

Risky Business Made Safer

Corridors of Hope: An HIV Prevention Program in Zambian Border and Transit Towns¹



Truck near a Zambia border crossing.

ICRW

Livingstone, Zambia, is a bustling border town, filled with truck drivers, immigration officials, money changers, and many others who live there or pass through to take advantage of the town's economic opportunities. With eight neighboring countries, similar towns dot the country's borders and major transportation routes and are the heart of the nation's agriculture, mining, and trading activities. Yet economic opportunities are also what make these towns hotbeds for the HIV epidemic. Poor women from Zambia and neighboring countries come to these towns to sell sex, using what they earn to feed themselves and send their children to school. These women are vulnerable to HIV and violence because of their limited power with clients, and the illegal nature of their work makes it harder for them to access services to protect themselves. Their clients—truck drivers, vendors, and traders, as well as uniformed personnel such as police officers, immigration officials, and military servicemen—return home to their wives and other partners, spreading HIV throughout towns and across borders.

From October 2006 to September 2009, phase II of the Corridors of Hope program (COH II) worked with many of these groups as well as with the broader population to stem HIV transmission in seven high-prevalence border towns and corridor communities, including Livingstone. COH II taught individuals about HIV prevention, provided HIV and sexually transmitted infection (STI) health services in clinics and through mobile units, and used a behavior change and communication strategy to change risky sexual behavior. COH II also addressed gender-based violence and legal protection through referrals, as these were

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¹ An AIDSTAR-One compendium and additional case studies of programs in sub-Saharan Africa that integrate multiple PEPFAR gender strategies into their work can be found at www.aidstar-one.com/focus_areas/gender/resources/compendium_africa?tab=findings.

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PEPFAR GENDER STRATEGIES ADDRESSED BY CORRIDORS OF HOPE

- Reducing violence and coercion
- Engaging men and boys to address norms and behavior
- Increasing women's and girls' legal protection.

needs frequently identified by sex workers, and worked with men to change their unsafe sexual behavior.

This case study features how COH II addressed multiple gender-related barriers to HIV prevention. AIDSTAR-One conducted in-depth interviews with key informants at the Livingstone District Administration Office, Southern Province National AIDS Council, and the U.S. Agency for International Development (USAID) Mission. They also conducted group and individual interviews with program staff at the country level and with staff at the Livingstone and Kazungula sites. Additionally, AIDSTAR-One held five focus group discussions in Livingstone with Zimbabwean sex workers, “queen mothers,” truck drivers, police officers, and peer mentors. Truck drivers and police officers had not necessarily participated in the program; the other groups were selected for their participation in the program.

Gender and HIV in Zambia

In 2007, Zambia’s HIV prevalence was an estimated 14 percent: 16 percent among women and just over 12 percent among men (MEASURE DHS 2009). But in areas along the borders, HIV prevalence is much higher. For example, provinces that include two of Zambia’s major transportation routes—in a triangular area formed between Lusaka, the border with Zimbabwe, and the Copperbelt area in the north—have the nation’s highest HIV rates, with the highest at 21 percent among both men and women in Lusaka province (MEASURE DHS 2009). HIV prevalence among sex workers is particularly high—65 percent in Lusaka, according to 2005 data (Joint UN Programme on HIV/AIDS and World Health Organization 2008).

The Zambian Government has demonstrated a strong commitment to addressing HIV with its National Multi-Sectoral Response that uses a “Three Ones” approach² and encompasses the public sector, civil society, cooperating partners and donors, the private sector, and politicians (Zambia National HIV/AIDS/STI/TB Council 2006). The government has also created a high-level Cabinet Committee of Ministers on HIV and AIDS, and all line ministries are assigned HIV/STI/tuberculosis focal point persons.

Further, national priorities are taken up at the provincial and district levels by provincial AIDS task forces and district AIDS task forces (DATFs), which

² Partners engaged in the global, national, and local responses to HIV have agreed on the “Three Ones”—one national AIDS framework, one national AIDS authority, and one system for monitoring and evaluation—as guiding principles for improving the country-level response (Joint UN Programme on HIV/AIDS 2005).

operate as decentralized coordinating structures for private, civil, and government service providers. DATFs further build the capacity of community AIDS task forces, which similarly coordinate efforts at the local level. Organizations often adapt their services based on DATF recommendations.

