community commitment to VCT; and available financing for VCT.

In Zambia, the literature indicates that several models of VCT are applied throughout the country by different health agencies. The following VCT models in Zambia were identified in the literature: social marketing of VCT; private-sector VCT; VCT for special groups; home testing; VCT integrated into health care services; free-standing VCT services; and function-specific VCT services. All of these different models have advantages and disadvantages in terms uptake and coverage.

Comprehensive, consolidated, and categorized national data on VCT acceptors for the 88 centers in Zambia are not available. At the time of this review, the Zambia VCT Services (ZVCTS), working with the national VCT and Care Working Group, is receiving technical assistance from the USAID-supported Rational Pharmaceutical Management Plus (RPM+) to design and establish a national VCT data and information system.

In addition to the reported national statistics, data from ZVCTS, and several VCT providers were examined to establish a picture of VCT uptake in Zambia. In 1998, the estimated proportion of the Zambia adult population that had been tested for HIV was between 12 and 15 percent. The number of those who had been tested and knew their results, however, was much smaller – about 6.6 per cent of the adult population (Central Board of Health/Ministry of Health, 1999b).

Many efforts are underway in Zambia to significantly increase uptake of VCT among the adult population. For example, between March 1999, and December 2001, the ZVCTS-supported centers in the country attended to 185,892 individuals as VCT clients, of whom 166,170 had taken the HIV test.

To further improve the VCT environment, the Zambia VCT Partnership fully supports the National HIV/AIDS Strategic Framework and the National HIV/AIDS Secretariat and Council. The primary goals of the Zambia VCT Partnership are:

- Mobilization of communities for expanded HIV/AIDS work
- VCT promotion through IEC
- High-quality service delivery
- Care and support for people who participate in testing

IV. The VCT Partnership: Overview of Activities January 2001–October 2002

The goal of the Zambia VCT Partnership is to support the Zambian Government's demand for and access to comprehensive, good-quality VCT services in selected areas. This goal is supported by three results: (1) VCT service delivery; (2) prevention, care, and support; and (3) community mobilization and communication. During the period January 2001 through October 2002, the Zambia VCT Partnership supported a number of activities with the intention of contributing toward the goal and results outlined above.

A. VCT Service Delivery

The VCT Service Delivery result of the Zambia VCT Partnership is supported by five sub-results, which include:

- Efficient well-resourced testing facilities
- VCT sites that adhere to set guidelines for client-friendly VCT services
- Adequate numbers of appropriately trained counselors
- Counselor-support and supervision mechanism developed

1. Efficient, well-resourced testing facilities

During the period January 2001 to October 2002, the International AIDS Alliance (AA) provided grants to six DHMTs under this sub-result. The aim was to enhance VCT counseling environments by establishing eight sites in various DHMTs through ZVCTS. These established sites, like the others, received regular provisions of testing supplies and technical assistance. During the period under review, the ZVCTS trained 22 counselors in HIV testing.

2. VCT sites that adhere to set guidelines for client-friendly VCT services

ZVCTS, with ZCC, made quarterly supervisory and support site visits. ZVCTS also developed and disseminated guidelines and protocols to VCT sites, in addition to providing HIV testing protocols. Kara Counselling and Training Trust (KCTT) trained counselors and VCT site staff in client hospitality and client-friendly procedures. Awareness and sensitization workshops were also conducted.

3. Adequate number of appropriately trained counselors

KCTT, Chainama, and ZCC trained 450 counselors and counselor supervisors. In the same period, the AIDS Alliance developed proposals and provided grants to three counseling institutions.

4. Counselor support and supervision mechanisms developed

KCTT and DAPP provided space and infrastructure for psychosocial counselors to hold regular weekly and biweekly meetings. They both also developed supervision and support mechanisms in VCT. KCTT and DAPP, along with Chainama and ZCC, conducted capacity-building workshops for 70 counselors. Through DAPP, 91 counselors in the counseling support groups provided support to one another while KCTT managed to develop, pilot, and revise the curriculum for counselor supervisors over the same period.

B. Prevention, Care, and Support Services

Under the result, Prevention, Care, and Support, activities supported by the Zambia VCT Partnership between January 2001 and October 2002 centered around the following three results:

- Increased post-test activities
- Expanded and strengthened community prevention, care, and support services
- Increased involvement of PLWHA in prevention, care, and support services

1. Increased post-test activities

Several activities were conducted to support this result. Among these was training to post-test club leaders conducted by DAPP. The post-test club leaders provided new ideas and directions to the post-test club program and income-generating activities (IGAs). DAPP also trained PLWHA in positive-living skills and advocacy. At the time of the review, 125 PLWHA had graduated and 147 were undergoing training. In addition, DAPP trained more than 400 post-test club members in basic psychosocial counseling and community care mobilization.

2. Expanded and strengthened community prevention, care, and support services

DAPP mobilized church and faith-based organization (FBO) leaders to begin involving the congregations in the awareness of, and participation in, HIV/AIDS prevention, care, and support services, and VCT. With this effort, DAPP reached more than 2,385 people from various congregations. Apart from forming and supporting community HIV/AIDS task forces, DAPP trained task force members to coordinate and spearhead care and support activities in the community. At the time of the review, the positive-living clubs were actively involved in sharing knowledge and advocating for VCT in the communities.

The International AIDS Alliance established focal-point NGOs in seven districts: Livingstone, Chipata, Kabwe, Kitwe, Ndola, Chibombo, and Mwense. The Alliance also provided grants to five NGOs. These grants were designed to strengthen prevention, care, and support services and to encourage VCT collaboration with other health services. To enhance the faith response to HIV/AIDS, the Alliance provided grants to the Zambia Interfaith Nongovernmental Organization (ZINGO). SFH produced and distributed IEC materials for use in VCT sites. Such IEC materials included brochures on sexually transmitted infections (STIs), nutrition, condom use, and information on the meaning of HIV testing.

3. Increased PLWHA involvement in prevention, support, and care services

As part of the activities to achieve this result, the International AIDS Alliance implemented and circulated a study on PLWHA involvement in delivering community-based prevention, care, and support services in Zambia. In collaboration with NGOs, community-based organizations (CBOs), and the Zambia Integrated Health Program, AA developed a strategy to expand and strengthen PLWHA involvement in HIV/AIDS programs in the country. AA also conducted a regional workshop in Zambia on PLWHA involvement in HIV/AIDS programming. The Network of Zambian People Living with HIV/AIDS (NZP+) facilitated the workshop, in which six Zambians participated. In partnership with NZP+, AA presented a weekly radio program on PLWHA involvement and social stigma.

DAPP aided PLWHA in establishing IGAs, and significant improvement in community activities was made. To reduce stigma, DAPP participated in training anti-AIDS clubs in schools, and 72,000 pupils were reached. DAPP also trained two PLWHA in VCT counseling. Eight DAPP-supported peer educators offered informal counseling support sessions. DAPP-trained PLWHA were actively involved in discussing their experiences and answering questions at various events, including World AIDS Day.

SFH widely disseminated the study promoting employment of PLWHA in the Partnership and other organizations. ZCC trained two PLWHA in referral network information and capacity building, while KCTT, in collaboration with ZCC, trained 24 known PLWHA as counselors.

C. Community Mobilization and Communication

Between January 2001 and October 2002, Zambia VCT Partnership activities to support this result focused on the following:

- Improved knowledge and attitudes related to VCT
- Increased community acceptance of, and support for, VCT
- Reduced stigma toward PLWHA

1. Improved knowledge and attitudes related to VCT

As part of the effort to improve knowledge and attitudes related to VCT, SFH produced and distributed 48,000 English-language VCT brochures, out of which 30,000 were for youth and 18,000 for adults. SFH also produced and distributed 25,000 brochures in different local Zambian languages and 10,000 "Free Your Mind" posters. The organization also produced 10,000 "couple" and 10,000 "girl" versions of the "Free Your Mind" poster. SFH conducted more than 30 VCT shows through the mobile video unit, which reached approximately 9,000 people. The organization produced "Free Your Mind" jingles for use on radio spots, and "What is VCT?" brochures. SFH attended monthly government and stakeholder meetings in the operational districts and also conducted collaborative outreach programs that targeted high-risk populations. The organization completed formative qualitative research on VCT in Zambia, targeting youth, couples, and high-risk populations.

SFH also presented VCT talks in schools, churches, sports clubs, and bars. Apart from conducting 576 drama shows, SFH organized more than 60 outreach activities in Phase 1 Districts reaching more than 3,000 people. The organization also completed preliminary work on videos, promoting VCT among the youth in Nyanja language. The organization conducted four VCT shows on stigma and PLWHA, reaching six percent of the urban population. Other achievements recorded by SFH included the introduction of a storyline on positive living on Zambia's most popular soap opera called "Kabanana." In collaboration with DAPP in Chipata District, SFH conducted one or two weekly shows on Radio Maria that discussed the benefits of VCT and positive living. Jointly with DAPP, SFH participated in the International Trade Fair and Agricultural and Commercial Show in Ndola and Lusaka. DAPP and SFH also promoted benefits of knowing one's HIV status. AA made two national radio presentations on VCT during the review period.

2. Increased community acceptance of and support for VCT

As a part of the activities implemented to achieve this result, the International AIDS Alliance conducted skills-building workshops on community mobilization for NGOs, CBOs, FBOs, and the Zambian Government in seven Districts. One hundred organizations and 171 people participated. AA also developed tools for facilitating community dialogue on VCT. The tools were piloted and revised in Lusaka District. AA developed District action plans for expanded VCT services in 12 Districts and carried out community mobilization and sensitization activities in the same districts. Over the same period, AA conducted full community VCT baseline studies in five districts and VCT rapid assessment baseline studies in seven Districts. Each DAPP Hope Station had several positive-living advocates (PLAs) and 24 post-test club leaders (HIV positive and HIV negative).

3. Reduced stigma toward PLWHA

To support this result, the International AIDS Alliance conducted skills-building workshops on stigma in Livingstone District, in which 25 participants from NGOs, CBOs, the Zambian Government, and the private sector participated. To strengthen the role of the network at central level, AA provided grants and technical support to NZP+. AA established or strengthened District NZP+ chapters in 12 Districts. It also supported monthly AIDS debates. To address legal, ethical, and human rights issues, AA provided technical support and a grant to ZARAN (a lawyers association). In collaboration with KCTT, AA established a network with the International Council for Research on Women (ICRW**)** and a Kara counseling study on HIV-related social stigma. DAPP introduced a workplace program on stigma, reaching more than 15 workplaces in Lusaka District and in the Copperbelt Provinces.

