No.

ザンビア国
国境におけるHIV/エイズ及び性感染症啓発活動
プロジェクト
終了時評価調査報告書

平成 18 年 4 月
(2006年)

独立行政法人　国際協力機構
ザンビア事務所

ザン事
JR
06-02

目　　　　次

序　　文

ザンビア共和国における2004年の同国の一人当たり国民総所得は、450ドル（世界銀行；2004）と依然として後発開発途上国に分類され、１日１ドル以下の生活を余儀なくされる国民は全人口の64％といわれています。ザンビア共和国では、他の南部アフリカ諸国と同様にHIV／エイズの拡大が深刻な問題となっており、15歳から49歳の生産年齢におけるHIV感染率は約16％、特に15歳から24歳までの女性の感染率は男性のそれに比べると約４倍と高く、この国を担う若年層へ大きな打撃を与えています。

このような状況に鑑み、国家HIV／エイズ・性感染症・結核戦略計画（2001～2005）は、HIVの感染拡大の危険があるハイリスクグループ（性産業従事者及びそのパートナー）を対象にした取り組みを強化しています。

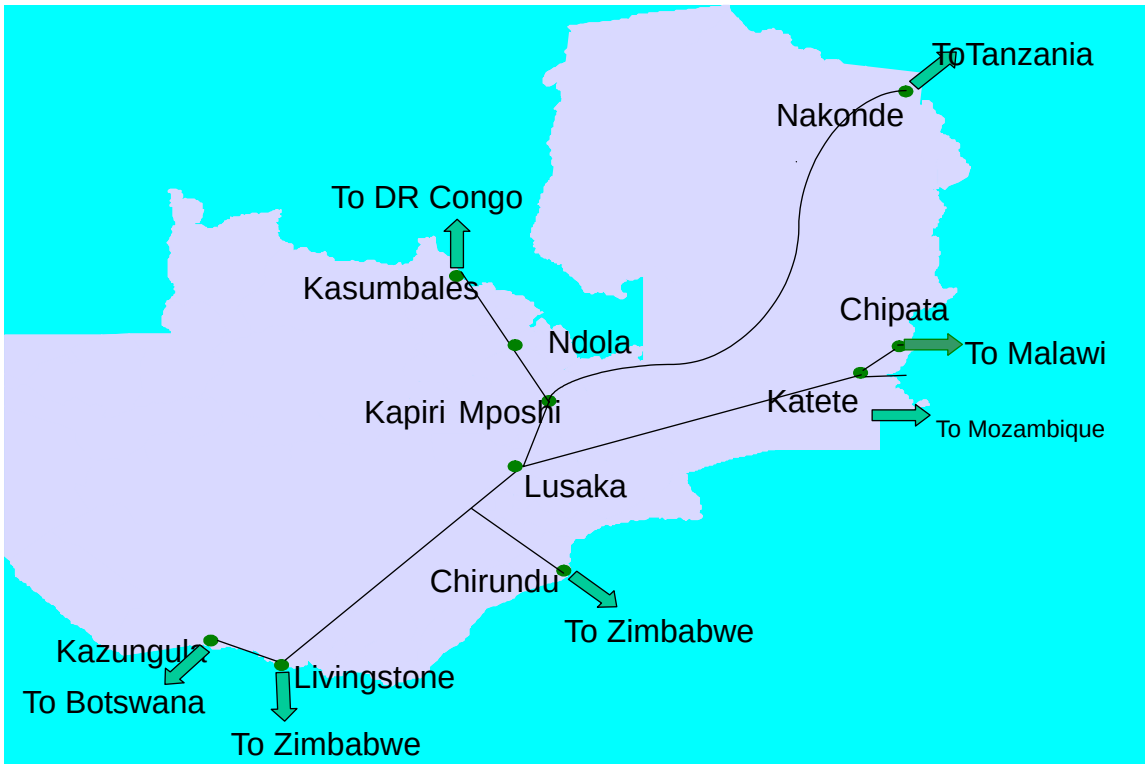
本プロジェクトは、「保健分野における日米パートナーシップ」のもと、2003年６月から2006年３月まで、８つの国々に囲まれた内陸国であるザンビア共和国の国境地域において、HIVに対し脆弱なハイリスクグループを対象とした活動を展開したものであり、日米両国が効果的に連携した案件といえます。

本調査は、プロジェクトの終了時評価調査の結果を取りまとめたものであり、ここに調査にご協力を賜りました関係各位に対しまして、深甚なる謝意を表します。

平成18年４月

独立行政法人国際協力機構
ザンビア事務所長　乾　英二

プロジェクトサイト対象地域地図



長距離トラック運転手に啓発活動をするプロジェクトスタッフ及びJICA専門家

国境地域の町の様子。長距離トラックが長い列を作っている。

啓発活動の劇の練習をするピア・エデュケーター達

略　語　表

AIDS	Acquired Immunodeficiency Syndrome	後天性免疫不全症候群（エイズ）
ART	Anti-retroviral Treatment	抗レトロウイルス薬療法
ARV	Anti-retroviral	抗レトロウイルス薬
DHMT	District Health Management Team	郡保健管理チーム（ザンビア基本行政単位である72郡の保健行政を所掌する組織）
FHI	Family Health International	本プロジェクトを実施するNGO連合体の代表（米国NGO）
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	世界エイズ・結核・マラリア対策基金
HIV	Human Immunodeficiency Virus	ヒト免疫不全ウイルス
HMIS	Health Management Information System	保健管理情報システム
JICA	Japan International Cooperation Agency	国際協力機構
NAC	National HIV/AIDS/STI/TB Council	国家エイズ／性感染症／結核対策評議会
NGO	Non-Governmental Organization	非政府組織
PEPFAR	President’s Emergency Plan for AIDS Relief	米国大統領エイズ救済緊急計画
USAID	United States Agency for International Development	米国国際援助庁
VCT	Voluntary Counseling and Testing	自発的カウンセリング及び検査

評価調査結果要約表

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<tr><td rowspan="3">協力期間</td><td rowspan="3">2003年６月６日から
2006年３月31日</td><td>先方関係機関：保健省</td></tr>
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技術協力プロジェクト「エイズ及び結核対策プロジェクト」
医療特別機材「エイズ対策及び血液検査医療特別機材」
無償資金協力「第一次、第二次感染症対策計画」
在外基礎調査「パイロット地域におけるVCTサービス実施能力強化プロジェクト」
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<tr><td colspan="3">１－１　協力の背景と概要
1999年４月より４年間日米連携の枠組みにて実施した開発福祉支援事業「HIVハイリスクグループ啓発活動プロジェクト」の後継案件として開始した案件である。開発福祉支援事業では、ハイリスクグループといわれる性産業従事者及び長距離トラック運転手等のパートナーに対し、性感染症の治療管理の強化、行動変容のため啓発活動の奨励、コンドームの使用の促進、等を実施し、各プロジェクトサイトでの性感染症治療体制の整備、同僚等に対し啓発活動が実施可能な性産業従事者数の増加、ソーシャルマーケティングを通じたコンドーム配布体制の拡大等が確認された。
しかしながら、ハイリスクグループの性行動に関する変容は、文化的、経済的な背景も含めそのアプローチ方法を確立していくには更なる時間を要するとの結論に至り、2003年から新たに技術協力プロジェクトとして協力を開始した。日米連携の枠組みは継続しつつ、USAIDはFHIに資金を拠出する一方、JICAは実施委託団体であるNGOのWorld Visionザンビアに対し専門家派遣、研修等の技術協力を行い、共同で計画、実施、モニタリング及び評価を実施した。

１－２　協力内容
（１）上位目標
ザンビア国におけるHIV感染率が低下する。

（２）プロジェクト目標
国境地域におけるハイリスクグループ（性産業従事者及びそのパートナー）のHIV感染率が低下する。

（３）成　果
１．ハイリスクグループ間において、性感染症治療に関して質の高いサービスが提供されその</td></tr>
</table>

受診率が向上する。

２．ハイリスクグループ間において、コンドームの使用が促進（安全な性行動への変容）される。

３．国境地域における準ハイリスクグループの、HIV／エイズ及び性感染症への知識が向上し、コンドームの使用が促進される。

（４）日本側投入

現地活動費　0.48億円　　短期専門家１名

１）現地活動費（JICA分）（性感染症治療薬購入、プロジェクト活動経費、研修経費等）

2003年度：16,075千円

2004年度：16,924千円

2005年度：14,873千円

内訳（千円）

年　度	管理費	資機材（性感染症治療係る薬剤・機材等）	研修・ワークショップ等	その他（教材開発等）
2003	4,018	4,020	5,626	2,411
2004	7,615	9,308	－	－
2005	6,841	6,991	1,041	－

資機材の購入実績の詳細については、付属資料３の（１）参照。

２）専門家派遣実績

沢崎　康：2004年２月10日から2004年３月８日

指導科目：プロジェクトモニタリング及び評価

（５）米国側投入

約8.8百万ドル（プロジェクトを実施するNGO職員の人件費など）

２．評　価

（１）妥当性

以下のことから、案件の妥当性は高いと判断される。

・ザンビアの15歳から49歳におけるHIV感染率は約16％（ザンビア人口動態保健調査：2002）と南部アフリカ地域の中でも非常に高く、同国の社会経済発達の阻害要因になっていることから、エイズ対策支援は人道的見地や保健開発支援の観点のみではなく、社会経済開発支援の観点からも重要である。

・国家エイズ／性感染症／結核対策評議会は、「国家HIV／エイズ／性感染症／結核戦略計画（2002－2005）」を策定し、青少年及び女性におけるHIV／エイズ及び性感染症の感染を軽減することを目標の一つとして推進している。

・周辺諸国からのエントリーポイントとなる国境地域、及び国境に近い都市部にプロジェクトサイトを設定したことにより、同地域に集中するハイリスクグループに直接支援することが可能となった。

・HIV感染者に対する質の高い治療へのアクセス拡大を目標とするわが国のHIV／エイズ分野

における協力プログラムとの整合性も確保されている。
・HIVに対し脆弱なハイリスクグループに絞り込んだ活動は、社会的に弱い立場にある人々に確実に届く活動として、「人間の安全保障」の考えに合致している。