While the Government of Zambia has demonstrated a strong commitment to tackling HIV, it has only partially addressed the link between HIV and gender inequality. In 2000, facilitated by the Gender in Development Division, the government adopted a national gender policy. Subsequent initiatives included the establishment of victim support units for women within police stations, greater involvement of men in HIV prevention and caregiving, more frequent collection of gender disaggregated data, free legal advice for individuals seeking counsel on issues such as property rights and violence, and a Ministry of Health drop-in center for free HIV counseling. The Gender in Development Division has been working to strengthen the penal code on sexual and gender-based violence, align customary and statutory law to ensure gender equality, and enact an anti-domestic violence bill. Though Parliament has yet to pass the bill,³ the government has demonstrated political will to address the issue by launching a UN Children's Fund-backed campaign called "Abuse, Just Stop It" in November 2009.

However, efforts to address gender inequality have not been adequately integrated into the health sector. The government has not provided guidance on how to mainstream gender in HIV programming, and consequently programs targeting HIV outcomes at the local level are not adequately addressing the link between HIV and gender-related barriers such as poverty and sexual and gender-based violence. Further, service providers lack skills to incorporate gender into their assessment processes as well as the capacity to monitor and evaluate the outcomes

³ The Anti-Gender Based Violence amendment (Bill number 46 of 2010), along with the Penal Code amendment (Bill number 47 of 2010), went through a second reading in Parliament in February 2011.

of gender mainstreaming. There are also limited coordination mechanisms among ministries, donors, and service providers to address gender inequality and its linkages with HIV.

The Corridors of Hope Phase II Approach

COH II's approach followed guidelines suggested by the government, such as targeting high-risk groups defined in the national HIV policy, and expanded its HIV prevention services and behavior change programs to the broader population in response to more recent government recommendations. Its activities reflected the government's efforts to use a coordinated response by working with other service providers to provide women and men with comprehensive services, such as care and treatment, counseling, legal protection, and income generation. For example, incidents of gender-based violence and legal protection were referred to local police, while violence-related health care needs were referred to government hospitals. Some participants were also referred to education and economic activities and programs, operating in locations with COH II sites.

Development and Implementation

Program Design and Start-up: COH II, funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through USAID, was the 3-year U.S.\$11 million phase of a now 10-year-old program (COH). It was managed by Research Triangle International and implemented by Family Health International in partnership with three Zambia-based nongovernmental organizations: Afya Mzuri, Zambia Health Education and Communication Trust, and the Zambia Interfaith Networking Group on HIV/AIDS.

It aimed to reduce HIV transmission, morbidity, and mortality in seven high-prevalence border towns and corridor communities in Zambia. The program used the ABC approach (abstinence until marriage, be faithful, and correct and consistent use of condoms) to promote HIV prevention. COH II provided HIV testing and counseling services, STI testing and treatment services, and condom distribution at its seven centers. Mobile units provided STI and HIV outreach services such as voluntary counseling and testing to the general population including residents in remote areas. The program also used a behavior change and communication strategy to raise awareness and knowledge about risky sexual behavior of high-risk groups and the broader community. COH II sought to change attitudes and practices around unsafe sex, particularly among men, whose high-risk behaviors increased their own risk of HIV infection and that of their female partners. COH II targeted the broader community because the large numbers of transient populations in border and transit towns made the prevention, care, and treatment needs of the whole community more acute. Furthermore, the program worked with civil society and local and district government to coordinate efforts and better mobilize communities on HIV prevention, care, and treatment.

COH II built on the successes and lessons learned from COH I, a Family Health International program implemented from 2000 to 2006 in 10 Zambian communities. COH I began with behavior change and STI services targeted toward female sex workers and their clients, including truck drivers and uniformed services personnel. It added services for HIV testing and counseling, as well as services for youth aged 15 to 19 in 2004 when it began receiving PEPFAR funding.

While COH I successfully addressed HIV and STI infections among traditional high-risk groups, HIV had meanwhile become a generalized epidemic in Zambia, and HIV risk in border and transit communities went beyond program target groups

and was an issue for the general population. COH II therefore aimed to reach the community at large in the towns and surrounding communities of Chipata, Chirundu, Kapiri Mposhi, Kazungula, Livingstone, Nakonde, and Solwezi. COH II continued to pay special attention to the needs of sex workers, but it also targeted other groups potentially at risk of HIV, such as girls and young women engaging in transactional sex or cross-generational sex, survivors of sexual and gender-based violence, and the HIV-negative partner within a serodiscordant couple. A wide array of transient populations—including truck drivers, uniformed personnel, traders, money changers, customs officials, and migrant workers—and their sexual partners were targeted by the program. School-aged youth were also targeted. COH II targeted services at each site to groups that were at highest risk in that area.