V. Findings from Interviews in Chipata, Kabwe, Livingstone, and Lusaka

This section summarizes key findings from interviews conducted with VCT counselors, members of DHMT, and various participants in the Zambia VCT Partnership activities in Chipata, Kabwe, Livingstone, and Lusaka districts. Interviews focused on these themes: counselors as a key human resource; physical space needed for VCT; VCT participation rate by districts and sites; district model of community mobilization; post-test services; test-kit supplies; and IEC.

A. Chipata District

Chipata District, the provincial headquarters of the region, is located in the eastern province of Zambia, about 570 kilometers from the capital, Lusaka. It borders Lundazi District in the north, Katete district in the west and Chadiza district in the south. It also shares a border with the Republic of Malawi in the east. The district covers a surface area of about 6,112 square kilometers and has a population of 381,207, most of whom live in rural areas (Central Statistics Office/Ministry of Health, 2000). The district serves as a hub of activities, including cross-border trade, and it is a transit point for tourists to the south Luangwa National Park and other game parks in the Luangwa Valley. The Zambia VCT Partnership in Chipata is composed of, Chipata General Hospital, Kapata Clinic, DAPP, SFH, Lutheran World Federation (LWF), and the Catholic Archdiocese of Chipata.

Table 4: VCT Partnership Members and their Roles in Chipata

Stakeholder	Type of Organization	Roles
Chipata General Hospital	Government	HIV testing and counseling
Kapata Clinic	Government	HIV testing and counseling
DAPP	NGO	Capacity building for PLWHA and youth IEC materials
SFH	NGO	VCT/IEC materials; community VCT mobilization
LWF	FBO	Community VCT sensitization
Catholic Archdiocese	FBO	Counseling; food supplements

B. Kabwe District

Kabwe district is situated in the central part of Zambia, about 140 kilometers from Lusaka along the Great North Road. Provincial headquarters of the central province, the district occupies an area of 1,577 square kilometers and has a population of 180,129, with growth rate of 0.5 percent, (Central Statistics Office/Ministry of Health, 2000). Kabwe shares its boundaries with Chibombo District in the south and Kapiri Mposhi in the north. The HIV/AIDS prevalence rate in the district stands at 25.6 percent. The DHMT and Partnership members were resolved to reduce the HIV/AIDS prevalence rate by one percent. There are five Zambia VCT Partnership members in the district: SFH, DAPP, Kabwe Adventist Family Health Institute (KAFHI), NZP+, and the Catholic Archdiocese of Lusaka.

Table 5: Zambia VCT Partners Members in Kabwe and their roles

Stakeholder	Type of Organization	Role
SFH	NGO	VCT community mobilization
Kabwe Adventist Family Health Institute	FBO	HIV/AIDS/TB/ home-based care; counseling
DAPP	NGO	HIV/AIDS; counseling; post-test services
Catholic Archdiocese	FBO	Counseling; home-based care
NZP+	Network	Advocacy

C. Livingstone District

Livingstone District is situated in the southern part of Zambia, 472 kilometers south of Lusaka. Apart from being the provincial headquarters, the district is a tourist town hosting the famous Victoria Falls, and is only a stone's throw away from the Zimbabwe border. The district covers an area of 1, 427 square kilometers, and the population is 179,715 with about 67.08 persons per square kilometer (Central Statistics Office/Ministry of Health, 2000). Approximately 85 percent of the population is concentrated in urban areas, with the remainder in peri-urban areas. The HIV prevalence rate is 31 percent, the highest in the country. The Zambia VCT Partnership members include four Zambian Government ministries, eight NGOs, one CBO, and two churches.

Table 6: VCT Partnership Members and their Roles in Livingstone District

Stakeholder	Type of Organization	Role
Social Welfare and Community Development	Government	Takes care of the orphans and the vulnerable, as well as sensitization on VCT
Ministry of Education (MOE)	Government	Empowers girl child and provides VCT sensitization
Zambia Police	Government	Provides counseling through the Victim Support Unity
Zambia Air Force	Government	Provides counseling through the training school
SFH	NGO	Promotes HIV/AIDS/STIs VCT and condom distribution; promotes safe nets and use of chlorine
Young Women's Christian Association	NGO	Helps the youth to get information on HIV/AIDS and VCT through creative arts, distributes condoms and peer education
Planned Parenthood Association of Zambia	NGO	Is mainly involved in reproductive health issues and provision of information on STIs and VCT
Red Cross	NGO	Provides disaster management, home-based care and VCT sensitization
Livingstone Women Make a Difference	NGO	Initiated by the United Church of Zambia, supports orphans and widows; and addresses gender and sexuality issues
Livingstone Widows Association	NGO	Supports the widows' community sensitization on VCT
Tusole Drama	NGO	Provides information on HIV/AIDS and STIs, mainly to youth
St. Frances Home-based Care	NGO	Provides care to chronically ill people; is involved in counseling and VCT awareness
Livingstone Fish Mongers' Association	NGO	Gives information on HIV/AIDS/STIs; condom use; and distribution and mobilization of communities on VCT
Restoration Church	Church	Involved in care for orphans and provides information on HIV/AIDS/STIs and VCT to church members

D. Lusaka District

Lusaka District is both the country's capital city and the provincial headquarters of Lusaka Province. The district occupies 360 square kilometers and has a population of over one million (Central Statistics Office/Ministry of Health, 1997). Mtendere compound is about 10 kilometers northeast of the town of Lusaka and the Mtendere VCT facility is located within Mtendere Health Center.

E. Counselors as a Key Human Resource

VCT counselors are men and women who counsel others on HIV/AIDS issues. The district consultation findings reported a shortage of VCT counselors in VCT sites throughout the Phase 1 Districts. The focal-point persons on the DHMTs and the VCT counselors were interviewed during the district consultation and said that though there were enough trained VCT counselors, only a few were active. For example, out of 80 trained VCT counselors in Kabwe District, only 40 were actively involved in VCT at the VCT sites. In Livingstone District, only 30 out of 60 trained VCT counselors were active. The situation was reportedly the same in Chipata and Lusaka Districts. The focal-point persons and VCT

counselors identified two main reasons for this inactivity: 1) the lack of incentives for VCT counselors; and 2) the majority of VCT counselors were full-time health workers in government health centers.

The focal-point persons and VCT counselors recommended providing incentives to VCT counselors at VCT sites. Incentives were defined not only in monetary terms, but also in terms of training, workshops, and protective clothing such as umbrellas, gumboots, and gloves, particularly during the rainy season. The majority of VCT counselors said sending VCT counselors for training was a good incentive that would motivate them and other counselors to do VCT work, and they cited examples of past training as effective incentives.

One senior VCT counselor in Chipata District attended training offered by the Japan International Cooperation Agency in Lusaka and was trained on HIV testing protocol. Many other VCT counselors in the district were motivated and were looking forward to attending similar training. VCT counselors in Livingstone District also mentioned "time off" as a strong incentive, considering "we volunteer our spare time to do VCT work."

Speaking about incentives, a respondent said:

> *We are not talking of a lot of money, but a token of appreciation for time and effort devoted to counseling people. We understand that counselors elsewhere in Lusaka are given something. We are all counselors. Why can't we be considered as well?*

Shortages of VCT counselors at VCT sites were also attributed to the fact that most VCT counselors work concurrently as full-time health workers such as nurses in government health centers. VCT clients should not have to wait for VCT services because any delay could cause the client to change his or her mind about taking the HIV test. The VCT counselors interviewed at the VCT sites during the district consultations said it was difficult to attend to VCT clients immediately because priority must be given to ordinary patients who come in for other diseases.

An interviewee expressed the situation as follows:

> *Counseling is not only part-time work, but also voluntary. And, as such, priority is given to patients. If patients are waiting, and you are seen attending to VCT, you will be perceived as an irresponsible nurse without a professional heart. The health authorities do not expect you to abandon patients and instead attend to VCT clients.*

Based on this information, the Partnership recommends that the Ministry of Health and the Central Board of Health consider incentives for VCT counselors and recruit retired counselors, e.g., nurses, NGO staff, and volunteers, to staff VCT sites in an effort to address the shortage of VCT counselors. The Partnership also recommends that at least one full-time VCT counselor and one laboratory technician assigned to VCT clients be employed at each VCT site.

F. Space for VCT

Appropriate physical space for VCT is an important element in counselling HIV/AIDS patients. The counselling space can encourage or discourage clients, and the area is an indication to clients as to the quality of VCT service offered at facility. Throughout the Phase 1 Districts, VCT services are located within the government health facilities. The district consultation findings reported these spaces were

inadequate because they were either too small or were being shared. "When the space is too small, it is difficult even to conduct good counseling sessions," said one VCT counselor in Livingstone District.

The VCT counsellors interviewed throughout the Phase 1 Districts said privacy and confidentially were likely to be compromised in cases where physical VCT spaces were shared. The district consultation found that counseling spaces at some health centers were used for both antenatal and VCT services. A counsellor described the situation as follows:

> *This situation creates a problem because you may find that the antenatal mothers are using the space when you have a VCT client to counsel. For confidentiality purposes, we advise VCT clients to wait or give them an appointment.*

In Chipata and Kabwe Districts, the district VCT services are conducted from the storerooms where food for home-based care is kept. VCT counselors said that conducting VCT in such rooms was problematic because people entered the space to collect the food, thus disturbing the counselling sessions.

To address these challenges, the Partnership recommended that each VCT site have at least one dedicated counseling room with an appropriate environment for effective counselling. The second recommendation was that VCT sites have good record-keeping facilities, comfortable furniture, and lockable file cabinets to contain counseling records. The third recommendation was to immediately remedy the inadequate counselling situation in VCT sites with no space dedicated to VCT counselling. The Partnership stressed the need to monitor available counseling space as VCT service uptake increases.

G. VCT Participation Rate by Districts and Sites

An increase in the VCT participation rate by districts and sites was reported in all the Phase 1 Districts visited. The focal-point persons and VCT counselors interviewed at the DHMTs and VCT sites throughout the Phase 1 Districts said the number of people coming from long distances for VCT services was increasing. In Livingstone District, the focal-point person at DHMT and the VCT counselors reported that the number coming for VCT had risen dramatically. From August 2002 to October 2002, the number increased from 30 to 109. Amazed at this increase in clients, one respondent said:

> *I was impressed to see a queue of people waiting to be tested for HIV at Maramba Clinic. What was so interesting was that the Family Planning, Youth Friendly Corner and the VCT rooms were all being used for counseling. This shows that people were appreciating the benefits of VCT.*

At the Mahatma Gandhi VCT site in Kabwe District, it was reported that about 100 HIV tests were conducted each month. The VCT counselors interviewed, however, said that the numbers of clients testing would have been higher if the site had had two laboratory technicians. The laboratory technician at the site said he worked long hours each day to cope with the high demand for VCT.