（２）有効性

以下のことから、案件の有効性は高いと判断される。

２年毎に実施されるZambia Antenatal Clinic Sentinel Surveillanceでは、妊産婦のHIV陽性率を測定している。本プロジェクトでは活動地域毎のハイリスクグループにおけるHIV感染率について測定したデータはないものの、ハイリスクグループに一定の割合を占める15歳から19歳までの妊産婦のHIV陽性率について、２つのプロジェクト活動地点において開始前の2002年に比べ、開始後の2004年の数値が低下している。

このことにより、本プロジェクトがハイリスクグループのHIV感染率を低下させる効果的な活動を展開したことを窺うことができる。

調査地点	2002(%)	2004(%)
リビングストン (Livingstone)	24.1	11.7
カピリ・ムポシ (Kapiri Mposhi)	20.5	14.4

（Zambia Antenatal Clinic Sentinel Surveillance Report 1994-2004）

一方、旧開発福祉支援事業からのプロジェクト活動を通じ、ハイリスクグループにおいてHIV感染の拡大に結び付く性感染症の罹患状況について、下記１）及び２）の成果が確認された。これは、全てのプロジェクトサイトに設置されたDrop in Centre（支援を必要とする人々が性感染症の治療を受けたり、HIV／エイズ等に関する情報を得るために立ち寄る場所）で常時治療薬が整備される等、性感染症の治療が可能となり、プロジェクト期間中はハイリスクグループが差別を受けることなく、継続的に治療を受けることができたことが大きいと思われる。

１）性産業従事者間の性感染症の罹患率（その年から遡り過去12ヶ月）は、中間実績では上昇を見せたが終了時評価時にはやや減少した。

	2000 (ベースライン)	2003 (中間実績)	2006 (終了時実績)
性器分泌物	107／401 (26.6)	217／574 (38.4)	211／736(27.3)
性器潰瘍	128／399 (31.4)	214／575 (37.2)	212／727(36.8)

（Behavioral Surveillance Survey (BSS) 2006）（カッコ内は%）

２）性産業従事者のパートナー（長距離トラック運転手）における性感染症の罹患率（その年から遡り過去12ヶ月）は、2000年から2006年かけて減少した。

	2000 （ベースライン）	2003 （中間実績）	2006 （終了時実績）
性器分泌物	36／562（6.4）	32／565(5.7)	24／901（4.9）
性器潰瘍	30／562（5.3）	47／587（5.6）	25／901（2.8）

（Behavioral Surveillance Survey (BSS) 2006）（カッコ内は%）

また、啓発活動に関しても、以下の成果が達成されている。

3）性産業従事者の、金銭を介するパートナーとの間でコンドームの使用率が上昇した。

	2000 （ベースライン）	2003 （中間実績）	2006 （終了時実績）
前回の性交渉時におけるコンドーム使用	200／403(49.6)	313／573(54.6)	575／732（78.6）

（Behavioral Surveillance Survey (BSS) 2006）（カッコ内は%）

4）ピア・エデュケーター（同じような境遇に置かれた人々：ここでは性産業従事者）の投入により、性産業従事者に対して行動変容促進のためのグループワーク、個別啓発活動等を行い、性感染症及びHIVに係る知識の向上が確認された。

	2000 （ベースライン）	2003 （中間実績）	2006 （終了時実績）
HIVに関する正確な知識	248／399(62.2)	333／564(59.0)	502／719（69.8）

（Behavioral Surveillance Survey (BSS) 2006）（カッコ内は%）

更に、以下の点が考察される。

・VCTを活動に組み入れたことから、性産業従事者におけるVCTサービスの利用者率が向上した。

	2000 （ベースライン）	2003 （中間実績）	2006 （終了時実績）
性産業従事者におけるVCTサービス利用者率	55／398（13.7）	86／569(15.1)	363／729(49.8)

（Behavioral Surveillance Survey (BSS) 2006）（カッコ内は%）

・性感染症及びHIV抗体検査の実施状況が各郡保健管理チームに報告され、HMISを通じ国家統計に反映されているなど、保健行政機関からプロジェクトの直接裨益者までをカバーする包括的な事業運営が実施された。

（3）効率性

以下のことから、案件の効率性は高いと判断される。

・本プロジェクトでは、60万人以上が行動変容に係る啓発活動に参加し、更に3.3万人以上のハイリスクグループが性感染症の治療を受ける、８千人近くがHIVのテスト及びカウンセリングを受ける、などの成果が上げられている。
・JICAの予算はUSAIDの約20分の１程度であったにも拘わらず、制度上USAIDが供与できない性感染症治療薬をJICAが支援するなど、相互に補完できる体制を構築し日米連携のメリットを十分享受することができた。
・日本人専門家の投入は初年度１名のみであったが、その後はJICA専門家「HIV／エイズ及び結核対策支援プログラム・コーディネーター」がFHIの専門家と共同でモニタリングを実施するなど、本案件以外の日本側のリソースを活用し、コスト面での効率性を高めるよう取り組んだ。
・適切な資機材調達、及び各サイトの備品管理簿等の整備を通じ、機材の効率的な運用に取り組んだ。

（４）インパクト

プロジェクト活動地域では妊産婦のHIV陽性率は低下していることから、HIV感染の活発な地域における予防啓発活動が、今後「ザ」国全体のHIV感染率の低下に貢献していくことは十分考えられる。

また、関係者へのインタビュー結果では、プロジェクトが地域にもたらした正の波及効果として、以下の点が指摘されている。

・啓発活動（寸劇やポスター等）により、一般住民のHIV／エイズ及び性感染症に対する知識が向上し、地域の性産業従事者のパートナーの性感染症治療へのアクセスが可能となった。
・性産業従事者への偏見、差別が緩和し、当事者同士の支援グループの活動が活発化することで、性産業従事者の存在が地域住民に受け入れられるようになった。
・関係機関、運送会社間での連携が強化され、職場での啓発活動が展開されるようになった。

（５）自立発展性

日米連携の枠組みで実施した結果、自立発展性において以下にあるような制約が発生したと考えられる。

例えば、質の高い性感染症の治療、VCTサービス等は、活動期間中はプロジェクトとDHMTとの連携を通じて、ハイリスクグループの性感染症罹患率の低下、啓発活動に成果を上げてきた。

そして、プロジェクト終了後は、ザンビア政府により、地域とDHMTとのリフェラルシステムの更なる強化及び性感染症の治療、VCTサービス等に必要な資機材の適切な供与等が確保されることで、プロジェクトの成果が維持、拡大されることになるが、米国側の援助手法（現地NGOへ技術協力を委託し、限られた期間内で指標に基づく成果実現に集中すること、等）と調整することが求められた結果、JICA独自でプロジェクト期間中に上記の自立発展性を意識した活動が十分行うことが困難な面があった。

また、性産業従事者といった、移動が多く一般の地域住民とは生活様式が異なるグループに対する直接的なアプローチは、ピア・エデュケーター等の地域で啓発活動に関わるスタッフの能力向上には貢献したが、上記のとおりザンビア政府の継続的な支援が確保されない限り、性感染症の治療等に携わる一般の保健医療施設においてプロジェクトの成果が定着するまでには、一定の時間を要するものと考えられる。

３．特記事項（提言・教訓等を含む）

本プロジェクトは、プロジェクト期間中に米国政府から「大統領エイズ救済緊急計画(PEPFAR)」により巨額の資金が投入されたこともあり、プロジェクトサイト及び活動範囲の拡大が図られた。それによって直接裨益者が増加するという利点も見られたが、拡大したプロジェクトを維持するために参加するNGOの数を増加し、それに伴い実施体制を再構築することに時間が費やされた。

このような日米間におけるプロジェクト管理サイクルの相違、且つ援助手法の相違（JICAは、専門家による直接的な技術協力を含んでいるのに対し、USAIDは全面的にNGOに技術協力を委託している点）等の共通認識を深める必要があった。

本プロジェクトにより、性産業従事者という生命、生活及び尊厳が脅かされ且つ社会的に弱い立場にある人々が疾患に対して正確な知識を身につけ、コンドームを使用することにより自らを性感染症から守り、安全な性行動を実施するとともに、彼（女）らに必要な治療サービスを提供することは、彼（女）らの社会的な脆弱性を克服し、将来はその能力強化（エンパワーメント）をも促進することが期待される。そのためにもザンビアの社会が彼らの自立を経済的な側面も含めてどう保障していくかが課題となろう。

４．付属資料

・プロジェクト終了時評価調査報告書（英文）
・プロジェクト開始時ミニッツ（2003年６月）
・プロジェクト作成の評価用資料

付　属　資　料

１．プロジェクト終了時評価調査報告書（英文）

２．プロジェクト開始時ミニッツ（2003年６月）

３．プロジェクト作成の評価用資料

（１）投入実績及び活動実績

　１）研修・活動投入 Track Record of Training and Activities

　２）資機材購入リスト Track Record of Provision of Equipment

（２）成果品リスト List of Project Productions

　１）ガイドライン・マニュアル及び調査報告書一覧

　List of Publications (Guidelines and Researches)

（３）評価指標（要約）

（2000年、2003年、2006年 Behavioral Surveillance Survey）

CORRIDORS OF HOPE PROJECT
FINAL EVALUATION REPORT

-Report based on three sites: Kapiri Mposhi, Livingstone and Lusaka -

Evaluation carried out by:
Jolly Kamwanga
Joseph Simbaya
Charles Luhana

The study was commissioned by the Japan International Cooperation Agency (JICA), and the United States Agency for International Development (USAID) and financed by JICA.

February, 2006

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DISCLAIMER

This report does not reflect the views of the financiers Japanese International Cooperation (JICA) or the United State Agency for International Development (USAID), but is an evaluation of the Impact of Corridors of Hope (COH) based on data collected from secondary sources and interviews of stakeholders.

ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
ARV	:	Anti-Retroviral
BCC	:	Behavior Change Communication
CBH	:	Central Board of Health
CBO	:	Community Based Organization
COH	:	Corridors of Hope
CSW	:	Commercial Sex Worker
DATF	:	District AIDS Task Force
DHMT	:	District Health Management Team
FBO	:	Faith based organization
FGD	:	Focus Group Discussion
FSW	:	Female Sex Worker
GD	:	Group Discussions
GIPA	:	Greater Involvement of People Living with AIDS
GRZ	:	Government of the Republic of Zambia
HIV	:	Human Immunodeficiency Virus
IEC	:	Information, Education and Communication
IDI	:	In-depth Interview
IGA	:	Income Generating Activities
JICA	:	Japan International Cooperation Agency
M & E	:	Monitoring and Evaluation
MSF	:	Med Sans Frontier
NGO	:	Non Governmental Organization
NZP+	:	Network for Zambian People Living with HIV/AIDS
OVC	:	Orphans and Vulnerable Children
ORW	:	Outreach Worker
PLHA	:	People Living With HIV/AIDS
PMT	:	Project Management Team
PMTCT	:	Prevention of Mother to Child Transmission of 'HIV€ 31
RPR	:	Rapid Plasma Reagin
RHAP	:	Regional HIV/AIDS Project of USAID
STDs	:	Sexually Transmitted Diseases
STI	:	Sexually Transmitted Infection
UNAIDS	:	Joint UN initiative on HIV/AIDS
USAID	:	United State Agency for International Development
VCT	:	Voluntary counseling and Testing
VSU	:	Victim Support Unit of the Zambia Police
WHO	:	World Health Organization

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1.10 Background

The Corridors of Hope (COH), a joint USAID and JICA funded cross-border project targets high-risk populations in border and selected towns along major truck routes in Zambia. The project aims to reduce HIV infection through the provision of appropriate, sustainable and cost effective interventions.

The implementers of COH, Family Health International (FHI), World Vision Zambia (WVZ), Society For Family Health (SFH) and Zambia Health Education and Communication Trust (ZHECT) work in collaboration with District Health Management Teams (DHMT), District AIDS Task Forces (DATF) and other local partners. The project has sites in 10 border areas and other towns perceived to be high-risk regions for HIV infection. These sites are Livingstone, Kazungula, Chirundu, Kapiri Mponshi, Kasumbalesa, Ndola, Nakonde, Chipata, Katete and Lusaka.

FHI has the overall responsibility and ensures that the project is working to achieve its objectives and targets as set and agreed with financial and other partners. Specific roles of FHI include providing technical expertise, managing the monitoring, evaluation, research and reporting systems and coordination of the project's steering committee. **WVZ** is responsible for providing STI and VCT services at site level as well as administrative and financial management of the sites. **SFH** is responsible for the BCC activities including a youth component and social marketing of condoms. **ZHECT** is entrusted with implementing the workplace initiative.

1.20 Evaluation methods

The COH project winds up in March 2006, and JICA and USAID to this end commissioned an End-of-Project Evaluation, which was aimed at assessing whether the project had been effective in meeting the set objectives, how efficient the operations had been and the impact the project has had on the target and wider communities.

The evaluation mostly used qualitative methods, while quantitative data was collected from secondary sources. Qualitative data allowed for the investigation of processes, and thus was used to understand the perceptions of key players on the subject. Secondary sources of information were consulted for quantitative data.

Primary data was collected mainly through In-depth Interviews and Focus Group Discussions. Staff from COH central and site offices as well as partner organizations were interviewed using in-depth interviews. Commercial Sex Workers, Neighborhood Health Committees and other Community Based Organizations were interviewed through FGDs. Others interviewed included Peer Educators in bridging communities (police, immigration and ZRA), trucking companies and the general communities surrounding the evaluation sites.

1.30 Results of COH Activities

The effective **prevention and control of STIs** depends on three dimensions that are at the core of its spread: comprehensive case management; management of sexual partners and behavior change interventions. The COH project catered for all the three components.

The project management of STIs had gone through changes over the project life span. Initially, COH offered presumptive care, which entailed treatment of CSWs at the first contact. This was subsequently modified with the introduction of screening for syphilis.

Mobile STI services were also included to cater for clients in the communities. The practical difficulties of continuing with this model and negative impact on the quality of services led to a reduction in such services.

The project used various **BCC methods** to disseminate information on STIs and HIV/AIDS: peer educators, outreach workers, and drama clubs.

The findings of the study showed that the BCC activities had impacted on the behavior of the target population, as evidenced by the reported reduction in the number of partners and improve health-seeking behavior among CSWs. After starting off exclusively as STI delivery points, the COH overtime introduced **VCT services.**

In the early days of the VCT services, CSWs were hesitant about testing for HIV, in part because of the lack of follow-up alternatives in the event of testing positive. But with the advent of ARVs, more CSWs were opting for VCT.

The main goal of the **workplace** policy was to establish and strengthen HIV/AIDS prevention and care programmes at the workplace in order to reduce the further spread of HIV infection and to maintain a healthy work force.

A lot of work had been done in trucking companies and employees sensitised about HIV/AIDS. As a result, employees and in some cases their spouses had been reached with HIV/AIDS and STI messages.

1.40 Results of COH Outputs

Gauging from the empirically **verifiable reduction in the prevalence of STIs** and reported appreciation of services among the target population, the project was successful. The quality of STI services was rated to be high. Nonetheless, **there were limitations with regard to the quality of mobile STI services.**

As with the STI, so too with BCC component, the project **succeeded in recording positive behavior change** both among the target and wider communities. At the

community level, there had been a gradual acceptance of CSWs. Through the knowledge that had been gained from COH activities, the CSWs were in some cases utilized as community resources for: health education, and access to health care at COH drop-in centers. However, **the lack of parallel initiatives to offer CSW alternative livelihoods militated against these achievements.**

The introduction of **VCT services had improved the effectiveness of the project** activities, and this was evidenced by the observed increase in the uptake overtime. The VCT services had facilitated synergies with the STI component.

While the **workplace awareness campaigns** and introduced workplace polices at selected transport companies in Lusaka, much could have been done to ensure effectiveness. This was clearly illustrated by the limited level of knowledge about the policy among many of the respondents, and **limited involvement of management** in the activities.

1.50 Evaluation of the project activities

Were the project activities relevant?
The project **was relevant in that it targeted its activities among the loci of the HIV/AIDS epidemic**, which impacted positively on the rate of infections. HIV/AIDS is not just a medical problem, but much more importantly a development concern and hence by forestalling the further spread of the epidemic, socio-economic development was being safeguarded.

Within the **JICA and USAID programme to Zambia, HIV/AIDS has been identified as one of the major areas of cooperation**. And the resources spent in this area were appropriately targeted and relevant to the priorities of JICA. JICA is further involved in supporting the tuberculosis programme in Zambia. Given the relationship between HIV/AIDS and tuberculosis, the COH project contributed in addressing the combined challenge of the two diseases.

Was the project effective?
There were no indicators set at the outset of the project, against which effectiveness could be assessed. However, **the trend in outputs showed that there were improvements overtime**. From this perspective, it could be concluded that the project was effective, as evidenced by the increase in the number of project beneficiaries; and reduction in risky sex behaviors.

How did the project impact on the community?
The consistence in the **provision of both care and supportive services impacted positively on the communities by reducing the stigma** that was associated with STI and HIV/AIDS.

The extension of COH services to the wider community, other than the immediate

target population, as was originally designed, further helped to reduce the stigma.

In relative terms, the COH services were unanimously rated to be better than similar services provided from other sector outlets.

Was the project efficiently run and sustainable?

The **combination of competencies from the various partners who were involved in the project increased the pool of resources** for interventions. Thus the project was able to do more than would have been possible with single partner participation.

However, the **pool of various partners also posed serious challenges,** not least of which were the **management of human resources and accounting systems.** In some instances, managers were not able to effectively manage staff who belonged to partners, and divergences in conditions of service sometimes resulted in resentment among staff.

Lessons learnt

The project learnt that exclusively targeting the primary project populations was not an effective way of reducing the prevalence of the STIs. Overtime, **the STI services were extended to the wider community**.

With time, **mobile STI services were also provided.** However, since such services were provided from the community, the quality was low and the services were subsequently scaled down.

For the workplace component in Lusaka, respondents indicated that other than the initial awareness meetings, nothing much had been done to institutionalise the activities. The **lack of a systematic mechanism for monitoring the workplace activities and limited company involvement** had reduced its effectiveness.

While the project activities focussing on CSWs and the bridging communities had registered some positive changes, **establishing links with other partners involved in income generating activities** would have been beneficial to CSWs.

The project had benefited from the involvement of various partners, each bringing in their expertise. Thus **more was achieved than would have been possible with a single principal.**

While recognising the **good working relationship between the project and the DHMTs, the links could have been better developed in order to ensure sustainability** of the activities.

Recommendations

Although there was evidence of behaviour change among the target population, there were no weaning strategies for CSWs once they decided to cease commercial sex activities. It would probably have been a **good strategy to link the COH project to income generating projects.**

Given the community disapproval of public sector provided services, it is imperative that the relationships with districts are developed further, in order to share experiencs. Although the COH collaborated with the DHMTs, **the operational links should be strengthened, in order to ensure sustainability** of the project activities.

Although the major sources of funding for the project are about to end, **the clear evidence of project success could be used to mobilise other sources** of support for the continuation of the activities.

While the project had initiated and implemented the workplace policy, **Peer Educators in Lusaka expressed misgivings about its effectiveness.** It is imperative that company management became more interested in order for the workplace component to achieve better results.

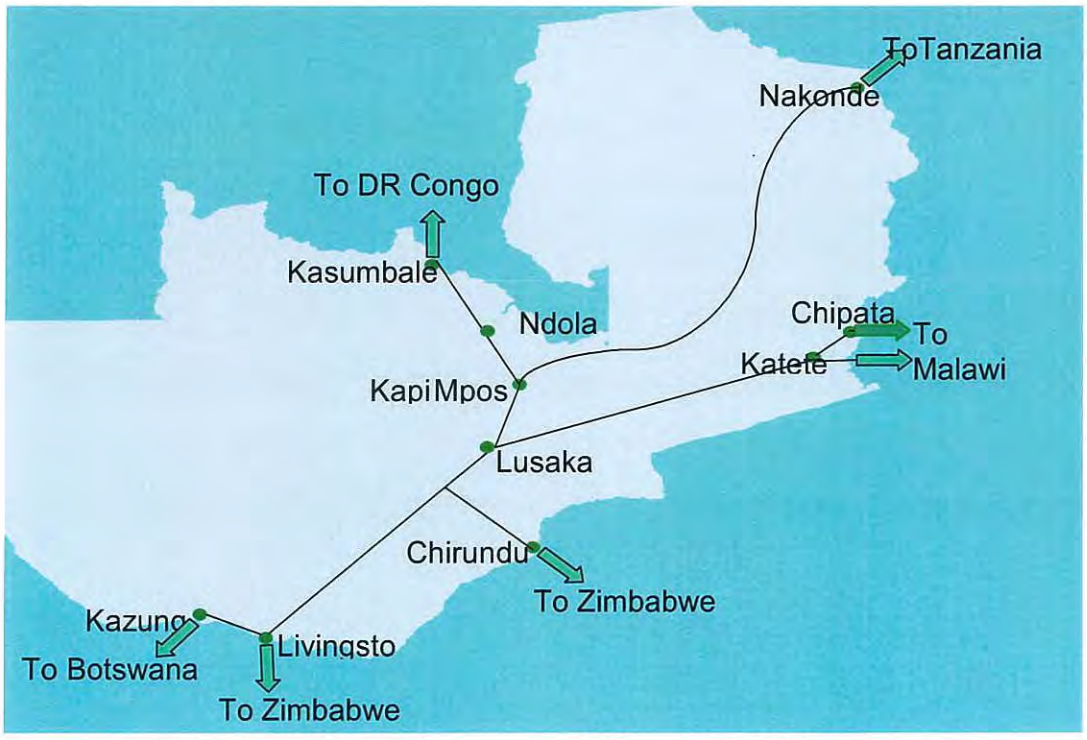
1.0: INTRODUCTION

The HIV/AIDS epidemic continues to take a heavy toll on African communities. In Zambia the prevalence rate is 16%, with Lusaka (22%), Copperbelt (19%) and Southern (13%) provinces taking the lead (CSO, 2003). Presently, the major means of HIV transmission is through sexual intercourse. Border towns are especially known for high levels of commercial sex activities, which make them a nexus for the transmission of HIV, and consequently prime areas for interventions.