In addition to recognizing the need to go beyond traditional risk groups, program staff identified other lessons from COH I, such as increasing service accessibility and working with community members to reduce stigma and discrimination against sex workers. Staff learned that involving community leaders in decision making and developing strong partnerships with civil society and government was important for sustaining the program.

Behavior Change and Social Change: A key component of COH II is behavior and social change. The project's behavior change and communication team used group sessions that employed a reflective, participatory methodology with the general population and at-risk groups in particular to change individual risk behavior (Zambia COH II 2008a, b). These REFLECT⁴ sessions sought to

⁴REFLECT is the acronym for "Regenerated Freirean Literacy through Empowering Community Techniques." Pioneered by the Brazilian educator Paulo Freire, this approach is based on conscientization theory and uses techniques of participatory rural appraisal to explore, and find solutions to overcome, development challenges. The emphasis is placed on dialogue and action, raising awareness, cooperation, and empowerment. Action AID developed REFLECT in 1993, and it is now used in over 60 countries to address societal issues such as HIV and conflict resolution.

help individuals meaningfully participate in decisions about their own lives by helping them reflect on and create action plans to address their own concerns. The program used participatory tools to create an open, democratic environment for sharing and to stimulate discussion. Participants were encouraged to find their own solutions for reducing their HIV risk. For example, a few truck drivers interviewed as part of this case study said that they now sometimes traveled with their wives so that the sex they engaged in was with a safe partner.

Staff held REFLECT sessions as informal meetings with groups of women or men in spaces where they felt safe or comfortable—in the rooms of sex workers or in the truck parks where truck drivers slept, for example. The Zimbabwean sex workers interviewed for this case study said that COH II staff came to talk to them in their guest house about once a week, sometimes more.

To bring about social change, COH II used a social mobilization approach based on community participation and action. Community groups worked collaboratively to spread prevention messages among their members to change broader social norms around safer sex practices. Each COH II project site had a Behavior Change Communication Steering Committee of local organizations to ensure that community members, particularly vulnerable groups, had a voice in COH II program activities. COH II also partnered with a variety of local stakeholders ranging from leaders to community groups to government officials to coordinate services so that messages and other behavior change efforts would be more effective.

As another part of its efforts on behavior and social change, COH II set up a peer educator program to disseminate messages among target groups and the broader community. Peer educators were affiliated with a range of community organizations and groups, including churches, theater groups, youth groups, support groups for people living with HIV, and former

COH II clients. Peer educators shared messages in ways that were appropriate for a particular group. For example, a former sex worker and COH II client said her background legitimized her messages when she went to bars to talk to sex workers. Another peer educator with a church group said she could not discuss sex—and thus could not discuss abstinence—publicly, but was able to promote HIV testing within the church. Each peer educator appeared to recognize the limitations of his or her own approach and the importance of coordination. They were willing to work with other groups even when they did not promote HIV prevention the same way.

Working with Sex Workers, “Queen Mothers,” and Men: Commercial sex work is common in Livingstone District, a hub for tourism and cross-border trade, with Zambian sex workers often coming from the poorer Copperbelt Province or from Lusaka and foreign sex workers coming from neighboring countries such as Zimbabwe. COH II met with groups of sex workers on a weekly basis. They discussed HIV and STI transmission and strategies for protecting oneself against infection, as well as information on accessing complementary services provided by other agencies.

COH II also worked with “queen mothers,” women in their 30s and 40s and often former sex workers, who landlords hire to supervise sex workers in guest houses. The program trained them in safer sex practices, information they then shared with the sex workers they monitored to better protect them against HIV, STIs, and violence. Queen mothers also sometimes led REFLECT sessions with sex workers to help them discuss and solve their problems.

REFLECT sessions were also held with at-risk groups of men, such as truck drivers, male police officers, immigration officials, money changers, and traders to provide them with information on safer sex practices, STI and HIV transmission, alcohol as a risk to safe sex, and risks associated with multiple

MONITORING AND EVALUATION

Monitoring data shows that COH II reached over 1.6 million individuals between 2007 and 2009 with efforts to curb risky behaviors for HIV, along with those in HIV prevention, care, and support. During the same period, over 1,600 individuals were trained in various program areas, including messaging around abstinence and faithfulness, and the promotion of condom use. From 2007 to 2009, COH II provided 69,000 men and women with HIV testing and counseling, and from 2007 to 2008, an additional 7,800 individuals accessed STI screening services.

partnerships. The program encouraged men to examine behavior that increased their risk of HIV and asked them to offer realistic solutions to protect themselves.