The focal-point persons at DHMTs and VCT counselors at VCT sites attributed the increased VCT demand to the contribution of the Partnership at the community and district levels. SFH had produced brochures and other IEC materials on VCT health benefits. AA also played a leading role in the promotion of VCT and expanded HIV/AIDS responses through collaboration with NGO partners. DAPP's role in training PLWHA and setting up positive-living clubs was also a factor. The VCT

counselors indicated that another factor contributing to the increased demand was the gradual willingness of HIV-positive people to come out in the open and reveal their HIV status.

The VCT counselors said information about antiretrovirals (ARV) had also increased the rate of VCT participation in the Phase 1 Districts. The VCT counselors observed that women were more receptive to taking HIV tests than were men. The district consultation found the majority of clients who came for VCT were between 15 and 24 years old and came primarily to find out their HIV status before getting married.

To further increase the VCT participation rate throughout the Phase 1 Districts, the Partnership recommended immediate facilitation of the required policy on finger-prick and fast-testing (saliva) technologies, and working with the National AIDS Council (NAC) through VCT and the CRIS Technical Working Group (CTWG). Another recommendation was to expand more VCT testing sites to other health centers within the Phase 1 Districts, especially those in rural areas.

H. District Model of Community Mobilization

Community mobilization was district-focused. This model involves the participation by various VCT Partnership members in planning and implementation of VCT activities as a team. The DHMTs provide testing facilities and physical spaces for VCT services. SFH is responsible for IEC materials, DAPP for post-test services, and AA provides grants through focal-point NGOs. During community mobilization meetings on VCT, representatives from each organization are available to provide expert answers on issues concerning their respective areas of operations.

To enhance the District Model of community mobilization, it was recommended that stakeholders strengthen the networking aspects with the DHMTs and District AIDS Task Forces (DAFT) and support their advocacy and leadership roles in VCT at the district level. The Partnership recommended more coordination and input from ZVCTS to ensure that issues pertaining to VCT site logistics, supplies, testing, assessment, and quality control are shared with other partners.

I. VCT Referral System

After a person has gone through VCT and has tested HIV positive, his or her needs are numerous. They include: counseling; general information about HIV/AIDS and home-based care; advice on what to eat and how to remain healthy; moral support from other PLWHA; advice about behavior change and safe sex, as well as help with employment and IGAs. The district consultations found an informal VCT referral system was operational throughout the Phase 1 Districts. In collaboration with DAFTs, the VCT counselors initiated the referral system to ensure that the needs of HIV-positive and HIV-negative people were adequately met.

The referral system was not yet formalized and institutionalized by the Ministry of Health and the community-based organization. The referral system was initiated because VCT counselors throughout Phase 1 Districts realized no single organization could meet all the needs of tested clients. The focal-point persons at the DHMTs and the VCT counselors at VCT sites said plans to have the system formalized had reached advanced stages at the time of the consultations and that overall, the referral system was working well, though there was still room for improvement.

VCT counselors in Chipata District reported HIV-positive or HIV-negative people who need more HIV/AIDS information or VCT are referred to SFH, where they receive IEC materials in the form of

leaflets, pamphlets, and brochures. Those who wish to be trained as positive-living advocates (PLA) or wish to form positive-living clubs are referred to DAPP. Those in need of food items are referred to the community home-based care organizations.

To improve the VCT referral system in the Phase 1 Districts and elsewhere, the Partnership recommended it collaborate with the Ministry of Health, the Central Board of Health, and the stakeholders to formalize the system and develop a standard referral form with information such as when, where, why, how, and to whom the HIV-positive or HIV-negative client was referred.

J. Post-Test Services

Post-test services are meant for all those who go through VCT. People who are HIV positive need help and support from other PLWHA and counseling on how to live positively. Those who are HIV negative need counseling and skills on how to maintain their HIV-negative status. The district consultation found post-test services were available in all Phase 1 Districts. The idea is to train individuals (whether seropositive or negative) who are willing and able to advocate for and explain healthier lifestyles to people who test regarding nutrition, exercise, the implications of sexual contacts, etc. In this regard, DAPP is providing a six-month training course for PLHWA which provides the graduates with enough knowledge and confidence to start functioning as PLAs.

VCT counselors interviewed said available post-test services were not being used as much as they could because some clients come for VCT only after the have begun to experience full-blown AIDS and can not effectively participate in post-test services. The VCT counselors also said those who are HIV negative often do not want to participate in the post-test services because they are too preoccupied with survival issues such as income, shelter, and food). According to the VCT counselors, however, there has been a positive response toward income generating activities and training in PLA among the HIV-positive clients throughout the Phase 1 Districts.

To improve post-test services, the Partnership recommended that work already initiated to establish post-test support services be consolidated and expanded. Another recommendation was to pay attention to establishing groups based on the commonality among members. For example, young people (possibly further divided by gender or marriage) could be grouped together. It was further recommended that links between post-test clubs and the NZP+ District Chapter should be established and strengthened. The Partnership recommended that people who are tested should become advocates for VCT in the community. The Partnership revisited the post-test model to learn from the Zambian and sub-regional experience.

K. Test Kit Supplies

Medical Stores Limited (MSL) currently supplies VCT test kits throughout the Phase 1 Districts. Until the end of 2002, the supply of VCT test kits had been the responsibility of ZVCTS. Interviews with laboratory technicians indicated none of the testing sites experienced shortages of testing kits in the month prior to the district consultation. However, at the time of the consultation itself, Mahatma Gandhi Testing Site in Kabwe Districts reported shortages of vacuum containers, syringes, and needles. The laboratory technician said it was unclear to him which organization was responsible for supplying test kits. He said he had heard unofficially that ZVCTS was no longer responsible for supplying the test kits to VCT sites.

The findings of the district consultation regarding test kits indicated some laboratory technicians did not know about the change from ZVCTS to MSL. Those who knew about the change had not been informed as to the ordering procedures. One laboratory technician in Livingstone District wanted to know how the ordering of VCT test kits was to be done and should they to be ordered directly from MSL or ZVCTS. He also asked what to do when testing kits run out before the MSL delivery was due. "We are yet to be educated on how the new system works, although we did not have any problems with the old one," he said.

The Partnership recommended ensuring a consistent and adequate supply of essential VCT commodities at all sites, by implementing a drug procurement system with direct links to the central stores that supply drugs. It was anticipated that RPM+ would play an important role in setting up such a system. Current government policy requires HIV tests to be conducted on venous blood samples. Following the developments in finger-prick testing and saliva testing, it was recommended that the decision to continue using venous blood sample testing be reconsidered. The need for the Partnership to organize a strategic discussion with the Ministry of Health and the Central Board of Health on this subject was proposed. To enhance smooth implementations of decisions, it was recommended the Ministry of Health and the Central Board of Health immediately communicate important decisions to the implementers on the ground.

L. Information, Education, and Communication

For any activity to succeed, IEC issues are important. Only when people are aware and knowledgeable about an issue can they change their behavior and attitudes in relation to HIV/AIDS and VCT. The district consultation finding throughout the VCT sites indicated IEC materials were available but were insufficient. Common IEC materials found at the VCT sites were in the form of posters, leaflets, brochures, and booklets. Such IEC materials were mainly found at the VCT sites and *not in the communities and in public areas such as markets.*

The most common IEC materials at almost every VCT site visited focused on HIV/AIDS/STIs and VCT, in that order, and most were written in English. VCT counselors at VCT sites said English IEC materials were in high demand, while demand for those in local languages (Nyanja, Lozi, Tonga, and Bemba) was high in the rural areas, as educational levels are generally higher in towns than in rural areas. SFH is the main producer and supplier of IEC materials throughout the Phase 1 Districts, and DAPP produces such materials on a smaller scale.

The Partnership recommends reducing the cost of producing IEC materials, while maintaining the quality and impact. The use of fewer colors on VCT posters was recommended, as was a strategy of developing target-group-specific materials. Another recommendation was to explore ways in which IEC materials produced under the Partnership could be made available to non-Partnership districts.

VI. Data Review Meeting of Core Members of the Zambia VCT Partnership

As part of the participatory process, the core partners of the VCT Partnership held a retreat to review the data from the field interviews, discuss the findings, and develop recommendations for future activities. Representatives from five core partners—International HIV/AIDS Alliance, Society for Family Health, Development Aid from People to People, Zambia Voluntary Counseling and Testing Services, and Zambia Counseling Council—were in attendance. The discussions focused on the VCT environment and what can be done to make VCT sites welcoming and user-friendly; counseling space; monitoring of VCT services; and recommendations for next steps.

The core Partnership members made operational recommendations on planning, coordination, and collaboration of VCT activities national- and district-level. In addition, recommendations were made on a variety of VCT program activities to be implemented by the Partnership with its results framework. The following section presents a summary of the recommendations, the implementation of these recommendations is expected to build the capacity and effectiveness of the Zambia VCT Partnership to support the Zambia Government's efforts to expand access to and demand for quality VCT services in integrated sites and to link VCT services with other key HIV/AIDS prevention and care services.

A. National-level Planning, Coordination, and Collaboration

The VCT partners expressed the need for the Partnership to expand beyond the current 12 districts. The participants cautioned, however, that the roles of some, if not all, partners require intensive sustained input. Further, the speed at which further districts can be accommodated is constrained by the need to consolidate activities and impacts in existing districts and establish quality services. If and when new districts are to be added to those districts currently supported, a participatory process should be followed, including consultations with all current partners, and the DHMTs of the potential district to ensure consensus and support for the choice from all relevant stakeholders.

1. Selection of the New District VCT Site

It was recommended that the DHMT select new district VCT sites and that they be led and supported by the ZVCTS. Once a new site has been determined, this decision should be communicated to the Partnership as soon as possible to avoid confusion about the location of the new site and about how to best accelerate the initiation of partner activities.

2. The Partnership Composition

In order to strengthen the capacity of the Partnership to effectively respond to the lessons, challenges, and emerging issues related to VCT service delivery, uptake, and linkages with prevention and care services, it is recommended that the Partnership:

- Re-assert the need for more active and regular participation by the **NZP+** in the Partnership and ensure that NZP+ has the support required to participate in a meaningful and effective way at both the central and the district level.