Although all sexually active populations are at risk of HIV infection, there are high-risk sub-groups. These include Commercial Sex Workers (CSWs), Long Distance Truck Drivers (LDTD) and the bridging communities like uniformed personnel and tax drivers. It is on this premise that the Cross Border Initiative Project now known as Corridors of Hope (COH) was designed in 1999, targeting CSWs and their partners with multiple interventions aimed at halting the spread of the epidemic.

The Corridors of Hope (COH), a USAID and JICA funded cross border project, is an HIV prevention project targeting high-risk populations in border and selected towns along major truck routes in Zambia. The implementation of the project began in 1999 as part of the regional HIV and AIDS program (RHAP) in Southern Africa. The project aims to reduce HIV and AIDS infections through provision of appropriate, sustainable and cost effective interventions to high risk and bridging populations and abstinence only messages to youths at borders and other selected towns.

Figure 1: Project Sites



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The overall goals of the project are;

1. To reduce the transmission of STIs among high-risk populations of women and their sex partners in borders and main inland towns.
2. To prevent transmission of STIs/HIV among youths aged 10 - 19.

The project goals are met through the following specific objectives;

1. Increase access to correct condom use among the high risk populations
2. Increase access to quality STI management
3. Behaviour change communication strategies
4. Provision of Voluntary Counseling and Testing services

The project primarily targets female sex workers and their clients and in-and out of-school youths aged 10 to 19 years. The strategies include provision of behaviour change information, including condom promotion through social marketing, quality STI services at drop-in centers and through outreach services, HIV counseling and testing (VCT) services at the drop-in centers, work place intervention, and skills building and messages on abstinence among the youth.

The implementers of COH, Family Health International (FHI), World Vision Zambia (WVZ), Society For Family Health (SFH) and Zambia Health Education and Communication Trust (ZHECT) work in collaboration with District Health Management Teams (DHMT), District AIDS Task Forces (DATF) and other stakeholders.

The implementing partners' roles and obligations can be summarized as follows:

- **Family Health International** has the overall responsibility for the project and ensures that the project is working to achieve its objectives and targets as set and agreed with financial and other partners. Specific roles of FHI include providing technical expertise, managing the monitoring, evaluation, research and reporting systems and coordination of the project's steering committee.
- **World Vision** is responsible for providing STI and VCT services at site level as well as administrative and financial management of the sites. The responsibility of initial entry and communication of site-level data for the project's monitoring and evaluation system also rest with WV.
- **Society for Family Health** is responsible for behaviour change communication (BCC) activities including a youth component and social marketing of condoms
- **Zambia Health Education and Communications Trust** is entrusted with the responsibility of implementing a workplace initiative targeting cross-border trucking companies in project areas.

The project has undergone various organizational changes from the time it commenced activities. From August 1999 to July 2000, WVZ was funded through FHI to implement the project in Chirundu, Kapiri Mposhi, Kasumbalesa and Livingstone. Chipata was included half through this sub-agreeement. Partner organizations were identified in the sub-agreement with and among whom collaboration would be provided.

In February 2000, JICA assumed funding for specific programmes in STI management and Behavior Change Interventions. JICA's initial agreement with WVZ ended March 2003. The project sites covered under this sub-agreement were Chirundu, Kapiri-Mposhi, Livingstone, and Kasumbalesa.

December 2000 to November 2001, FHI with RHAP funding entered into a sub-agreement with WVZ for a Chirundu-specific program. Partner organizations and functions were the same as in the first agreement.

March 15 2001 to March 14 2002, FHI funded WVZ for Chipata and Nakonde programs. The Center for Disease Control (CDC) funds were used for these activities. New funded activities included an assessment and mapping exercise in Nakonde, increased support for PEs, improved monitoring of incidence of STIs in the community, integration of STI services into existing health facilities, improved monitoring of CSWs utilization of clinic services, training of HCP in Nakonde and improved record keeping.

December 2001 to November 2002, FHI funded WVZ for the continuation and expansion of the CBI in Livingstone, Nakonde, Chirundu and Chipata. RHAP funds were again utilized for these activities.

In 2003 a memorandum of understating was signed among the partners to continue the activities. Two further drop-in centers were opened one each in Lusaka and Ndola. An important difference during this phase was the introduction of a youth only component, which targeted out-of-school-youth with abstinence messages and for which funding was accessed from the PEPFAR. Voluntary Counseling and Testing Services were also introduced.

2.0 EVALUATION METHODOLOGY

2.1 Objectives of Evaluation

2.2 Evaluation Design

The evaluation design was non-experimental and exploratory in nature. The evaluation mostly used qualitative methods, while quantitative data was collected from secondary sources. Qualitative data allows for the investigation of processes, and thus can be used to understand the perception of key players regarding the evolution of a project over time.

2.3 Data Collection

As indicated above, both qualitative and quantitative data were collected for the study. This was done by using both primary and secondary sources of data. The qualitative data were collected through: Participant Observer Methods (POM), Focus Group Discussions (FGD), and In-depth Interviews (IDI). Stakeholders were interviewed at six different levels.

1. COH Central Office and their partners
2. Project Site Staff
3. Project site partners/stakeholders(i.e. NGOs, district hospitals, DHMTs, DATF)
4. COH Target groups
5. General Community
6. Bridging communities (i.e., ZRA, Customs, Police, Money changers)

After the respondents were identified, interviews were held using a checklist for either group discussion or in-depth interviews as the case dictated. In-dept interview guidelines were used to collect data from: COH project staff and representative of partner organizations. The data from Outreach Workers, Queen Mothers and CSWs was collected using Focused Group discussion guidelines. There were five data collection instruments that were prepared: management of STIs; BCC and VCT; Workplace policy; organization of the project; and Community/CSW Focus Group Guide.

The Workplace checklist was used to get information from both managers and Peer Educators. The respondents were asked for their views on the workplace policy, how it was developed and implemented at the companies. The respondents were further asked about how the project had impacted on the staff, and their views solicited regarding how the policy could be improved.

The checklist for the STI component sought to find out how STIs were managed. Issues raised investigated included: the extent to which the STI management practices adhered to the standard protocols, availability of drugs and other essential supplies and the competence of health providers. A review of records was also done in order to determine the changes in STI attendance over time.

The BCC and VCT checklist sought to find out the views of the respondents on the behavior interventions for both the target and wider communities. The views of communities on the sources and usefulness of BCC messages were assessed. Respondents were asked how such interventions had impacted on sexual behavior. The respondents were also asked whether VCT service provision followed the national guidelines. Records were reviewed to determine the trends in the utilization of BCC and VCT services over time.

In order to understand the organization arrangements and challenges posed, a series of interviews were held with organization representatives. The respondents were asked to explain the challenges faced, how such arose, how they had impacted on the project and suggested solutions. The interviews also raised the issue of project sustainability and whether the project activities were relevant.

The FGD guide was used to collect data from both the target and wider populations. The discussants were asked about their sources of the information on HIV/AIDS and STI, and what they perceived to be the most reliable modes. The respondents were also asked to indicate how they obtained information on VCT, how such services were organized and suggestions on how the services could be reorganized. The discussants were asked to indicate whether and how the project had impacted on the community.

2.4 Respondent Selection

The evaluation examined all the project components: the BCC, VCT, and STI in the selected study sites. However, the workplace component was confined to Lusaka district. For purposes of collecting data, the COH operational zones were used as a basis for selecting respondents for group discussions. For each target population group selected, a parallel general community group was also selected in order to compare the results. Thus in both Kapiri Mposhi and Livingstone project sites, a group of queen mothers from all zones was interviewed. One FGD was help with CSWs in each zone. At the project site level, in-depth interviews were held with site managers, health care workers, VCT counselors and BCC coordinators and Outreach Workers.

Table 1: Respondent groups and method of data collection*

Respondent Group	Method used (no)	Total Number of sessions Kapiri	Livingstone
COH Staff (Central Office)	IDIs (13)		
COH Staff (Sites)	IDIs and FGDs	6	5
Stakeholders/partners	IDIs FGDs	5 2	7 2
Beneficiaries (CSWs)	FGDs	4	4
Beneficiaries(Queen Mothers)	FGDs	1	1
Clients of beneficiaries (LDTD)	S-structured interviews	4	3
Bridging Communities	IDIs and FGDs	4	2
Wider Community	FGD	2	2

2.5 Limitation of the evaluation

While logistical arrangements were adequate, the time allocated for the evaluation was very short. This had various implications; firstly, some individuals with a stake in the project were not reached for interviews. Secondly, it was very difficult to have adequate time with certain officials due to their busy schedules. Thirdly, the learning period for the consultants was very limited. And lastly, the evaluation covered only three project areas out of the total ten and as such the conclusions may be very specific to the study areas.