Referrals and Collaborations: Where COH II did not provide a service required by its target groups, it offered clients referrals, including those for antiretroviral therapy and care services for HIV-positive clients. It referred women in need of legal protection services to the police and legal aid centers, and gender-based violence victims to hospitals and the police. Thus, COH II developed an extensive referral network in each community to provide a comprehensive response to client needs.

Additionally, COH II collaborated and coordinated with district and local government and civil society. For example, COH II was a key member of the DATF in each district in which it implemented activities and helped build the capacity of DATF members in peer education. COH II staff also participated in activities such as Field Days, in which multiple service providers offered a wide array of services to residents within a select remote area.

What Worked Well

COH II contributed to PEPFAR’s goals in Zambia to prevent new HIV infections and provide individuals with care and support services. Mobile outreach units were successful in increasing demand for and use of voluntary counseling and testing and other HIV prevention services. Nearly 85 percent of the individuals tested by COH II were seen at the mobile units. The program also offered voluntary counseling and testing services during local ceremonies such as harvest celebrations at the invitation of traditional leaders; unanticipated demand often resulted in the mobile units having to stay additional days in the community.

In interviews with sex workers, women said the COH II program was one of the few services available to them and the only one in which they were treated with dignity and respect. They reported that the clinic-based services were reliable for treating STIs effectively, and behavior change sessions had helped them develop strategies to protect themselves from HIV, STIs, and violence. The COH II facility was centrally located in a nondescript house, and its services were well known. In informal conversations around the Livingstone site, COH II was described as having a trusted reputation in the community and providing accessible and effective treatment services for STIs.

Many sex workers from Zimbabwe interviewed as part of this case study said that they knew how to protect themselves from HIV and STIs as a result of COH II training, which reinforced what they had learned from school-based sex education programs in Zimbabwe. They reported that REFLECT sessions gave them the skills and confidence to refuse men who did not want to use condoms without fearing consequences—they felt it was their choice. They also said they talked to recent arrivals (fellow sex workers) at their guest house, encouraging them to protect themselves from HIV and sharing strategies on doing so. Most men did not want to use condoms and had to be convinced, they reported. Some of the women said they talked to their clients about HIV and STI prevention, which convinced some men to utilize condoms while others were uninterested.

Queen mothers reported that they worked with sex workers to develop prevention tactics. For example, they taught sex workers techniques to make sure men did not take off a male condom or push aside a female condom. Queen mothers also said that some sex workers kept the light on to ensure that

men did not secretly remove the condom or cut off the tip. Queen mothers reported that condom cutting had gone on because women had become better at monitoring men. Queen mothers also said they addressed alcohol and HIV risk with sex workers, explaining that alcohol interferes with the effectiveness of antiretroviral drugs, and forbade drinking in the guest houses. They encouraged women to wear a female condom when soliciting clients at bars to ensure they were protected if drunk.

Queen mothers stated that they helped protect sex workers from violence. Both sex workers and queen mothers said during interviews that physical violence and sexual and gender-based violence were a frequent occurrence for sex workers. Queen mothers said they encouraged sex workers to use peer groups for protection, and sex workers reported that they looked after each other to prevent abuse, using tactics such as keeping doors unlocked and monitoring when a client entered a room with a sex worker. Queen mothers reported that while they relied on male guards and other women in the house to respond to violent men, they rarely called the

PROGRAM INNOVATIONS

- Targeting at-risk groups in conjunction with the broader community responded to the generalized epidemic in Zambia.
- Working with sex workers, particularly foreign sex workers, helped address the needs of a key target group that is particularly vulnerable to HIV, yet has little or no access to services.
- Targeting high-risk groups in each site based on the local context allowed for more effective programming.
- Close coordination with civil society organizations and local and district government through DATFs and other efforts ensured geographic and service gaps were addressed.
- Including community stakeholders and beneficiaries in designing, implementing, and evaluating the program, as well as building the capacity of local implementing organizations in administering, implementing, and evaluating the project, helped the project build in sustainability.
- Working with men and creating a referral network of services for women, such as for those who have experienced gender-based violence, recognized the need to address gendered vulnerabilities.

police or neighborhood watches because of stigma and fear of arrest.