- Re-assert the need for more coordination and input from the **ZVCTS** to ensure that issues pertaining to VCT-site logistics; supplies; testing data and assessment; and quality control are shared with other partners and effectively addressed.

- Engage **Central Board of Health** support for and involvement in the Partnership. This could be achieved by:
  - holding quarterly wider stakeholder meetings at the CBOH offices; and
  - providing quarterly written updates and reports to the CBOH.

- Engage **National AIDS Council** support for and involvement in the Partnership. This could be achieved by:
  - inviting NAC representation at quarterly key stakeholder meetings held at the CBOH; and
  - providing quarterly written updates and reports to the NAC.

- Re-establish links with **ZIHP-SERV** to identify opportunities for ZIHP to expand their role in supporting VCT promotion and service delivery based on their comparative advantage

3. Potential new partners and/or collaborations

Recommendations were made on potential new Partnership members. The agencies were identified on the basis of the value they will add to the partnership. Among the proposed organizations to be approached are:

- **Linkages,** which who will bring to the Partnership the experience and learning of the Ndola Demonstration Project and will explore ways in which the Partnership can support taking this initiative to scale, including the provision of ARVs for prevention of mother-to-child transmission (PMTCT);

- **RPM+,** which will join as a new USAID partner with a mandate to support ZVCTS to strengthen VCT supplies and data management systems; and

- **CIDERS** 'Call to Action' Project.

4. Partnership Coordination and Planning

To more fully realize the collective impact of the organizations contributing to the Partnership results framework, and to ensure key stakeholders' support and input, it was recommended that partners increase the effectiveness of and commitment to regular meetings by undertaking the following:

- The purpose and outputs of Partnership meetings must be more clearly defined, thus making partners more committed to allocate time to participate in meetings.

- The Core Partners (ZVCTS plus those organizations receiving USAID funding for VCT-related work: International AIDS Alliance, SFH, DAPP, ZCC, and NZP+) should continue to meet on a monthly basis. These meetings should be action oriented, and the primary purpose should be to address key strategic issues and to coordinate workplans. The meetings should be considered an essential component of each organization workplans and not an optional activity.

- The International AIDS Alliance should continue to chair the meetings and provide secretarial services, and the venue should rotate between partners with suitable meeting facilities.

- Every third meeting (i.e., once each quarter) a wider group of key stakeholders should be included, and these meetings should be hosted by and held at the Central Board of Health. The

main purpose of these meetings would be to ensure wider support for the Partnership; to share information; and to raise key strategic and policy issues.

- The counseling organizations within the Partnership should improve coordination of inputs through joint analysis of issues, gaps, and needs in each district; the joint development of workplans should help avoid duplication and ensure that the counseling-related needs in each district are met. One possibility is that these organizations have districts assigned to them for which they are responsible.

- 'Sub-meetings' between the three partners that work in strengthening the VCT-counseling component should continue, and they should focus on monitoring progress in each district, joint planning, and identification of advocacy issues.

B. Monitoring and Evaluation

Monitoring and evaluation is regarded by the Partnership as an important element in their efforts to adequately measure the achievement of results of activities undertaken within the Partnership results framework. Recognizing this, the core VCT Partnership members recommended the need to strengthen regular monitoring and reporting of Partnership activities against the framework. The partners will collectively track progress, support joint work planning, share information with wider stakeholders (in particular, the CBOH, NAC, and the VCT and Care Working Group), and provide USAID and other donors with information to support their reporting needs. To this end, it is recommended that the Partnership produce a biannual VCT Partnership Report that will include:

- key achievements against the results framework from the USAID-supported components;

- summary sheets for each Partnership district outlining key collective achievements of the entire Partnership in the three key results areas (Community Mobilization and Communication; VCT Service Delivery; and Linkages with HIV/AIDS Prevention and Care Services), as well as a summary sheet for national-level achievements; and

- VCT-testing data and highlights from site-monitoring visits from ZVCTS and information on new sites.

Responsibilities regarding coordination of inputs from the various partners and the production of the final report must be discussed. Options might include having one of the partners add this task to its workplan and/or contracting the activity out to a consultant on a regular basis.

1. Advocacy Role of the Partnership

Participants at the retreat believed that with advocacy, VCT could be elevated to a level of importance that would result in increased interest in testing among Zambians. It was recommended that the Partnership assume an expanded advocacy role on issues affecting VCT service delivery. Advocacy activities could focus on government policy around testing technology; availability of counselors at the VCT sites; consistent and adequate VCT testing supplies; site monitoring; and quality-assurance issues. It was recognized that membership by VCT partners in the National Care and Treatment Technical Working Group, as well as in the Quarterly Key Stakeholder Meetings, provides advocacy opportunities on these issues.

C. District-Level Planning, Coordination, and Collaboration

Coordination and collaboration of VCT Partnership activities at the district level are important factors in the process of improving VCT service delivery; community mobilization; and prevention care and support. Realizing this, the VCT core partners put forward several recommendations to further strengthen partnership activities at the district level.

1. Partnership Coordination at the District Level

- In all districts, the DHMT District VCT Coordinator has responsibility for overall coordination of the expanded VCT program. It was recommended, however, that the core members of the VCT Partnership should be more active and should play a key role in supporting the District VCT Coordinator.

- It was also recommended that regular meetings between core partners with representation at the district level (SFH, DAPP, the selected International AIDS Alliance focal-point NGO, and NZP+) would allow for the effective coordination of Partnership inputs and activities at the district level.

2. Partnership Support to DHMTs

In general, the Partnership recommended strengthening linkages with DHMTs to support their role in advocating for and providing leadership on VCT at the district level. Recommendations on improving the relationship included:

- Facilitate a lesson-sharing/skills-building forum for DHMT directors on VCT service delivery.
- Invite DHMT directors to participate periodically in Partnership meetings, possibly at the Quarterly Stakeholders Meetings mentioned earlier.
- Facilitate cross-fertilization and learning exchange between DHMTs around VCT service delivery.

In Lusaka, the recommendation was to strengthen links between the VCT Partnership and the Lusaka DHMT to increase understanding of and support for the work of the Partnership in the Mtendere compound. A positive response to the DHMT request to support the formation of a Multisectoral HIV/AIDS Task Force should be forthcoming, but would be perhaps better focused on the Mtendere compound rather than district-wide.

3. Partnership Support to Key District VCT Staff

Motivating and building the capacity of VCT staff at the district level were identified as key elements in improving VCT services. It was recommended that the Partnership facilitate learning exchange between key staff involved in supporting VCT at the district level (i.e., District VCT coordinator, key VCT counselors/counselor supervisors, SFH, DAPP, and a selected AA focal-point NGO) in the different districts. This could be achieved through:

- facilitating exchange visits, e.g., between government integrated sites, to New Start, to the NGO sites to expose people to new and different ways of thinking and working; and.
- conducting workshop(s) to strengthen linkages, share lessons, and build skills between those involved with provision of VCT services.

D. Recommendations for Program Results Improvement

The VCT Partnership results framework supports the achievement of the goal to support the Government of Zambia to increase demand for and access to comprehensive, good-quality VCT services. During the period January 2001 through October 2002, the Partnership members implemented a broad range of VCT activities aimed at fulfilling the goal of the Partnership. However, as evidenced from the interviews with VCT staff and other stakeholders' in the Phase 1 communities, there is more that can be done to improve VCT in Zambia.

1. Increasing Demand for VCT Services

The partners saw print and mass communications regarding VCT as a way to increase demand for VCT in Zambia. Several recommendations toward stimulating demand were put forward by partners. Utilization of television and radio to convey VCT messages was a very important recommendation. It was suggested that the current strategy of developing target-group-specific materials, as well as materials aimed at the general public, should continue. Partners were to make sure that IEC materials already produced are available in the districts, and to explore ways to make IEC materials developed under the Partnership available in non-partnership districts.

2. Community Dialogue and Mobilization on VCT

Community dialogue and mobilization create an enabling environment for acceptance and delivery of VCT. They also help to sensitize community members toward PLHWA. During the retreat, the core partners decided to initiate VCT activities using community-mobilization and interpersonal-communication strategies to create community dialogue and support. In order to achieve results, these elements must be consolidated and strategically expanded.

Specifically, the Partnership recommended:

- Mobilization of NGOs and CBOs in each district to integrate VCT dialogue into existing community-outreach work; this requires close monitoring for quality and coverage at the community level and identification of technical support needs.

- Further focus on mobilizing traditional, political, faith, and youth leadership as VCT advocates in the community.

- Expanded empowerment activities for PLWHA as VCT advocates.

- Integration of positive aspects of the VCT community mobilization model used by Thandizani into Partnership-supported programs.

- Scaling-up of interpersonal-communication strategies, including door-to-door approaches, group discussions, and interactive drama.

- Use of community events as opportunities to promote VCT, e.g., sports events.

3. Reducing HIV/AIDS Related Stigma

Stigma is a major barrier to people's accessing VCT services. Reduction of stigma is a major result that the VCT Partnership hopes to achieve through its community mobilization activities. During the retreat

review meeting, the partners agreed to undertake a specific communications strategy around stigma reduction that would include print media, as well as radio and television.

The partners recommended the following:

- Stronger links should be developed between the VCT Partnership and the ICRW Social Stigma Study, as well as between the Partnership and other stigma-related projects, e.g., The POLICY Project).

- AA support to ZARAN, an association of young lawyers who work on legal, ethical, and human-rights issues, should continue; and synergies between their focus and the work of Partnership should be sought.

- The concept of "PLWHA-friendly health services" should be actively promoted and practiced at the integrated VCT sites (and ultimately at all hospitals and health centers).

- Support to NZP+ aimed at strengthening the network at the central level and in the Partnership-supported districts should continue and be intensified.

- Closer links between district-level partners and existing and/or emerging NZP+ Chapters must be developed and nurtured.

4. Increasing Access to Quality VCT Services

The following recommendations seek to address issues and challenges experienced at the VCT service delivery point.

E. The VCT Site and Counseling Environment

- To further improve the counseling environment, the VCT Partnership recommends re-enforcing the concept and practice of client-friendly services at the VCT sites. These could be achieved by:
  - providing training to clinic administrative and support staff to increase the quality of client reception;
  - helping clients locate the VCT service by ensuring clear directions to and labeling of VCT services;
  - attention to waiting environments, including availability of IEC materials; and
  - ensuring that VCT services are available at times most convenient to clients–with consideration of different client group needs.