* Refer to Appendix I for a detailed list of interviewees

3.0 PRESENTATION OF FINDINGS

3.1 Results of COH Activities

3.1.1 STI Management

The effective prevention and control of STIs depends on three dimensions that are at the core of its spread: comprehensive case management; management of sexual partners and behaviour change interventions. The COH project catered for all the three components in their prevention and control of STIs. The drop-in centers endowed with health facility status had qualified staff who provided quality STI services. Behavior change interventions generated community messages, which created awareness about STIs, their complications, and benefits of STI prevention and control. This in turn generated demand for the service while at the same time provided opportunities for individuals and targeted communities to assess their risk behaviors.

The management of STIs had gone through changes over the project life span. Initially, COH offered presumptive care, which meant that at the first contact with CSWs, they were treated presumptively for all common STIs, as well as given an injection for syphilis. With time, this was changed and the project clients were screened for syphilis, and only those with positive RPR results would be treated. However, presumptive treatment continued for other STIs

Most of the STIs services are provided from the drop-in centers. However, given the difficulties of reaching out to some of the client population, it was thought prudent to combine static and mobile service delivery systems. Hence in addition to the services provided from the drop-in centers, the project also had mobile services were they held sessions in the communities, in order to reach those that they were not able to access services through the static service points.

While the STI outreach provided complementary services, with time, it was scaled back when the managers observed that the quality of services provided in such settings was below par. This arose on account of the difficulties of mobilizing all the requirements for the effective management of STIs from an improvised community setting.

The project had employed qualified health care workers who provided STI services. By the time of the project evaluation, the same staff were involved in screening, testing and treatment of clients, which resulted in a high workload. The strain on the heath providers, notwithstanding, the levels of other inputs was favorable. For instance, the drugs were readily available and there were hardly any stock-outs. Even during the early stages of the project when stock-outs

would be experienced, the project was able to minimize the impact of such stock-outs by getting supplies from the DHMT, who would be reimbursed later.

3.1.2 Behavior Change Communication

The project used various methods to transmit behavior change communication messages to their target populations. The media used included: peer educators, outreach workers, and drama clubs, through which the direct project and wider communities were targeted with BCC messages.

The messages transmitted were both preventive and treatment related. The BCC component includes messages regarding awareness about STIs, their complications, benefits of prevention and control and availability of STI services. The client population were advised on the kind of STI-related symptoms to look out for and the need to take prompt action.

The messages regarding the consistent and correct used of condoms had been well spread in the community. And the interviewees indicated that there had been an increase in the utilization of condoms in the project areas. However, there were some practices that hindered the further popularization of condoms, which included the refusal by some men to use condoms, adverse practices among CSWs such as the tendency not to use condoms with permanent partners and when offered more money.

One of the difficulties relating to behavior change as regards the management of STIs was that sometimes clients would not want to come for treatment when they did not have symptoms, and sometimes they did not turn up for reviews. In order to address such shortcomings, the peer educators reminded the population on the need for early treatment and review of cases.

Given the sensitivities of the subject matter, initially there was resistance from the target population about the need for such services. Attracting the target population was difficulty, as they would disparagingly counter that they were not the major sources of infection. However, with time, both sex workers and their clients came to appreciate the importance of the services and readily accessed them.

3.1.3 Voluntary Counseling and Testing

After starting off exclusively as STI delivery points, the COH overtime introduced VCT services. The synergy between STIs and HIV infection prompted the programme managers to go a step further by providing a comprehensive service. The STI clients whose chances of being infected with HIV were high were also given an opportunity to have an HIV test and know their status.

Knowing ones status is the entry point to care and support, especially now that ARVs are provided free of charge. At the same time, individuals who are tested are provided with information on positive living through behavior change processes. Those who test

positive learn how to protect themselves and others from infection and re-infection, having good nutrition and moderating or stopping harmful practices like smoking, beer drinking and stress. In like manner, those who test negative learn how they could maintain their status.

The VCT practice conforms to WHO guidelines on HIV counseling which indicate that testing should be voluntary. The steps followed by the project are in line with those advocated by the MOH, namely pre-test counseling, post-test counseling and continuum of care. The VCT providers ensured confidentiality of the clients by not divulging information to third parties and keeping records in lockable cabinets.

Coersion was tactically avoided because treatment for STIs was not tied to counseling and testing for HIV. At every level, the clients were given an opportunity to opt out. The results of the assessment showed that it was initially difficult for the CSW to volunteer for VCT. However, overtime they appreciated the importance of such a service. The initial reluctance of CSWs to undergo VCT was because of the limited range of alternatives in the event that one tested positive. With the advent of ARVs, however, this changed since one could get ARVs, after testing positive.

3.1.4 Workplace Awareness and Policy

The Corridors of Hope (COH), through the workplace component has reached many people with information on HIV and AIDS. The primary aim of the workplace component was to reach potential clients of CSWs. The goals of a workplace policy are to: i) establish and strengthen HIV/AIDS prevention and care programmes at the workplace in order to reduce the spread of HIV and to maintain a healthy work force; ii) provide supportive care services to employees infected with and those affected by HIV/AIDS; and iii) ensure equity in the application of rules and regulations to all employees, regardless of their social and medical status. While the COH workplace design took care of the first goal, not much was done with regard to the second and third goals.

The process of establishing a workplace policy entails undertaking various activities, which include: awareness creation among staff, formulation of policy, skills building and identification and training of trainers:
(i) awareness sessions (first with general staff, thereafter with company management);
(ii) recruitment and identification of Peer Educators from among the workers;
(iii) facilitation of the workplace policy;
(iv) sensitization of workers' spouses, which is preceded by sensitization of staff. The workers are then requested to send their wives for a 'workshop' to learn about HIV;
(v) Skills building by bringing spouses together; and
(vi) Training of trainers (TOT).

It is evident that a lot of work had been done in trucking companies and employees sensitised about HIV/AIDS. As a result of the workplace activities, employees and in some cases their spouses had been reached with HIV messages and there were

indications of behaviour change in these companies. For instance, demand for condoms had gone up and HIV/AIDS issues were being discussed openly.

While information form the quarterly reports showed that the workplace activities had proceeded well, this assessment was only confined to Lusaka and hence the finding may not be reflective of the general picture. From the interviews held in Lusaka, some Peer Educators in trucking companies expressed reservation about the workplace policy. The policy had not been implemented as was originally envisaged. While efforts were made to involve management, in most companies, this was minimal and there was no real sense of ownership. Secondly, not all employees had been involved in the policy formulation process.

These reservations notwithstanding, it ought to be mentioned that the policy had just been introduced in Lusaka and was still in the early stages. Indeed, a reveal of the data from the quarterly reports showed the policy was more developed in the other sites.

3.2 Results of COH Outputs

3.2.1 STI Management

The quality of services provided at the COH drop-in centers were generally good and responses from the target and wider communities indicated that they appreciated these services. The organization of STIs services was comprehensive and included the three components of effective management of STIs, which are: comprehensive case management of STIs, management of sexual partners, and behavior change communication. As a result of these activities, there had been a decline in the major STIs, as Table 2 indicates. The BBSS results showed that there had been a fifty percent decline in the proportion of STIs from 25% in 2000, to 12% by the year 2003. The pattern was upheld for all the STIs in both Livingstone and Chirundu for which the results were available.

Table 2: Prevalence of STIs in Livingstone and Chirundu, 2000 and 2003

STI	2000			2003		
	L'stone	Chirundu	Total	L'stone	Chirundu	Total
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Gonorrhoea	23	20	22	14	7	11
Chlamydia	6	7	6	6	5	5
Trichomoniasis	51	49	50	30	28	29
Syphilis	36	29	34	30	15	24
Any of above	-	-	-	53	41	49
Gonorrhoea/Chlymidia	26	23	25	14	10	12
	26	23	25	14	10	12

Sources: FHI. 2003, Biologic and Behavioral Surveillance Survey, Zambia Female Sex Workers

Other than the decline in the prevalence of STI in the project sites, the recipients of the services from both the target and wider populations applauded the standard of services provided by the COH project. They observed that the drop-in centers always had sufficient stock of drugs, the providers were competent and provided quality services, and the services had resulted in healthier populations, which had reduced the incidence of STIs. The following quotes are illustrative of the views of the respondents regarding the COH STI services:

-"*...a long time ago there were many diseases, like syphilis, gonorrhoea, but this time you cannot find many people suffering from STI. The people are following what they are told....*€(35W, Kapiri Mposhi).

-"*...again they (presence of drop-in center) have made us to stop stigmatizing because we used to stigmatize ourselves. I am sick, and I can't tell my friend, but now we have learnt and we are becoming more open....*" (CSW, Kapiri Mposhi)

-"*....At the drop-in-centers, you will always find the medicine and anytime you go, they will treat but at the [public] hospital, you will need to wait on the queue, if you have gone in the morning, you will see the clinical officer at 16 hrs. There are also things like books, and paying K2500 for registration, but at CBOH, immediately you explain how you are feeling, they test the blood and give you treatment....*€(CSW, Livingstone)

-"*...Anyway confidentiality is there, when you are there only the doctor would know you are there. Same applies to VCT, because of that you even feel free to explain your situation to them. In addition, even those men there (at COH), though they are not our friends, they keep secrets. They even have respect for us and even if the doctor is not there, they treat you with the same courtesy. We live with them in our compounds, but you would not hear anything (like spreading rumors about you) ... you just greet each other....that is all. We thank you (COH) so much for that that...*"(CSW)

The reduction in STIs in the study population had also been facilitated by the new level of assertiveness that the CSWs had gained through the project. Talking about how she was not longer afraid to take the lead in ensuring condom use with a partner, a CSW observed:

-"*..at least this time because of being knowledgeable, we are not even ashamed, but I used to be ashamed if he tells me that dress me the condom...I used to hide my face and refuse but after [the project activities]..am more courageous. I would even ask him that let us stand like this and dress ourselves. I will dress [meaning putting on the condom]. I am no longer ashamed*€ (CSW, Livingstone).

Officials from DHMT also expressed appreciation for the services offered by COH. However, they also raised concerns about the sustainability of the project. In the words of a DHMT respondent:€ *COH should not wind up now, but strengthen the networks and strategize on the phase-out strategy.* [The] *DHMT cannot sustain the service because we have skeleton of staff...very few counsellors. There is also a high turnover and looking at the huge cost associated with the service, we may not be able to provide the logistics* (DHMT respondent)

3.2.2 Behavior Change Communication

As was explained above, the BCC strategy had various components: Peer Educators; Outreach Workers; Drama performance; and distribution of IEC materials. Using statistics from the last quarter, it was clear that drama attracted the highest number of participants relative to the other strategies. The IEC activities by both Outreach Workers and Peer Educators entailed both one-to-one meetings and group meetings. For both, Outreach Workers and Peer Educators, however, there were no major differences in the number of people reached for one-to-one and group meetings.