In interviews with truck drivers and police officers, some had accurate knowledge of HIV transmission and risk as a result of the COH II program and information provided by their employers. Truck drivers said that they sometimes used condoms with sex workers but never with wives. Some men reported that they did not protect themselves because they believed contracting HIV was inevitable. In contrast, when interviewed, male and female police officers demonstrated a sound knowledge of HIV risk and prevention, and reported that they had easy access to condoms as these were provided by the police department. Many of the officers indicated they even purchased better quality condoms to demonstrate that they practiced protected sex.

Challenges and Lessons Learned

Limits of a referral system: While COH worked effectively with women and men to change harmful behaviors that increased their HIV risk, the program was not designed to address broader gender inequalities that put women at risk. While sex workers sometimes discussed strategies to protect themselves from violent clients and gang rape during REFLECT sessions, sexual and gender-based violence was not discussed with men as part of program activities. The link between HIV and sexual and gender-based violence was also rarely made in discussions with men and women, except where sex workers themselves identified rape as a risk for HIV infection. This posed a missed opportunity for a program that was well placed to influence individual behavior as well as societal norms around violence against women, but whose mandate did not include it. Similarly, the program was not designed to address the need for legal protection, income equality, and

gender equality except through referrals to other services, some of which were limited in scope and effectiveness. In addition, program staff said that clients often complained about the referral system, as they found it difficult to access service providers in different locations because of transportation costs and the burden it placed on their other responsibilities. They also found it difficult to disclose their personal histories to different service providers at each referral agency. Program staff added that they tried to track clients to determine if they reached referral agencies, but that this often proved to be a challenge.

Police as a barrier: While police can be effective, respectful service providers, the police interviewed for this case study spoke openly about their discrimination against, and abuse of, sex workers. Sex workers repeatedly said in interviews that they did not feel safe seeking help from police officers, and foreign sex workers said they were particularly vulnerable to police abuse. As one woman explained, “If we go to the police, they ignore us because we are Zimbabweans.” Another woman said that she had gone to the police’s victim support unit when she had been badly beaten by a man, but was dismissed by police officers without receiving assistance. Women also said that violent men who were arrested were often quickly released, sending the message that violence against sex workers was not a priority of the police.

Police officers themselves said they felt no obligation to provide services to sex workers because their work was illegal and furthermore, some sex workers were not Zambian citizens. They admitted demanding sexual favors from attractive women who sought assistance in the victim support unit in exchange for police services, dismissing any responsibility because they were “only men.” One of the department heads even made jokes about violence as a useful way to “discipline” women, confirming that violence against women was not taken seriously by the department or its leadership.

These responses are particularly problematic in the context of the COH II program in that the program relies on violence-related referrals to the police department's victim support units. Clearly, there is an urgent need to work with police departments to change male attitudes and behaviors that harm the women they are supposed to serve.

Entrenched norms limit work with men:

Social norms around masculinity and how women are valued limit behavior change among men. For example, while some truck drivers interviewed in this study reported that they sometimes used condoms with sex workers and condom use with sex workers was perceived as acceptable, they also said that condom use with wives was completely unacceptable because of norms around male power in the home and because a partner requesting condom use was an admission of extramarital sex or HIV/STI infection.

Sex workers in this case study expressed a strong concern for the wives of their clients, whom they believed lacked information on STIs and HIV and thus were unable to protect themselves. One woman said, “[Men] come here, they want to have unprotected sex, they go home, they infect their wives.” Another added, “That’s why we encourage them to use condoms with us. Because if they go back home, they infect their wives.” These women said that there is an unmet need for programs to work with men, including educated men, on HIV prevention education.

On a more positive note, truck drivers expressed the desire for recreation opportunities other than drinking and sex, explaining that they sought sex workers because there was nothing else to do when waiting at the border for deliveries or border passes. They added that quicker transitions at the border or facilities for engaging in sports or similar activities would help them avoid these risky situations. This is a valuable insight that could be incorporated into program design as COH II begins its next phase.