- Each site should have at least one dedicated counseling room and the environment should be conducive to effective counseling and record keeping (i.e., it has comfortable furniture and fittings, and there is a lockable filing cabinet to contain counseling records). Sites without dedicated space or where allocated space is inadequate should be remedied immediately.

- The adequacy of available counseling space must be monitored as VCT-service uptake increases

F. Counselor Availability

Although large numbers of counselors have been trained, this training has not solved the issue of counselor shortages at VCT centers. Based on this urgent need for counselors, the Partnership developed the following recommendations:

- Dedicate government health staff with full time/VCT responsibilities.
- Provide incentives to health staff with counseling responsibilities.
- Attach trained counselors not employed by the government health services to the VCT sites, e.g., retired nurses, NGO staff, and volunteers
- Train more PLWHA as VCT counselors. These could be identified by NZP+ district chapters, through the post-test clubs, or from among the PLA trained by DAPP.

G. Voluntary Counseling and Testing and Prevention of Mother-to-Child Transmission

The Partnership should consider advocating for increased recognition and a higher profile of VCT through the establishment of a 'VCT/PMTCT Department' at health centers selected as VCT sites. This would have staff dedicated to VCT with specialist responsibilities.

1. Referral within the Integrated Site

- Referral mechanisms between VCT services and other key HIV/AIDS-related services at the health center should be better understood and strengthened, e.g., STI services, TB services, antenatal-care services (and ARVs, as they become available).

- Direct referral mechanisms between VCT services and post-test support services need to be institutionalized and strengthened.

2. Counselor Support and Monitoring Quality Assurance

There are no clear guidelines or consensus on the overall strategic role of ZCC. The VCT Partnership recommends that a proposal be developed for funding to support ZCC in a more active role. It was envisaged that ZCC should expand their role in monitoring the quality of counseling provided in each of the districts. It would be cost-effective if ZCC linked with the ZVCTS for quarterly site monitoring visits. These visits need to be documented and shared with the counseling training and support organizations (KCTT and Chainama), as well as the wider Partnership, so that issues can be more immediately resolved. In addition:

- Institutionalizing 'Mystery Client' and client-exit surveys at all VCT sites could strengthen monitoring and evaluation of VCT service delivery. SFH could provide the tools and training.

- Counselor supervision and support mechanism in each district should be consolidated and monitored. This mechanism should be the focal point for pro-actively addressing counseling-related issues at the VCT site and identifying technical support needs that can be met by the Partnership.

H. VCT Site Monitoring and Quality Assurance

The quality of VCT sites was discussed extensively at the Partnership retreat. Based on key findings during the interviews with partners, recommendations to improve the quality of VCT sites included the following:

- Site Assessment Tools should be developed or revised (with support from RPM+) for use by the ZVCTS in site assessments and follow up monitoring and quality-control visits.

- ZVCTS should continue to conduct and document quarterly visits to all VCT sites and share the briefing reports with other partners.

1. VCT Equipment and Supplies

A data management system for ordering supplies from central stores should be strengthened or put in place at VCT sites to ensure consistent and adequate supply of essential VCT commodities. It is anticipated that RPM+ will play a significant role in supporting the ZVCTS in this area.

I. Information Management and Use

The Partnership recognized the need for an effective management information system for management and decision-making. Recommendations were made to improve the collection, analysis, dissemination, and use of VCT-site data. This component is the mandate of ZVCTS with support from RPM+. However, it was decided that the wider Partnership should provide input into what data should be routinely collected. It was also recommended that ZVCTS should request testing information from DHMTs on all programs doing VCT testing in their districts so that ZVCTS records can be more inclusive. Having a good management information system was seen as a benefit to the Partnership, which will than have regular monthly reports from ZVCTS on VCT-site data to assist in tracking progress.

1. VCT Service Delivery Models

While the Partnership is committed to supporting an integrated VCT service-delivery model, the Partnership members, however, recognize other VCT service delivery models as complementary, each with its own advantages and disadvantages. It is recommended that consideration be given to supporting multiple models in order to increase the number of Zambians who know their sero-status and are linked with HIV/AIDS prevention, care, and treatment services.

2. Confidentiality Issues

Confidentiality at VCT sites is an issue of concern to potential service users. The current practice at the integrated sites of requiring client names may be a key barrier to service uptake. It is recommended that discussions take place regarding the pros and cons of anonymous and named testing, in order to develop a confidentiality policy.

3. Testing Technology

Current Zambian Government policy requires that HIV tests be conducted on venous blood samples. In light of developments in finger-prick testing and saliva testing, this policy might be reconsidered. It is therefore recommended that the Partnership have strategic discussions on this issue, with attention to the short-term and medium-term implications as simpler testing technology becoming available.

J. Program Activity Recommendations

Within the results framework of the Partnership, several recommendations were made on the activities to be implemented. These are presented below. The role of members in implementing these activities will be decided at a meeting of the Partnership.

Table 7.1: Recommendations for VCT Program Activity: Zambia VCT Partnership Results

1 - Increased access to quality Prevention, Care, and Support services at the community level	Recommendation/Solution	Responsible Party (ies)	Completion Date
Increased post-test activities	Post-test services should address the diverse needs of the community, e.g., HIV status, age, sex, and social status	VCT partnership members, **DAPP**	September 2003
	Delineate post-test reduction plan s into HIV+ and HIV- status	**ZCC**	
	Establish linkages between VCT sites and access to treatment of diseases such as STIs, TB, and access to ARVs	**Alliance**/Centre for Disease Control	June 2004
	Establish a support system for treatment adherence and sensitization strategy allowing communities to access treatments	**Alliance**/DAPP/Horizons	
	Establish a comprehensive referral system	ZVCT Partnership, CBOH, RPM+, **Alliance,** ZCC, KCTT	
	Incorporate a risk-reduction plan into the manual used to train counselors	**ZCC**	December 2003
Expand and strengthen community prevention, care, and support services	Develop a comprehensive referral system, including creating local referral guides, and formalizing referral processes and systems;	**SFH,** Alliance, NAC, CDC, ZCC	December 2003
	Consult with communities on PMTCT, treatment, and support	Alliance/**Linkages**/CIDRZ	December 2003
	Support a district network of VCT partners and production of IEC treatment materials for NGOs, CBOs, and individuals	**SFH**	
	Promote prevention work with vulnerable populations, especially girls and commercial sex workers	**SFH**/Family Health International, World Vision, Alliance	
	Support active participation in the District AIDS Task Forces and District VCT Coordinating Committees	**Alliance**/Policy Project/UNDP/DAPP	December 2003
	Establish a partnership with the District Directors of Health (DDH).	**Alliance**	
Involvement of PLWHA in prevention care and support services	Conduct more workshops on PLWHA involvement and increased advocacy to lessen HIV/AIDS-related social stigma	NZP+/DAPP/Kara/**Alliance,**	
	Prioritize different ways in which PLWHA can be involved	**NZP+,** DAPP, Kara, Alliance	
	Review current strategies and activities regarding PLWHA involvement in VCT	**DAPP**, Alliance	
	Contribute to effective and meaningful PLWHA involvement in VCT	Andy Mwale, **SFH,** NZP+/Alliance/Kara	

Table 7.2: Recommendations for VCT Program Activity: Zambia VCT Partnership Results

2 - VCT Service Delivery	Recommendation/Solution	Responsible Party (ies)	Completion Date
Efficient well-resourced testing facilities	Improve counseling and testing staff	ZVCTS/**ZCC**/Kara/Chainama	June 2004
	Increase numbers of VCT counselors and laboratory technicians at VCT facilities	ZVCTS/**ZCC**	June 2004
	Advocate for VCT to be a fully integrated section or department within health facilities, or designate persons to be exclusively responsible for VCT	**Linkages**, ZVCT Partnership	
	Display appropriate, clear, and conspicuous posters and labels for VCT	**SFH**	
	Display appropriate signs on walls indicating directions to VCT sites	**SFH**/DHMTs	
	Review counselor training and staffing to include increased numbers of elderly persons and young persons available to counsel different age groups and genders	**Chainama**/ZCC	December 2003
	Promote free VCT services for existing and new VCT facilities and agencies	**SFH**, DHMT, ZVCT Partnership	
	Consider recommendations made by RPM+ to the CBOH, NAC, and the MOH about a functional and efficient strategy or system for stock management, ordering, delivery, and distribution	SFH, **RPM+**	
	Provide filing cabinets and storage facilities in VCT sites	**Alliance**/DAPP/ZVCTS	December 2003
	Identify and resolve problems impacting some VCT sites' ability to provide same-day test results	**ZVCTS**, Alliance, Linkages	
	Improve VCT data management systems by working with ZVCTS, and a USAID-sponsored VCT data system project, in line with the NAC guidelines	**RPM+,** ZVCTS	
Improve the adherence of VCT sites to guidelines for client-friendly VCT services	Provide required amenities for counseling sites and VCT support staff; train and monitor regularly in client hospitality and other related areas	**SFH**/Alliance/DAPP	
	Advocate for policy on finger-prick and fast-testing (saliva) technologies	ZVCTS, CBOH, JICA/**Chairperson** for Partnership/USAID	
	Strengthen working partnership with NAC through VCT and CTWG	JICA/**Chairperson** for Partnerships/USAID	
Adequate number of appropriately trained counselors	Train health workers on VCT issues	**ZCC**	
	Integrate VCT into pre-service training of health workers	USAID/NORAD, **ZVCTS**, NORAD, JPHEIGO	
	Integrate VCT into the ZIHP health worker program	**Dr. Chilandu Chilaika**	
	Implement joint work planning and collaborative activities among the three training institutions	**Alliance**	December 2003
	Provide motivation for counselors	**Alliance**	December 2003
	Reorient health center staff to carry out VCT activities as part of their normal duties	DHMT/**ZCC**	

Table 7.3: Recommendations for VCT Program Activity: Zambia VCT Partnership Results

3 - Community Mobilization and Communication	Recommendation/Solution	Responsible Party (ies)	Completion Date
Improved knowledge and attitudes related to VCT	Promote messages that say most people who go for HIV testing actually test negative, to reduce fear and encourage people to go for VCT	**SFH**	
	Use mass media communication strategies as much as possible because they are more effective than other communication strategies	**SFH**/ZIHP/Linkages	
Increased community acceptance and support for VCT	Support what NGOs, CBOs, and FBOs were doing about VCT at the community level in the districts	**Alliance**/DAPP, Linkages	December 2003
	Emphasize messages on abstinence for young people, delayed first sex, sex with peers, consistent and correct condom use, and faithfulness to one sexual partner	**SFH**/Alliance	
Reduced Stigma toward PLWHA	Conduct skills-building workshops on stigma reduction in all Partnership districts	**Alliance**/Kara, DAPP	June 2004
	Intensify communication campaigns on stigma reduction, and increase involvement of the Partnership in the ICRW, KCTT, and HIV-related social stigma issues	SFH, DAPP, Kara, ZINGO	
	Promote stigma reduction work through ZINGO at both national and District levels	**ZINGO**	
	Train health workers in PLWHA-friendly health services in all Districts VCT sites and health centers	**Alliance,** DHMTs, ZVCT Partnership	June 2004
	Identify key issues that could be addressed through policy and regulatory framework	ZVCT Partnership	

VII. Conclusions

This report demonstrates the value of a participatory evaluation process in providing insights to stakeholders in the identification of evaluation issues; the evaluation design; the collection and analysis of data; and actions taken as a result of the evaluation findings. The process allowed the Zambia VCT Partnership members to reflect on their achievements and challenges; from this reflection, recommendations were developed for national- and district-level operational strategies and new program activities.