Both the review of secondary data and findings from the Focus Group Discussions showed that drama performances were the major BCC strategy and the respondents observed that this had been sustained over time. Secondary data showed that all the sites recorded significant increases in the number of contacts made through drama. During the third quarter of the year under review, a total of 55,737 people were reached through this medium (Table 3).

Relative to the previous quarter, the period under review showed a decline in the number of contacts made by outreach workers through one-to-one meetings. The reduction could be explained by the fact that some of the one-to-one contacts that could have been made by outreach workers were undertaken by Peer educators and accounted for separately. The reduction could further be attributed to the late funding of BCC activities. This led to Outreach Workers not being able to carry out their activities because of the lack of transport. The observed decline in activities undertaken by Outreach Workers, and converse rise in those undertaken by Peer Educators, could however be viewed to be a good indicator for the success of the project, since sustainability is more likely where community systems as opposed to project structures took the lead.

As a result of the BCC activities, the target population indicated that they had changed their sexual behavior as evidenced by: the reported reduction in the number of sexual partners; and insistence on condom use. The availability of STIs services to both the target and wider community had also minimized the stigma surrounding sex work and positively impacted on the health seeking behavior of the CSWs. The BCC strategies encouraged the CSWs to utilize the services without the fear of being stigmatized. The following quotes from FGDs are illustrative of the kind of behavior change taking place in the communities:

_"*...if that partner does not want (to use a condom), I tell him that look you are a family man and I have children. But most importantly, you don't know what I do, neither do I know what you do. Maybe you might be sick, but what would happen if am sick? What about your family? And also my children, and no one will care for them when or if you or I die. That means if he is wise, he cant refuse using the condom. But if he refuses, its to tell him that you can go and I will remain with my condom...*€.ß5CSW, Kapiri Mposhi).

-" *.we had a case where a sex worker was beaten by a patron because she refused to have sex without a condom. One interesting event was in a village, where a former boyfriend burnt the house of a sex worker after she refused to have sex without a condom...she told him she knew her status and advised him to go for VCT* ...(Outreach Worker, Livingstone)

-" *.I want to be precise on this one, but I feel it is another measure. The socially marketed condoms we have been selling in bars and chemists..these products are moving very fast, indicating that the people are really accessing the condoms and using in the end..though we cannot guarantee that*...(outreach Worker, livingstone)

-" *.we have to realize that it is not ok to have many boyfriends and we are reducing the number of boyfriends so that we can reduce on re-infecting each other*...(CSW, Kapiri Mposhi)

-" *.the information is very good and they teach us about a lot of things and when you have that information, it makes you change completely, it you had many boyfriends, you definitely change and reduce the number of boyfriends maybe you remain with only one man*€ 46CSW, Livingstone).

-" *.also the COH have enabled us to start rejecting those who want unprotected sex because if a man comes and I refuse to have unprotected sex, he will try to go to another girl and she will refuse...you will find that we all refuse and as a result he will simply have no option but to accept to use a condom*...(CSW, Livingstone)

While the respondents were generally well disposed to changing their sexual behavior, they also observed the limitation that they faced: the desperate situation that they faced, especially the poverty and lack of meaningful alternatives for earning a living. This forced to continue with sex work, even though they knew the repercussion of their activities.

The positive indicator for behavior changes reflected in the quotations above were also supported by findings from the BBSS surveys. The 2003 BBSS showed that about 47 percent of respondents in Livingstone had condoms on hand at the time of interview. This was a significant increase by 26.5 percentage points from the 2000 survey. There was also an increase in condom use at last sex with paying clients in Livingstone (48.8% to 55.2%). However, consistent condom use with paying clients in the past 30 days reduced in Livingstone by 3 percentage points. Condom use with non-paying sexual partners at last sexual act increased from 33 percent to about 49 percent in Livingstone.

In addition, the survey reported that the proportion of respondents who reported ever being tested for HIV increased in Livingstone from 12 percent in 2000 to 16 percent in 2003. However, of those that were tested, the number who said they voluntarily got an HIV test increased from 50 percent to 89 percent in Livingstone. (FHI, 2003 p.vi)

The results from the review of STI data and FSW respondents indicated that the project had had positive effects. In the word of one FSW: "*....in my case to use a condom...I never wanted that, I used to refuse to use and I did not know what a condom was. But through one Outreach Worker, she really helped me...in fact [initially] I used to insult her...and I nicknamed her: 'ci Maggie ma condom' [a derogatory expression to describe somebody who peddles in condoms]. Yes that is what we used to call her...[but] she really convinced a lot of young women. [Previously] we really had a lot of boyfriends, but this time, I have reduced and I have changed...there are more diseases this time..*€ 35SW, Kapiri Mposhi

Table 3: No. of people reached through various IEC strategies, July-Sept., 2005

Site	Drama	Outreach workers		Peer educators	
		One-one meetings	Group meetings	One-one Meetings	Group meetings
Chawama	7,980	4,154	2,773	954	818
Chipata	6,131	9,836	4,402	596	625
Chirundu	8,003	2,794	2,554	661	363
K' Mposhi	7,501	2,325	4,344	1,168	1,338
Kasumbalesa	5,954	2,834	1,400	205	-
Katete	7,442	1,144	267	246	-
Kazungula	4,364	2,048	2,862	226	-
Livingstone	4,477	812	1,176	376	-
Nakonde	2,949	2,661	3,313	-	-
Ndola	2,041	2,090	4,485	591	-
Total					

3.2.3 Voluntary Counseling and Testing

As indicated above, the COH project initially started by providing only STI services. Overtime, they included the VCT component to their activities. The COH VCT services were complementing those provided by other NGOs and the public sector. Responses from both program managers and communities showed that service recipients held the quality of COH VCT service to be better than those provided in the public sector.

Although the uptake of VCT services was low during the initial phases, this improved overtime as the community became more aware about the advantages of such services. As with the management of STIs, so too with the provision of VCT services, the extension of the services to the wider community helped in improving service uptake. Respondents were unequivocal about their support for COH supported VCT services, which they rated to be better than those provided in public hospitals. In the words of some of the respondents:

-"*...Yes they (drop-in center staff) really keep secrets, even if they work on you, you will never get it form anybody else or getting it from somewhere. No, unless you yourself have revealed to somebody else to your friends. We are very happy in that matter [that they keep secrets]...*" (CSW, Kapiri Mposhi)

-"*...Really the COH has helped us. [Previously]...people did not know and sometimes used to fear that if you tell them you had gone for VCT... to them...you were sick. But this time they have come to learn that not only HIV+ people go for VCT, but everyone and it is simply to know one's status. ...through education from COH, people have come to realize what it is...*" (CSW, Kapiri Mposhi)

-"...*sometime back we used to die [needlessly]..you are saying that maybe am bewitched but in actual fact you are suffering from HIV. You are slimming and without knowing....but this VCT has made us to be courageous and it has reduced suspicions because people used to hate each other in the family but VCT is making people not to talk too much and if you die, people will know you told them you are HIV+...*" (CSW, Livingstone)

-" .*Sometime back, we used to die instantly and you are lying that maybe am bewitched but in actual fact you are suffering from HIV/AIDS. You are slimming and without knowing but this VCT has made us to be courageous to go to the hospital and it had reduced suspicions.,..*(CSW, Kapiri)

The positive perceptions of the community regarding the quality of VCT services was buttressed by the review of secondary data which showed that there had been an increase in the utilization of services. The proportion of both target and wider population groups utilizing VCT services had increased over time.

The following quote from a CSW in Livingstone dramatically illustrates the community's appreciation of COH activities: -*...another thing is people used to fear to come for VCT, they thought if you test [positive] for HIV, [there is no future for you]. But here [at COH], they advise that when you are HIV positive, and you become pregnant, you can have a health baby. ...and I have a health baby at home who is one month old and that baby is COH...I have named him [after COH].. ...*(CSW, Livingstone)

3.2.4 Workplace Awareness and Policy

As indicated in the introduction, the assessment of the workplace component was restricted to Lusaka. According to the COH guidelines, a systematic process is supposed to be followed in order to implement a workplace policy. The process starts with a situation analysis of the institution where the workplace policy is to be implemented, followed by a workshop for institutional staff and an advocacy meeting involving management teams. The outputs from these activities are subsequently fed into a draft policy document. The draft policy document is discussed twice within an institution, before a debriefing meeting with COH staff, where it is finalized, and subsequently submitted to management for adoption as company policy.

According to the quarterly report of July-September, 2005, by the first quarter of the year 2005, a total of fifteen trucking companies had been helped to implement the HIV/AIDS workplace policy. Out of these fifteen companies, thirteen had trained Peer Educators who were implementing the prevention and care activities in their respective workplaces. The activities carried out by Peer Educators ranged from dissemination of information on HIV/AIDS/STI and other related topics using one-to-one discussions, group meetings, role-play, and distribution of IEC materials.

A review of secondary data showed that the number of companies recruited under this program had increased over time. While the increase in the number of companies

recruited is commendable, an assessment of the process among Lusaka companies showed that there were flaws. For instance, while Lusaka recorded very few referrals for STI services, both Ndola and Chipata had more referrals (Table 4). At the most the companies in Lusaka had undertaken awareness meetings for staff. Most of the Peer educators interviewed complained that there had been no effective follow-up by COH staff apart from the initial visits. Some Peer Educators indicated that they were not aware of the workplace policy being implemented in their companies.

Furthermore, the institutional arrangement for the workplace policy was not optimal, as the company management could have been more proactive than they were at the time of the study. For instance, none of the companies visited had taken the initiative to approach the COH offices to follow-up on the progress of policy. That no such initiative had been undertaken reflected the lack of deliberate interest on the part of the company authorities. This was further exemplified by the practice of the Peer Educators holding meetings during lunch-time, which was not adequate for effective work place awareness activities.

Among the activities planned by COH were awareness workshops for workers' spouses. However, only one such workshop was held for the whole year, about whose organization the Peer Educators were not happy as some companies were only told about it a day before the event. The Peer Educators observed that the program could have been improved by: having more technical advice since they sometimes found it difficult to adequately respond to queries; improving the incentives; the combination of workplace policy and VCT services.