Legal barriers: The stigma and marginalization of sex work in Zambia makes it extremely difficult for sex workers to seek services such as health care or legal protection in cases of rape or assault because they fear abuse and arrest. It also makes it easy for men—including authority figures such as police officers—to take sexual or financial advantage of sex workers without consequences. Sex workers who are in the country illegally are doubly vulnerable. They are more vulnerable to abuse and access services less because of fear of arrest or stigma than Zambian sex workers. According to sex workers and police officers, women identified as sex workers can be arrested in any public setting under the pretext of public nuisance, while a sexual double standard permits men to purchase the services of sex workers with impunity. Sex workers also reported that police raids of sex worker guest houses are common, and sometimes women are raped before release from police custody. The stigma of sex work that discourages women from seeking health and legal protection services, combined with men’s exploitation of women’s vulnerability in this regard, are key factors in worsening the HIV epidemic in Zambian border and transit towns.

Need for a regional response: Program staff at COH II stated that a key challenge in addressing HIV in border and transit towns is that the epidemic cannot be addressed by one country. Countries need to work together to ensure an adequate response, and programs need to involve entire regions to appropriately address the problem and the many groups involved. This requires regional programs that involve coordination across governments and service providers in neighboring countries.

Stigma and discrimination in health care settings: There is a need to provide services to stigmatized groups and foreigners in a nonjudgmental fashion. Sex workers said they preferred to receive health services at COH II’s clinics, where they were treated with dignity, rather than government health centers that treated sex

workers poorly and discriminated against foreigners. Foreign sex workers reported that they were charged higher rates in public hospitals than Zambian women and that examinations and treatment they received were badly administered because of the discriminatory attitudes of some health care workers. Changing discriminatory attitudes and practices requires raising awareness of service providers and the broader community in border areas as to the rights and treatment of sex workers and immigrants.

Poverty as a barrier for women: Sex workers interviewed in this study reported that men paid significantly more for sex without a condom. Queen mothers said that men paid about 15,000 Zambia kwacha (about U.S.\$3) for sex with a condom, and about 25,000 kwacha (about U.S.\$5) for sex without a condom. While many sex workers practiced safe sex, they said they sometimes made exceptions about condom use during difficult financial times to earn more money. Women understood that poverty put them at risk of HIV infection. A Zimbabwean sex worker explained, “They take the money because they are in need of it. They can’t think about tomorrow.” Sex workers said they dreamt of having an income from some alternative source—either running their own small business, securing a better job, or finding a stable partner who would provide for them—but none of them knew of any income generation programs. COH II program staff confirmed that few programs of this nature exist at their program sites.

Need to strengthen gender mainstreaming: Finally, government and civil society services that address HIV often do not understand or address gender-related barriers that can affect HIV outcomes, and that gender-related efforts such as the legal protection of women operate separately from the health sector. As one respondent explained, “Don’t look for coherence in these programs, because you won’t find it.” The Zambian Government’s response requires guidance on how to mainstream and implement gender equality in HIV programming. Adequate

training, guidelines, and coordination are needed to mainstream and implement gender strategies into HIV efforts. Service providers also need gender indicators and training on monitoring and evaluating gender mainstreaming efforts, and these measures can provide an opportunity for a program like COH to address broader gender inequalities, such as gender-based violence, that increase one’s HIV risk.

Future Programming

COH II was funded for an additional five years as COH III, which began in October 2009. The emphasis of this phase of the program will continue to be on reaching the broader population with behavior change efforts for HIV prevention. COH III has planned activities to address gender-based violence more effectively. It will provide outreach and counseling to women on gender-based violence, training to health care workers on violence-related risk assessment and medical care, and referrals to partner organizations, hospitals, and the police service’s victim support units. The program will also target youth to provide personal risk assessment skills and violence education, as well as target influential community members, such as traditional birth attendants and the wives of male community leaders, to provide violence-related communication and risk assessment skills.

Plans for COH III include targeting men specifically to change harmful male norms that are linked with HIV such as gender-based violence and multiple and concurrent partnerships through group-based sports activities for young and adult men. COH III will use the Stepping Stones training package (Welbourn 1995) and REFLECT discussions to train men in gender and sexuality topics, including violence and relationship skills, and to encourage them to develop their own solutions to problems such as violence. It will also use resources such as the Health Communications Partnership *Men’s Health Kit* (Health Communications Partnership

2009) and the *One Love Kwasila!* (One Love Kwasila! 2009) resources to address norms around multiple and concurrent partnerships. ■

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RESOURCES

Integrating Multiple PEPFAR Gender Strategies to Improve HIV Interventions: Recommendations from Five Case Studies of Programs in Africa: www.aidstar-one.com/gender_africa_case_studies_recommendations

Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa. Corridors of Hope II (p. 190): www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf

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RECOMMENDED CITATION

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