The review of achievements for the period January 2001 through October 2002 demonstrated the value of a VCT partnership within the context of Zambia, the most important of which are the collaboration and coordination of VCT services and promotion, which raise community awareness and acceptance of VCT. The results framework developed by the VCT Partnership is an important element in planning program activities. While all Partnership members are engaged in the provision of VCT services, each brings unique skills and experience to the Partnership.

In terms of the program results of the Partnership, SFH and DAPP have been active in implementing activities targeted at improved knowledge and attitudes related to VCT. The International AIDS Alliance has played a major role contributing through its activities toward increased community acceptance of and support for VCT (i.e., community dialogue and mobilization). Activities to reduce stigma toward PLWHA were implemented by KCTT, AA, DAPP, and SFH.

Several of the partners have participated in implementing activities to increase access to quality VCT services. AA and ZVCTS implemented activities that were targeted at providing efficient well-resourced testing facilities. In addition, KCTT, ZCC, and ZVCTS were active in implementing activities to make VCT sites adhere to established guidelines for client-friendly services. DAPP, KCTT, ZCC, and AA all participated in activities to improve the availability and quality of counselors at VCT sites. Post–test activities were implemented by DAPP, SFH, and ZVCTS. PLWHA involvement in prevention, support and care services were supported by activities implemented by AA, DAPP, KCTT, ZCC, and SFH.

District-level interviews with key stakeholders demonstrated the challenges that need to be overcome if VCT access is to be universal in Zambia. Staff shortage is a key challenge. Appropriate space to provide counseling also counts among key challenges to the quality of VCT service. There are several challenges in raising awareness about VCT and reducing stigma toward PLHWA. While several community-level program outputs were achieved by the Partnership, the members recognized in their deliberations that there are still inroads to be made in mobilizing communities and raising awareness and acceptance of VCT.

The evaluation demonstrates that VCT uptake is at best sluggish in an environment where the threat of HIV/AIDS is high. Even though results from the 2002 Demographic and Health Survey suggest prevalence rates among adults have dropped from previous years, the rate is still high and the trends remain the same. In their recommendations, VCT Partnership members emphasize increased use of mass-media strategies to improved knowledge and attitudes toward VCT and increased community acceptance and support for VCT. Training of counselors was recommended to increase the quality as well as remedy the shortage of counselors at VCT sites. Recommendations were also made to improve the counseling environment by making waiting rooms user-friendly and to train the support staff on customer service when receiving VCT clients.

To further improve and maintain quality VCT services, the Partnership in its recommendations emphasizes monitoring of VCT sites for quality assurance. While this seems to be a role that can be played by ZCC, there are no clear guidelines for doing this. In the years ahead, this might be an area on which the Partnership might spend some of its resources; VCT should be quality-driven, with decision-making based on data obtained through regular monitoring of sites.

Several activities are planned or recommended by the Partnership based on the findings of the evaluation. If implemented they will make significant contributions to increase demand and access to VCT services. The challenge is access to enough resources both financial and human to achieve all of these recommendations. However, with increased involvement of the communities in the activities of the partnership, the challenge is not insurmountable.

The next step is for the Partnership to identify the role each member will play in the implementation of the recommended program activities. In addition a time line should be developed and a performance-monitoring plan developed that will allow the Partnership to monitor its achievements regularly. A program-monitoring database could also add significantly to improving the monitoring and reporting of VCT activities by the Partnership members.

Appendix A

The Zambia VCT Partnership Achievements
January 2001- October 2002

1 – Increase demand for VCT Services		
Result	**Achievement**	**VCT Partner**
Improved knowledge and attitudes related to VCT	Produced and distributed 18,000 adult oriented English brochures promoting VCT	SFH
	Produced and distributed 25,000 brochures in different local Zambian languages	SFH
	Produced 10,000 and distributed 5,000 "Free Your Mind" posters	SFH
	Produced (recently) 10,000 each of 'couple' and 'girl' version of "Free Your Mind" posters to be soon distributed	
	Produced "What is VCT?" A youth-oriented VCT brochure	SFH
	Produced "Free Your Mind" jingles for use in future radio spots before the end of the year	SFH
	Produced and distributed Zambian language brochures in Silozi, Tonga, Nyanja and Bemba	SFH
	Produced and distributed 30,000 youth VCT brochures	SFH
	Attended monthly government stakeholders' meetings in districts	SFH
	Introduced awareness of, and work against, stigma issues into work place programs reaching 15 work places in Lusaka and Copperbelt provinces	SFH
	Conducted collaborative outreach programs targeted at high risk population groups	SFH
	Conducted 1 to 2 discussion shows per week on Radio Maria (Chipata) about the benefits of VCT and positive living (where program officers and participants talk about their experiences	DAPP/SFH
	Participated in the International Trade Fair and the Agricultural and Commercial Show in Ndola and Lusaka promoted the benefits of knowing ones' HIV status	DAPP/SFH
	Conducted 576 drama shows in Phase 1 districts reaching approximately 50 persons per show	SFH
	Conducted over 60 outreach activities reaching approximately1200 people	SFH
	Completed preliminary work on video, promoting VCT to youth, in Nyanja language	SFH
	Made 2 national radio presentations on VCT	AA
	Made 4 VCT shows on Club NTG, promoting VCT; reaching about 6% of the urban population	SFH

1 – Increase demand for VCT Services		
Result	**Achievement**	**VCT Partner**
	Completed formative qualitative research on VCT in Zambia, targeting youth, couples and high risk groups	SFH
	Introduced story line on Zambia's most popular soap opera – Kabanana – about VCT and need to know your HIV status	SFH
	Conducted VCT talks/presentations in schools, churches, sports clubs and bars	SFH
	Produced over 30 VCT shows for the mobile video unit reaching approximately 9000 people	SFH
Increased Community Acceptance of, and Support for, VCT (Community Dialogue and Mobilization)	Conducted full community VCT baselines in 5 districts. VCT Rapid baseline studies were conducted in 7 districts; and the partnership is planning on baseline studies in further 4 districts	AA
	Developed tools to facilitate community dialogue on VCT. These tools were piloted in Lusaka and revised taking into consideration findings from the pilot testing	AA
	Developed District action plans for expanded VCT services in 12 districts	AA
	Community mobilization and sensitization were carried in 12 districts. The partnership is planning on carrying out mobilization and sensitization in 4 additional districts during 2003	AA
	Skills building workshops were conducted in 7 districts for NGOs/CBOs/FBOs/Govt. on community mobilization. A total of 100 Organizations and 171 participants took part in these workshops	AA
	Participated in district level monthly meetings on VCT in Phase 1 Districts	SFH
Reduced Stigma towards PLWHA	Linkages were established with the ICRW/Kara Counseling study on HIV related social stigma. The partnership is also represented on the Leadership Advisory Group of the study	AA/KCTT
	Skills building workshop on stigma was conducted in Livingstone district. A total of 25 participants from 13 organizations (NGOs, CBOs, Govt. and private sector) participated in this workshop (AA)	AA
	Grants and Technical Support were provided to NZP+ for: - Strengthening the role of the network at central - Establish and/or strengthen district chapters of the NZP+ in 12 districts - Support monthly AIDS debates	AA

1 – Increase demand for VCT Services		
Result	**Achievement**	**VCT Partner**
	Provided technical support and grant to ZARAN (an association of lawyers) to address legal, ethical and human rights issues	AA
	PLWHAs are active in practical actions at stations in the community, demonstrating that PLWHAs can be valuable, productive members of the community in Phase 1 and 2 districts	DAPP
	Conducted Club NTG shows on stigma and PLWHA reaching approximately 6% of the urban youth	SFH
	Introduced work on/against stigma issues - Workplace Program – reaching more than 15 in Lusaka and the Copperbelt	DAPP
	Introduced story-line on positive living, into Zambia's most popular soap opera – *Kabanana*, reaching the entire Zambian population with access to television	SFH
	PLWHAs are active in practical actions at stations in the community, demonstrating that PLWHAs can be valuable, productive members of the community in Phase 1 and 2 districts	DAPP
	Conducted Club NTG shows on stigma and PLWHA reaching approximately 6% of the urban youth	SFH
	Introduced work on/against stigma issues - Workplace Program – reaching more than 15 in Lusaka and the Copperbelt	DAPP
	Introduced story-line on positive living, into Zambia's most popular soap opera, *Kabanana*, reaching the entire Zambian population with access to television	SFH

2 – Increased Access to Quality VCT Services		
Result	**Achievement**	**VCT Partner**
Efficient well-resourced testing facilities	Resources (grants) have been approved to be provided to 6 DHMTs, in order to enhance the VCT counseling environment	AA
	Eight (8) sites out of the targeted 12 were established in various DHMTs through the ZVCTS. These sites, like all the others, receive regular provisions of testing supplies and technical assistance through the ZVCTS arrangement	AA
	Twenty two (22) counselors were trained in HIV testing	ZVCTS
VCT sites that adhere to set guidelines for client friendly VCT services	Guidelines and protocols were developed and disseminated	ZCC/ZVCTS
	Counselors and VCT site staff were trained in client hospitality and client friendly procedures	KCTT
	Quarterly supervisory and support site visits were done	ZVCTs
	VCT sites have all been provided with guidelines and HIV testing protocols	ZVCTs
	Awareness and sensitization workshops were conducted	ZCC/KCTT
Adequate number of appropriately trained counselors	Proposals were developed and grants provided to 3 counselor training institutions	AA
	More than 450 counselors and counselor supervisors (to be included) were trained as tabulated below	Chainama/KCTT/ZCC
Counselor support and supervision mechanism developed	Curriculum for counselor supervisors developed, piloted and revised	KCTT
	Eighteen (18) counselor supervisors trained	KCTT
	Psychosocial counselors who have been providing networking and support among themselves were provided with space and infrastructure to hold their regular weekly and BI-weekly meeting	DAPP/KCTT
	Ninety One (91) counselors in the Counseling Support Groups have been providing support to one another, as at end of third quarter of 2002	DAPP
	Capacity building workshop has been provided to 70 counselors, during the period	KCTT, DAPP, Chainama, ZCC
	Supervision and support mechanisms developed	KCTT, DAPP