These shortcomings notwithstanding, the PE observed that the workplace program had: it availed them information on STI and HIV/AIDS; and facilitated the distribution of condoms to staff; there had been a high level of demand for the same; and there was a reduction in the risky sexual behaviors among staff.

Table 4 : Number of employees referred for VCT and STI services by region

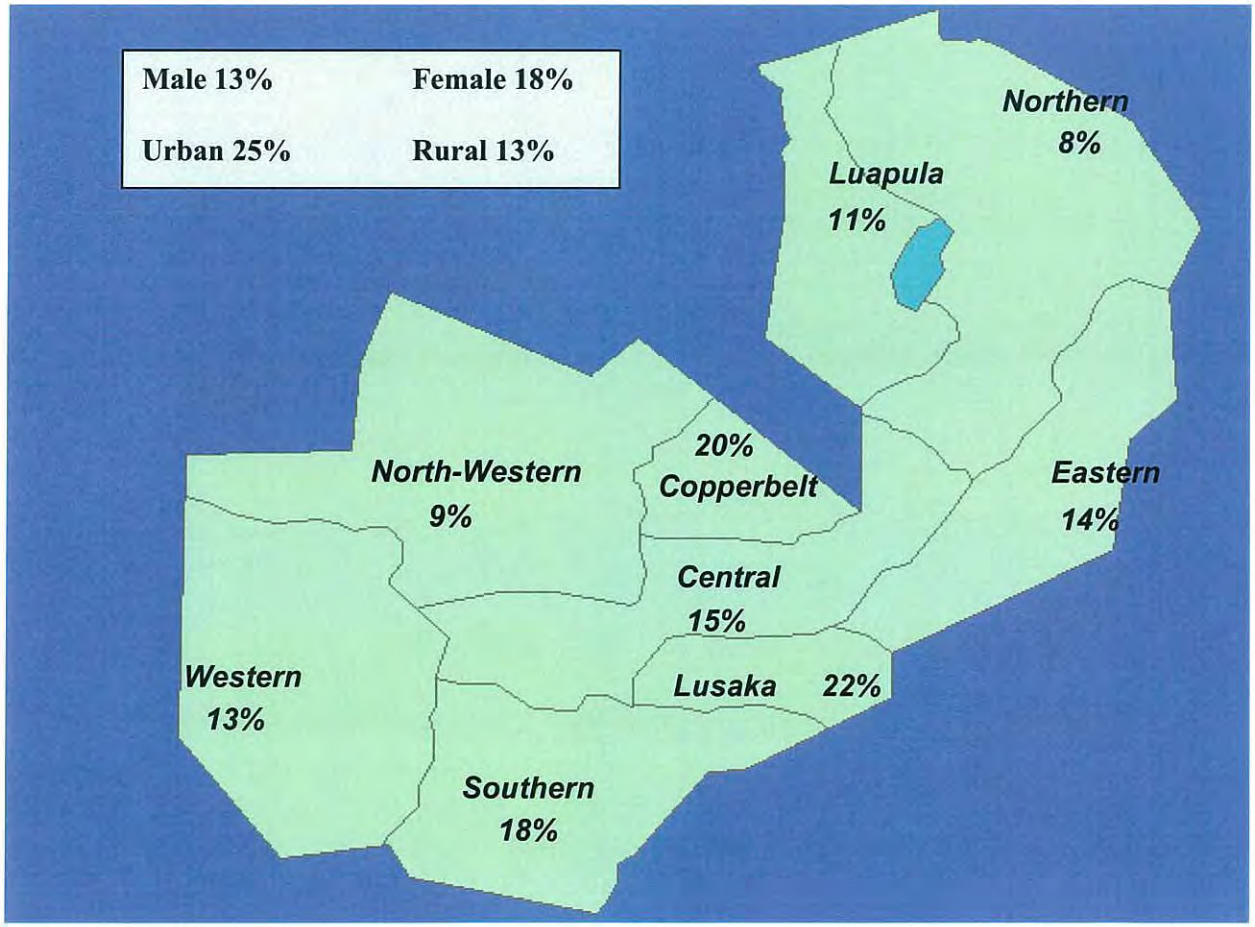
Region	Referred for VCT	Referred for STI	Total
Copperbelt (Ndola)	25	9	34
Lusaka	5	7	12
Eastern (Chipata)	33	0	33
Total	63	16	79

3.3 EVALUATION BY FIVE CRITERIA

3.3.1 Relevance

The overall HIV prevalence rate for the country was about 16% as per last Demographic and Health Survey (2002). In urban areas, the HIV prevalence rate among 15-49 years-old was more than 23% while in rural regions it was 11%. The estimated HIV prevalence is higher in the urban regions of Lusaka and the Copperbelt provinces where about one out of every five adults aged 15-49 is HIV infected. The rural prevalence rates were lower on average than urban rates, normally between 10% and 15% compared to between 25% and 30% in urban and peri-urban sites. The incidence appeared to be increasing in rural areas but may be stabilizing in urban areas. This could be due to a variety of reasons including high HIV incidence being offset by high mortality or a genuine decline in incidence (Fylkesnes, 1995).

Figure 2: HIV Prevalence, Ages 15-49, by Provinces



While the HIV/AIDS is national disaster, which has affected the whole country, the prevalence shows a geographical bias, with the urban areas being worst affected, as Figure 1 above shows. And within the urban areas, there are specific clusters of infection in which the epidemic is concentrated, such as the line of rail and other major transportation points, which are intersection points for the traveling public. In order to concentrate on the loci of HIV infection, the COH project sites were located along such major intersection points. These transportation nodes are also centers of commerce and attract a high proportion of CSWs. And it has been proved that CSWs, especially where partner change is frequent are an effective avenue for the transmission of the HIV and other STIs.

Hence the COH project was relevant in that it targeted its activities among the loci of the epidemic, which impacted positively on the rate of infections. HIV/AIDS is not just a medical problem, but much more importantly a development concern and hence by forestalling the further spread of the epidemic, socio-economic development is being safeguarded.

Within the JICA programme to Zambia, HIV/AIDS has also been identified as one of the major areas of cooperation between the two countries. And the resources spent in this area were appropriately targeted and relevant to the priorities of JICA. JICA is further involved in supporting the tuberculosis programme in Zambia. Given the relationship between HIV/AIDS and tuberculosis, the COH project contributed in addressing the combined challenge posed by the two diseases. The project was also relevant because it linked with and was worked within the existing health sector delivery systems.

3.3.2 Effectiveness

The findings of the study from interviews with both policy level and target population respondents showed that they shared the view that the project had achieved its objectives of addressing the HIV/AIDS pandemic through targeting CSWs and their partners. This, however, could have been better determined by studying the trajectory of preset indicators and how they changed over time. As there were no targets that had been set from the inception of the project, but only annual targets, the changes in outputs did not have a reference point. That observed, nonetheless, the trend in outputs showed that there was a general improvement in indicators overtime.

Gauging from the empirically verifiable reduction in the prevalence of STIs and reported appreciation of services among the target population, the project was successful. The quality of STI services was highly rated, as evidenced by the reported: promptness of treatment, availability of drugs, and confidentiality. Nonetheless, there were limitations with regard to the quality of mobile STI services.

As with the STI, so too with the BCC component, the project succeeded in recording positive behavior change both among the target and wider communities. At the community level, there had been a gradual acceptance of CSWs, which had been

facilitating by the extension of COH health services to the wider community. It was evident from the discussions that the stigma that once was attached to CSW was no longer there. Through the knowledge that they had gained from COH activities, the CSWs were in some cases being utilized as a community resource for: health education, and access to health care at COH drop-in centers. However, the lack of parallel initiatives to offer CSWS alternative livelihoods militated against these achievements.

The introduction of VCT services had improved the effectiveness of the project activities, and this was evidenced by the observed increase in outputs overtime. The VCT services had facilitated synergies with the STI component. However, the provision of both STI and VCT services was expensive and exerted pressures on the health care providers.

While the project had undertaken awareness campaigns and introduced workplace polices at selected transport companies, much could have been done to ensure that the activities were effective. This was illustrated by weaknesses identified by PE's such as poor incentives, lack of effective follow-up action and limited involvement of management in the workplace activities.

From these perspectives, it could be concluded that the project met its objective of reducing the transmission of HIV infection through interventions targeting the CSW and their clients. The effectiveness of the COH project is further illustrated by the results of the BBSS surveys, which showed that there had been a reduction in the prevalence of STIs over the project period. Although originally the focus was on CSWs and LDT drivers, this was expanded to include the so called-bridging communities: tax drivers, the police, customs and ZRA personnel, who patronized CSW outlets. And to the extent that the project succeeded in reducing the prevalence of STIs among the target communities, it was effective.

To summarize, the COH project attained the objectives set out through: recording a consistent increase in the number of beneficiaries overtime; reported and observed reduction in risky sexual behaviors as evidenced by the increased uptake of condoms among the target population, and reduction in the number of sexual partners; and reported behavior change. These achievements were, however, attenuated by various factors, such as: the none inclusion of other important population groups, which form part of the sexual networks; and the non-linkage of the project to other project/activities which would provide an opportunity for income generating activities, once the CSW ceased commercials sex activities.

3.3.4 Impact

Generally speaking it is difficult to ascertain with precision the impact of a recently completed project, let alone an ongoing one. While there may be systemic and behaviour change as a result of a project, the extent to which these changes are likely to be sustained cannot be adequately assessed at the end of the project. In addition, there

are many exogenous factors, beyond the project activities, which impact on outcomes. Consequently, impact is here used with reference to the result of project activities in the target group (CSWs)

In assessing the impact of the project on the direct beneficiaries and the wider communities, the study gauged the views of both institutional and community respondents. In general terms, the project impacted on the community through: provision of IEC/BCC services, which raised awareness about HIV/AIDS and STIs; provision of STI services, which reduced the prevalence of disease; and availability of STI services to the wider community beyond the immediate target groups.

All the component of the project had IEC and BCC parts, through which information on HIV/AIDS and STI was disseminated to the target audiences. The project had impacted on such communities by increasing the knowledge levels related to HIV/AIDS and STIs. All the community groups that were interviewed by the study indicated that they knew the basic facts on HIV/AIDS and STIs.