3 – Increased Access to Quality Prevention, Care and Support Services at Community Level		
Result	**Achievements**	**VCT Partner**
Increased Post-Test Activities	Post-test club leaders trained to give new ideas/directions to the programs for the Post-test Clubs; and in Income generating Activities	DAPP
	PLWHA trained in positive living skills and in advocacy for the same. 125 had graduated; and 147 were undergoing training at the time of the review	DAPP
	Over 400 Post-test Club members were trained in basic psychosocial, community care and mobilization. These are active country wide	DAPP
	More than 276 members of the Positive-Living Clubs are successfully giving support to PLWHA	DAPP
	Financial support is provided to post-test clubs to carry out community mobilization	ZVCTS
	SFH has managed DAPP's subcontract for post-test service	SFH/DAPP
Expanded and Strengthened Community Prevention, Care, and Services/Linkages	Church and other FBO leaders have been mobilized to involve their congregations in the awareness of, and participation in, HIV/AIDS prevention, care and support services, especially VCT; at the time of the review, more than 2,385 people from various congregations have been reached with information so far	DAPP
	Community HIV/AIDS Task Forces have been formed and supported. Members of the Task Force have been trained to coordinate and spearhead care and support activities in the community. There are 31 community task forces in the programmers to-date	DAPP
	Positive Living Training has commenced, amidst encouraging demand from the community; 100 graduates have so far undergone the training	DAPP
	The Partnership established 'focal-point' NGOs in 7 districts – Livingstone, Chipata, Kabwe, Kitwe, Ndola, Chibombo, and Mwense	DAPP
	Positive-living clubs are active in the community, sharing knowledge and advocating for VCT; with 70 very active advocates	DAPP
	Production and distribution of IEC materials for use in VCT sites for post-test issues, including brochures on STDs, nutrition, condom use and information on the meaning of HIV test result	SFH
	Proposals were developed and implementation grants to be provided to 5 NGOs to strengthen prevention and care services as well as link VCT with other health services	AA

3 – Increased Access to Quality Prevention, Care and Support Services at Community Level		
Result	**Achievements**	**VCT Partner**
	Strategic planning and proposal development done and grant provided to ZINGO to strengthen the faith response to HIV/AIDS	AA
Increased PLWHA Involvement in Prevention, Support, and Care Services	The study on the involvement of PLWHA in the delivery of community based prevention, care and support services in Zambia was carried out, completed, documented and circulated	AA
	Assessment was conducted and a strategy developed on expanding and strengthening PLWHA involvement in HIV/AIDS programs in Zambia through the Alliance, NGOs, CBOs and ZIHP	AA
	Regional Workshop conducted in Zambia on PLWHA involvement in HIV/AIDS programming. This workshop was facilitated by NZP+ and 6 Zambian participants took part	AA
	At least 3 PLWHAs from each district received training-of-trainers for PLA clubs	AA
	PLWHA are on staff at stations in various positions; with 16 "visible" PLWHA to-date	DAPP
	Post-test club and its graduates participate in monthly campaign at each station. There has been about 540 "activists" and about 6,533 participants	DAPP
	PLWHAs supported to establish IGAs, with some significant improvement in community activities (…people benefited from this support) – (DAPP) Alliance Work place HIV/AIDS finalized and instituted	AA
	NZP+ presented weekly radio program on PLWHA involvement and social stigma	AA/NZP+
	Twenty four (24) known PLWHA trained as counselors	Kara/ZCC
	Advocates have continued to support reduction of stigma by participating in training of anti-AIDS clubs in schools. Seventy Two Thousand (72,000) pupils were reached in 2002	DAPP
	One (1) PLWHA peer educator was formally trained as VCT counselor, while 8 peer educators were offering informal counseling support sessions	DAPP
	Two (2) PLWHA were involved in referral network /capacity building	ZCC
	PLWHA have been involved in discussing their experiences and answering questions at various events, e.g. World AIDS Day and local music concerts	DAPP
	Recruitment of Technical Support Specialist: PLA Involvement, is underway	AA

3 – Increased Access to Quality Prevention, Care and Support Services at Community Level		
Result	**Achievements**	**VCT Partner**
	Wider dissemination of the PLWHA involvement study was carried out, promoting employment of PLWHA in the partnership and other organizations	SFH

Appendix B

Phase 1 VCT Consultation Questionnaire Zambia VCT Partnership

District: Livingston_____ Lusaka_____ Kabwe_____ Chipata_____

Name of Interviewer: _____

Name of Respondent: _____

Title of Respondents:_____

Organization of Respondent:_____ _

A. Perception of the VCT Partnership by District Stakeholders	
1. How many NGOs in this district focus on providing VCT?	
2. Briefly describe the role of the key VCT partners in this district.	
3. Please describe the relationship between the VCT task force in your district and the DHMT.	
4. How would you describe the perception of VCT Partnership by the VCT stakeholders in this district?	
5. In your opinion, how can the VCT Partnership in this district be strengthened?	
B. Utilization of VCT Services	
1. What month and year was this VCT site opened?	Month_____ Year:_____
2. What are the hours of service?	_____ a.m. to _____p.m. Other:_____
3. How many tests do you conduct per month?	
4. What is the minimum, maximum, and average waiting time to receive pre-test counseling?	Minimum time: _____ Maximum time: _____ Average time; _____
5. What are the minimum, maximum, and average waiting time between taking the test and receiving results?	Minimum time: _____ Maximum time: _____ Average time; _____
C. Referral System	
1. Is there a post-VCT referral system in place?	Yes: _____ No: _____ ◄----- Skip to
2. How many referrals do you make monthly?	
3. What do you commonly make referrals for?	
4. Do you think there are gaps in the referral system?	Yes_____

	No: _____
5: If YES, what are these, and how can the system be strengthened?	
D. Support System and its Use	
1. How many counselors work at this facility?	
2. How many of these counselors have received training (formal or in-service) in counseling?	
3. How many counselors are available at this site at any one time?	
4. Are there mechanisms for support and supervision of counselors?	Yes:_____ No: _____
5. How many counselors received supervision this month?	
6. What would you say are the difficulties in conducting VCT?	
7. How does your organization or facility cope with them?	
E. Post-Test Services	
1. Do you have post-test groups?	Yes:_____ No: _____ ◄----- Skip to
2. How many post-test groups do you currently have?	
3. What is the average number of people per group?	
4. What is the total number of people attending your post-test groups?	
5. What types of activities are conducted by the post-test groups?	
6. How is VCT promoted in your district?	
7. What type of VCT sensitization activities do you conduct with the DHMT?	
8. Are there any issues of stigma around VCT in your community?	Yes:_____ No: _____
9. If YES, briefly describe these issues	
F. VCT Site Assessment	
1. What is the location of the VCT site?	
2. Where is counseling done?	In a separate room: _____ In the corridor: _____ In a building outside main facility:___ Other (Specify): _____
3. Where is testing done?	In a separate room: _____ In the corridor: _____ In a building outside main facility:___ Other (Specify): _____
4. In your estimation, is there appropriate privacy in the	Yes:_____

provision of VCT?	No: _____
5. Is there confidentiality when test results are given to clients?	Yes:_____ No: _____
6. How many laboratory technicians work in this VCT facility?	
7. Have you run out of any of the following within the last month?	Test kits Yes_____ No _____ Reagents: Yes _____ No _____ Needles: Yes _____ No _____ Syringes: Yes _____ No _____
8. How would you describe your communication with the supplier (MSL)?	
9. Are there any gaps in the delivery system of VCT materials?	Yes:_____ No: _____
G. Availability and Use of IEC	
1. Are BCC/IEC materials available at this VCT site?	Yes:_____ No: _____
2.In what languages are these materials?	English: _____
3. What type of BCC/IEC materials do you have?	Brochures: _____ Flyers: _____ Posters: _____ Other (specify): _____
4. What is the demand for these materials?	Very High: _____ High: _____ Low: _____ Very Low: _____
5. Who is the supplier of the IEC materials used by the VCT site?	
Do you have any other comments regarding VCT in this district?	

Appendix C

Organizations Contacted during the District Consultation in Chipata

No.	Name	Organization	Position
1.	Dr. Priscilla Manase Zulu	District Health Management Team	Director
2.	Mr. Patrick Mbewe	District Health Management Team	Manager Planning and Development
3.	Ms. Milika Malata Nyirenda	District Health Management Team	Manager Administration
4.	Mr. George Mwakanandi	Chipata General Hospital	Laboratory Technician/ VCT Coordinator/ Counselor
5.	Mrs. Nisi M'hango Tembo	Kapata Clinic	VCT Coordinator/ Sister In- Charge
6.	Ms. Mable T. Sakala	Kapata Clinic	HIV/AIDS Counselor
7.	Mr. John Ntapisha	Kapata Clinic	Laboratory Technician
8.	Ms. Given Malama	DAPP HOPE Station	Project Leader
9.	Mr. Joseph Nguvulu	DAPP HOPE Station	Programme Officer
10.	Mr. Edson Daniel Daka		Counselor
11.	Mr. Bennett Siachoono	Lutheran World Federation	Project Manager
12.	Mr. Mr. Rodgers Siyingwa	Lutheran World Federation	Technical Adviser Health and HIV/AIDS Prevention
13.	Mr. Doctor Jinja	Society for Family Health	VCT Coordinator
14.	Ms. Sharon Phiri	Society for Family Health	Communications Assistant
15.	Mrs. Magdalene Mwale	Families In Distress	Assistant Coordinator
16.	Mrs. Dorothy Shamakanda	Tikondane HIV/AIDS Prevention Project	Assistant Coordinator
17.	Mr. Ernest Kabilansando	Tikondane HIV/AIDS Prevention Project	Peer Educator/Coordinator