The consistence in the provision of IEC and BCC messages had also impacted positively in terms of reducing the stigma associated with HIV/AIDS. The community had come to accept HIV/AIDS as a chronic condition, which could be managed like any other health condition. While at the outset, communities stigmatized against those who patronized the drop-in centers, this changed with the extension of coverage to include the wider community and hence the centers were viewed as additional service delivery points and not as centers exclusively catering for CSWs. The observed increase in patronage at these drop-in-centers is testimony of the reduced stigma.

The extension of COH services to the wider community, other than the CSWs, as was originally designed had further reduced the stigma. Through the project, the CSWs had acquired knowledge on HIV/AIDS and STIs. And, in a sense the CSW had graduated from being a subject of scorn to a useful community resource. That the CSWs were able to meet freely among themselves as well with the wider community was testimony of the improved attitudes from the community.

The reduction in stigma had further been helped by the provision of ARVs through parallel service delivery points. In the early stages of the HIV/AIDS epidemic, there was a lot of stigma attached to the condition. This arose out of the sexual connotations that surrounded contraction of the disease, and the terminal nature of the condition since there was no cure. The combination of this and the concentration of initial project efforts on CSWs meant that patronage at the drop-in centers was very low. During the data collection exercise, participants openly indicated how the availability of ARVs had greatly improved the perception of the communities towards HIV/AIDS. Knowing their status, CSWs were able to live better lifestyles that helped them avert further contraction of STIs.

As was indicated above, although the project was originally centered on the principal target population, it had, overtime been extended to the wider community. And thus it

impacted on the wider community by availing them a source of HIV/AIDS and STIs services, to complement government provided services. In relative terms, the COH services were unanimously rated to be better than similar services provided from public sector outlets.

While the project had impacted positively on the target and wider communities: there were some negative outcomes. While ARVs were provided at parallel public health institutions, respondents consistently talked about the need for availing similar services at drop-in centers. There was no parallel weaning program for CSWs, and as such there was nothing the CSW could fall back on whenever they decided to cease the commercial sex trade. While the provision of quality services at the COH drop-in centers was appreciated, this had raised high expectations, which would have to be sustained if the same zeal was to be sustained once the public sector took over the management of the COH service delivery points.

3.3.5 Efficiency and sustainability

The combination of competencies from the various partners who were involved in the project increased the pool of resources for interventions. Thus the project was able to do more than would have been possible with single partner participation. Through the combined participation, the project was able to achieve the following: treatment of STIs; implementation of IEC and BCC strategies; awareness and policy formulation at the workplace and VCT services. The directly provided COH services were supplemented by those provided by other partners such as ARV facilities, to which referrals were made. The combination of competencies from various partners in a way improved efficiency of delivering services. For instance, the project had specialists who covered all the project sites irrespective of the combination of partners at the operational level.

While the larger pool of resources and efficiencies in the utilisation of staff facilitated project success, it also posed serious challenges, not least of which were the management of human resources and accounting systems. For instance within the COH central offices, there were parallel HR and accounting systems, which negatively mitigated against the effectiveness of the project. For instance, where disciplinary matters were concerned, superiors could only discipline staff who belonged to their institutions. Whereas Seniors Manager had operational areas, they could not supervise staff employed by other partners. The divergences in condition of service sometimes generated discontentment among staff and having parallel accounting systems was wasteful.

Although the partner institutions strove to achieve better collaboration, operational weaknesses were still prevalent. The weaknesses were particularly evident at the operational level, where the project had not forged long-term operational links with the local DHMTS. In the long run, the relevant public institutions would have to take over the running of the project activities.

While recognising the existing relationship between the project and the DHMTs, particularly in relation to QA for HIV tests and syphilis, utilisation of district storage for keeping project drugs, and drug transactions, the long-term sustainability of the project would entail that the DHMT took on most of the activities. However, the assessment team and respondents observed that the districts were currently not able to take over management of the project, and ensure the same level of quality that COH services have been renowned for.

4.0 LESSONS LEARNT AND RECOMMENDATIONS

4.1 Lessons Learnt

i. **Successful STI management interventions among high risk groups are those that do not target them in isolation, but involve the wider community.** Although the project originally targeted CSWs and LDT drivers for the treatment of STIs, this was not an effective way of reducing the prevalence of the disease. Hence over time, the project recognised the importance of targeting other groups, which were part of the sexual network involving CSWs. Treatment for STIs at drop-in centres was therefore extended to the bridging and wider communities.

ii. **Community involvement and taking services closer to the community creates ownership and enhances participation.** As with the inclusion of the bridging communities to treat STIs, the programmes also learnt with time and decided to include mobile STI services to supplement the services provided from the drop-in centres. This was helpful in reaching more CSWs, especially those that would otherwise not have been able to access the services because of the financial and geographical difficulties. Taking services closer to the general community facilitated improved access to the services, and acceptance of CSWs. However, there was a downside to the mobile STI services. As these services were provided from communities, the quality was low and with time, there was a reduction in the level of such services.

iii. **Involvement of senior management (decision makers) in HIV/AIDS workplace programmes increases the likelihood of success.** While it is evident that the workplace policy had been implemented in Lusaka and employees sensitised about HIV/AIDS, there were some areas that could be improved. In most of the Lusaka sites visited, respondents indicated that other than the initial awareness meetings, nothing much had been done. Enhanced engagement with the trucking companies at all levels of staff would have resulted in better management commitment to the project and enhanced project effectiveness.

iv. **Successful behavior change strategies are those that are accompanied by livelihood alternatives aimed at sustaining the behaviour change.** Although there was evidence of behaviour change among the target population, there were no weaning strategies for CSWs once they decided to cease commercial sex activities. With hindsight, more could have been done by way of alternative livelihood strategies that CSWs could utilise in the event that they decided to cease commercial sex activities. This could have been done by having working partnerships with other NGOs.

v. **The promotion of VCT services and active involvement of CSWs in community interventions helps reduce stigma and change stereotypes about sex workers.** The introduction of VCT services had helped in reducing the stigma that was associated with HIV/AIDS. Before the provision of VCT services, testing positive for HIV/AIDS was, as was frequently observed during the interviews equivalent to "...a death sentence...." But since the advent of VCT services, this had changed, as people could lead normal lives despite being HIV positive. The VCT services provided by the COH were judged to be better than those provided by government health facilities. The competence of COH staff and assurance of privacy were given as indicators of good VCT services. On the other hand, opening VCT and STI services to the general community helped reduce the stigmatization of CSWs and created acceptance of both CSWs and the project as part of the community.

vi. **Housing many different systems and procedures within one project could be wasteful.** The project benefited from the involvement of various partners, each bringing in their expertise. Thus more was achieved than would have been possible with a single principal. However, this also exposed challenges in the management of the project, not least of which were parallel HR and accounting systems, which were a source of inefficiency. Unified HR and accounting system could have improved the efficiency of the project.

vii. **Establishing strong networks among key partners is necessary for sustaining project activities.** While recognising the existing operational links between the project and DHMTs, there were some areas where improvement would have been effected. Much more engagement with the districts, especially regarding the continuation of the activities beyond the current funding would have delivered sustainable activities.

viii. **Health services can be effectively provided by NGO organizations.** That the COH was able to effectively provide STI services debunked the myth that such services were the preserve of the public domain.

ix. **Sex work is not necessarily a moral issues, but a multidimensional social phenomenon.** Most of the sex workers have histories relating to social, economic, political, cultural and legal factors that led them to engage in sex work.

4.2 Recommendations

i. The evaluation recognised the important operation links that the project had developed with DHMTs, pertaining to use of district storage facilities, district provision of QA services for VCT and syphilis. But it was also clear that if the current funding partners withdrew their support, the project activities could not be sustained by districts. Assuming that there is some interim support to continue the project activities, it would be imperative that:

> **Project managers deepen their engagement with districts in order to start devising mechanisms on how the project activities could be continued after the principal funders cease providing support.**

ii. While the project had initiated and implemented the workplace policy, and the activities were entrenched especially in districts like Ndola where the policy had been running for a long time, Peer Educators in Lusaka where the project had just been introduced expressed misgivings about its effectiveness. They observed that they had limited contact with COH staff, who had not made follow-up visits beyond the initial contacts. **In order to improve the effectiveness of the workplace policy in Lusaka, it would be imperative to:**

> **Enhance the contact between the COH staff and workplace staff, so as to ensure project effectiveness;**
>
> While responses from managers showed that they appreciated and provided support to the project, they could have done more. Closer contact with COH staff and facilitating improved working environment for COH activities would have been helpful. Tacit commitment is not enough. Enhanced commitment from management must be sought to ensure effective implementation of the workplace programs.

iii. Although there was evidence of behaviour change among the target population, there were no weaning strategies for CSWs once they decided to cease commercial sex activities.

> **While recognising that the project is not an income generating activity, it would be within the project interests to explore the possibility of linking it to some income generating activities.** The project has enough components as it is and we do not envisage that it can effectively take on extra tasks, let alone have an in come generating component. It would probably have been a good strategy to link the COH project to other projects that emphasised income-generating activities.

iv. **Given the apparent disapproval of public sector provided services, it is imperative that the project works more closely with the public sector in order**

to share experiences and facilitate the improvement of the services there. This is especially essential in order to ensure sustainability of the activities.

v. **Although the major sources of the funding for the project are about to end, the clear evidence of project success could be used to mobilise other sources of support for the continuation of the activities.** Alternative sources of funding such as the Global Fund could be approached to feel in the gap, and simultaneously improve on the relationship with districts in order to ensure sustainability of the activities. Given further funding, the project should design and concentrate on a phase-out strategy that would ensure sustainable activities.

vi. **Due to the amount of workload on Clinical Health Providers, and assuming that additional funding was sourced, the project should employ laboratory technicians as a way of improving the STI services.**

5.0 References

Bill Gates Foundation;	STI Training Manual for Health Workers (2004)
CDC;	STI management Guidelines
Craft, D.	Selected excerpts of the implementation Evaluation report of the WVZ Cross Border Initiative (Lusaka, 2006)
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ILO;	ILO Code of good practice on HIV/AIDS (Geneva, 2003)
Magnusson, Ake (editor);	HIV/AIDS and the WorkPlace; *A documentary of why and how to fight a pandemic (Odeshog, Stockholm, 2005)*
Ministry of Health (GRZ);	National STI Syndromic Case Management Guidelines in Zambia
WHO	Guidelines for the Management of STIs (2005) Global prevalence and incidence of selected curable STIs