Organizations Contacted during the District Consultation in Kabwe

No.	Name	Organization	Position
1.	Mrs. Kate Kabwe	Acting Director	District Health Management Team
2.	Ms. Eva M.M. Wonani	Clinical Care Expert	District Health Management Team
3.	Mr. Patson Mwandu Chibwe	Zambia Enrolled Nurse ***Psychosocial Counselor***	Mahatma Gandhi Clinic
4.	Mr. Raymond Chombana	Medical Laboratory Technician	Mahatma Gandhi Clinic
5.	Ms. Mary Namata	Enrolled Nurse	Mahatma Gandhi Clinic
6.	Ms. Mary Mutali	Environmental Health Technician	Mahatma Gandhi Clinic
7.	Ms. Georgina Mwamba	Acting Nursing Officer/ Counseling Supervisor	Kabwe General Hospital - Medical Department
8.	Mr. Joshua Muzyamba	Laboratory Technician VCT Coordinator	Kabwe General Hospital
9.	Ms. Georgina Belemu	Zambia Enrolled Nurse Counselor	Pollen Clinic
10.	Ms. Martha Kyalusanza	Programme Officer	DAPP HOPE Station
11.	Mr. Wibon Muntanga	VCT Site Coordinator	Society for Family Health
12.	Mr. Lewis Sinyinza	Sales Representative	Society for Family Health
13.	Mrs. Yoccobeth A. Simutanyi	Coordinator	Kabwe Adventist Family Health Institution

Organizations Contacted during the District Consultation in Livingstone

No.	Name	Position	Organization
1.	Dr. Jelita. Chinyonga	Director	District Health Management Team
2.	Mr. Ronald Akakakulubelwa	HIV/AIDS Coordinator	District Health Management Team
3.	Mr. Harnony Hamilimo	Laboratory Technician	Maramba Clinic
4.	Mr. Richard Mwanza	Laboratory Technician	Livingstone General Hospital
5.	Mr. Geoffrey Ngulube	Counselor Support Group Coordinator	DAPP HOPE Station
6.	Mr. J Jabbez Kanyanda	Trainee Psycho-social Counselor	DAPP HOPE Station
7.	Ms. Heille Schlickum	German Development Service	Society For Family Health
8.	Mr. Dennie Hamoonde	VCT Site Coordinator	Society For Family Health
9.	Ms. Cheep Buumba	Senior Communications Assistant	Society For Family Health
9.	Mrs. Regina Chiyunza Akakakulubelwa	Counselor HIV Test Assistant (Nurse)	Maramba Clinic
10.	Ms. Francescan Nyambe	Counselor (Nurse)	Livingstone General Hospital.

Organizations Contacted during the District Consultation in Lusaka

No.	Name	Position	Organization
1.	Dr. Moses Sinkala	Director	District Health Management Team
2.	Mr. Graham Samungole	ASTLP Coordinator	District Health Management Team
3.	George Ngwenya	HIV/AIDS District Programme Officer	District Health Management Team
4.	Mrs. Queen Naulapwa Chisanga	Assistant HIV/AIDS District Programme Officer	District Health Management Team
5.	Mrs. Dorothy Zgambo	Secretary	District Health Management Team

Appendix D

VCT Partners Who Attended the Review Meeting at Lilayi Lodge

No.	Name	Position	Organization
1.	Dr. Karen Shelley	Senior Technical Advisor for HIV/AIDS and Child Survival	USAID
2.	Ms. Chris Maclanachen	Senior Programme Officer	International HIV/AIDS Alliance
3.	Mr. Daphetone Siame	Country Director	Alliance Zambia
4.	Mr. Andrew Mlewa	Technical Support Provision Specialist	Alliance Zambia
5.	Ms. Shannon England	Technical Advisor	SFH
6.	Mr. Collin Sikwibele	VCT Communications Coordinator	SFH
7.	Ms. Jane Jensen	Managing Director	DAPP
8.	Ms. Wendy Dunnett-Dagg	HOPE Station Coordinator	DAPP
9.	Mr. Ernest Sibande	HOPE Station Leader	DAPP
10.	Mr. Hector Chiboola	General Secretary	ZCC
11.	Mr. Pascal Kwapa	Chairperson	ZCC
12.	Mr. Bristol Cheembo	Coordinator	ZVCTS
13.	Mr. Cuthbert Mumbi	Accounts and Logistics	ZVCTS
14.	Mr. Patrick D. Mwanza	Consultant	Synergy Project
15.	Ignatius Kayawe	Consultant	Synergy Project

Appendix E

References

Becker, M. 1974. "The health belief model and personal health behavior." *Health Education Monograph* 2: 324- 508.

Cameron, K.S., and D.A. Whetten. 1984. *Developing Management Skills.* London: Scott, Foresman and Company.

Central Board of Health/Ministry of Health. 1999a. *HIV/AIDS in Zambia. Background, Projections, Impacts and Interventions.* Lusaka, Zambia.

_____.1999b. *Zambia HIV Sentinel Surveillance. Time Trends in the HIV Epidemic in the 1990s*. Lusaka, Zambia.

Central Statistics Office. 1998. *Living Conditions Monitoring*. Lusaka, Zambia.

Central Statistics Office/Ministry of Health. 1997. *Zambia Demographic and Health Survey 1996.* Macro International Inc.: Calverton, Maryland.

_____. 2000. *Zambia Sexual Behavior Survey 2000.*

_____. 2002. *Zambia Demographic and Health Survey 2001-2002.*

Chanda, C., and R. Baggaley. 1994. "Does counseling help to empower women to negotiate for safer sex?" Presented at the *10th International Conference on AIDS,* Yokohama, Japan, Abstract 063D.

Family Health International/IMPACT. 2000a. *Round 1 Behavioral and Biologic Surveillance Survey Zambia 2000. Long Distance Truck Drivers.* Arlington, Virginia.

_____. 2000b. *Round 1 Behavioral and Biologic Surveillance Survey Zambia 2000. Female Sex Workers.* Arlington, Virginia.

Horizons and International HIV/AIDS Alliance. 2002. *The Involvement of People Living with HIV/AIDS in the delivery of community-based prevention, care and support services in Zambia. A diagnostic study.*

International AIDS Society. 2002. *IAS Newsletter,* 22: 24

International HIV/AIDS Alliance. 2000a. *Chipata District VCT Planning Meeting Report, 27–29 September 2000.*

_____. 2000b. *Livingstone District VCT Planning Meeting Report, 18–20 October 2000.*

_____. 2000c. *Expanding and Improving Voluntary Counseling and Testing in Zambia. Current needs and Future Strategies.*

_____. 2001a. *Assessment and Strategy Development for An Expanded and Strengthened HIV/AIDS prevention and care response in Lusaka's Mtendere Compound, with a specific focus on VCT Service provision and mobilizing community support and demand for VCT Services. Report for District Level Discussion.*

_____. 2001b. *Zambia VCT Core Partnership Retreat.*

_____. 2002. *AIDS Alliance – The Involvement of People Living with HIV/AIDS (PLWHA) in the Delivery of Community-Based Prevention, Care and Support Services in Zambia.*

Kamwanga, J. 2001. *Overview of Studies on the Impact of HIV/AIDS in Zambia, Research and Policy Issues.* Zambia Social Investment Fund, Ministry of Finance and Economic Development (unpublished).

Kayawe I., et al. 1998. "Client's views on HIV Counseling and Testing–Is it helpful?" Presented at the *12th World AIDS Conference*, Geneva, Switzerland, Abstract 33265.

Ministry of Finance and National Planning. 2002. *Zambia Poverty Reduction Strategic Paper 2002–2004.* Lusaka, Zambia.

Muhwava, W.; and T. Kusanthan. 2002. *Analysis of Client Intake Data at the New Start Center in Lusaka, Zambia.* Society for Family Health.

National HIV/AIDS/STD/TB Council. 2000. *Strategic Framework 2001–2003.* Lusaka, Zambia.

National HIV/AIDS/STI/TB Council. 2002. *National HIV/AIDS/STI/TB Intervention Strategic Plan 2002–2005.*

Ndubani, P. 2001a. *Expanded HIV/AIDS Prevention Program and VCT Strengthening in Zambia. Community Baseline Survey, Lusaka District Report.* International HIV/AIDS Alliance.

_____. 2001b. *Expanded HIV/AIDS Prevention Program and VCT Strengthening in Zambia. Community Baseline Survey Chipata District Report.* International HIV/AIDS Alliance (unpublished).

_____. 2001c. *Expanded HIV/AIDS Prevention Program and VCT Strengthening in Zambia. Community Baseline Survey Kabwe District Report.* International HIV/AIDS Alliance (unpublished).

_____. (2001d). *Expanded HIV/AIDS Prevention Program and VCT Strengthening in Zambia. Community Baseline Survey Livingstone District Report.* International HIV/AIDS Alliance (unpublished).

Orobaton, N., C. Mukuka-Chilaika, S. Mutonyi, C. Mukwakwa, and A. Mlewa. 2001. *Responding to the dynamic complexity of the HIV/AIDS epidemic in Zambia: The case of community-based Thandizani NGO* (unpublished).

Senge, P. 1994. *The fifth discipline: The art and practice of the learning organization* (First paperback ed.) New York: Doubleday.

Society for Family Health. 2002a. *Formative Qualitative Research for Voluntary Counseling and Testing (VCT) Communications in Zambia.* Lusaka, Zambia.

_____. 2002b. *Multiround Survey of Youth, Round I 2002.*

Stall, R.; T. Coates, and C. Hoff. 1988. "Behavioral risk reduction for HIV infection among gay and bisexual men" *American Psychologist* 43: 878–85.

UNAIDS. 2001. The Impact of Voluntary Counseling and Testing: A global review of the benefits and challenges. http://www.unaids.org.

VCT & Care Working Group. 2002. Activity and Progress Report for the half year period January 1–July 31, 2002 submitted to the NAC, September 2002 Council Meeting.

Voluntary HIV-1 Counseling and Testing Efficacy Study Group. 2000. "Efficacy of Voluntary HIV-1 Counseling and Testing in individuals and couples in Kenya, Tanzania and Trinidad: A randomised trial." *Lancet* 356: 103–12.

Zambia Counseling Council. 2001a. *Inventory and Appraisal of Counsellors in twelve districts in Zambia.* Lusaka, Zambia: Zambia Printing Company.

_____. 2001b. Report on the Capacity Building Workshop, December 17–20, 2001.