A Community Based HIV Prevention Strategy for Priority Population (PP).

USAID Zambia Community HIV Prevention Program (Z-CHPP)
Cooperative Agreement No. AID-611-A-16-00001
December, 2016
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December, 2016.

Disclaimer:

This strategy paper is made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). The contents of this strategy paper are the sole responsibility of Pact and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government.

Recommended citation:


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I. Introduction

The USAID/PEPFAR-funded Zambia Community HIV Prevention Project (Z-CHPP) is a five-year cooperative agreement led by Pact to accelerate progress towards Zambia’s goal of reducing new HIV infections. The project supports Zambia to reach the United Nations Program on HIV/AIDS (UNAIDS) 2020 goal of having 90% of all people living with HIV (PLHIV) know their status, 90% of those who know their HIV positive status receive sustained anti-retroviral therapy (ART), and 90% of those on ART achieve viral suppression.

To accomplish its goal, Z-CHPP will increase the adoption of high impact HIV services and protective behaviors among at-risk populations using evidence-based and locally owned solutions. Z-CHPP has four specific objectives:

1. Key determinants of risky behavior mitigated among priority populations
2. Increase in completed referrals from community programs to high impact services
3. Actions adopted by communities to reduce young women’s vulnerability to HIV, unintended pregnancy and SGBV
4. Strengthened capacity of local stakeholders to plan, monitor, evaluate and ensure the quality of prevention interventions

Z-CHPP maximizes the impact of USAID resources by focusing on where the greatest gains can be achieved: in high prevalence districts, especially those that are densely populated; targeting population groups that are at high risk of becoming infected or infecting others; and by tailoring approaches to different segments of the population. Activities are implemented directly by Pact and its core international partner Plan, as well as by local partners through sub-grants. The approach leverages existing relationships at the community level by engaging and supporting traditional and religious leaders, community-based service providers and the decentralized government structures.

Z-CHPP implements activities in 25 priority districts across Lusaka, Central, Copperbelt, Western, North Western and Southern provinces. Within each district, Z-CHPP aims to achieve high saturation of interventions, focusing first on rapid scale-up of HIV testing services (HTS) and reaching PLHIV who are outside of the treatment cascade, then expanding the coverage and scope of activities including a comprehensive package of interventions to reach priority high risk populations, namely:

- Adolescent girls and boys (10-19 years)
- Young women and men (20-24 years)
- PLHIV
- Sero-discordant couples
- Other priority populations including male sexual partners of adolescent girls and young women (AGYW), cane cutters, miners, fish traders, long distance truck drivers and other migrant workers.

II. Z-CHPP Behavioral Prevention Strategy

HIV-related behavior change research in Zambia and globally has affirmed that moving from awareness to action requires interventions that go beyond the individual level. Z-CHPP’s approach to behavior change follows the Network-Individual-Resource Model, an ecological model that argues that prevention, access to treatment, and adherence efforts are more successful and sustainable when they (1) prompt positive behavior changes that can be sustained by existing individual and community resources; (2) are consistent with the individual’s current situation/developmental stage; (3) are trusted and valued; and (4) target high
HIV risk networks. This model recognizes the interplay between factors at the individual, interpersonal, community, institutional and structural levels, and holds that risks and prevention needs depend importantly on the life stages and socio-economic circumstances of individuals.

Within this model, Z-CHPP delivers a comprehensive mix of behavioral, biomedical and structural interventions that are prioritized to meet the prevention needs of targeted individuals and communities. This combination package emphasizes direct provision of or referrals to proven high impact prevention interventions (e.g., condom provision, voluntary medical male circumcision, post-exposure prophylaxis, sexual and reproductive health services including family planning, and immediate initiation of ART) and to the continuum of HIV testing, care and treatment. The following table provides an overview of Z-CHPP’s combination prevention interventions:

<table>
<thead>
<tr>
<th>Behavioral</th>
<th>Biomedical</th>
<th>Structural</th>
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</thead>
<tbody>
<tr>
<td>• Community and door-to-door outreach</td>
<td>• Condom provision</td>
<td>• Guided community dialogue addressing:</td>
</tr>
<tr>
<td>• Community conversation meetings</td>
<td>• Community-based HTS</td>
<td>- SGBV</td>
</tr>
<tr>
<td>• Individual and small group peer education</td>
<td>• Referrals to:</td>
<td>- Social and cultural norms</td>
</tr>
<tr>
<td>• Mentorship (for adolescents)</td>
<td>- Facility-based HTS</td>
<td>- Gender equity</td>
</tr>
<tr>
<td>• Condom promotion and provision</td>
<td>- SRH/FP</td>
<td></td>
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<tr>
<td>• Skills education</td>
<td>- STI screening</td>
<td></td>
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<tr>
<td>• Basic literacy for HIV prevention</td>
<td>- PMTCT</td>
<td></td>
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<tr>
<td>• Hotline counseling</td>
<td>- VMMC</td>
<td></td>
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<tr>
<td>• Targeted mass media prevention</td>
<td>- Care and treatment/ART for prevention</td>
<td></td>
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<tr>
<td>education (e.g. local FM Radios)</td>
<td>- TB screening</td>
<td></td>
</tr>
<tr>
<td>• Interpersonal communication (IPC)</td>
<td>- Post-exposure prophylaxis (PEP)</td>
<td></td>
</tr>
<tr>
<td>• Parenting skills for families</td>
<td>- Pre-exposure prophylaxis (PREP), when approved and available</td>
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</table>

Z-CHPP’s behavioral interventions include a range of social and behavioral change communication activities (SBCC) designed to promote HIV risk-reducing behaviors and uptake of high impact services. SBCC activities span community outreach and mobilization, interpersonal communication (IPC), and information, education and communication (IEC) materials distribution that all have the objective of improving the knowledge, attitudes and skills of priority populations (PP) for HIV prevention. In particular, IPC such as one-to-one and small group education and outreach activities is a cornerstone component of Z-CHPP’s overall prevention strategy. IPC entails a dynamic two-way process of conveying messages and receiving messages, but to be effective, it must extend beyond awareness-raising and use strategies to motivate and sustain behavior change. It requires trained peer educators and continuous program oversight to ensure that all are delivering consistent messages using standardized approaches, whether it is during a one-time encounter or repeated sessions with the same individual or group.

IPC interactions must also meet the minimum components for the provision of prevention information, services and referrals defined in PEPFAR’s key indicator for prevention in order to be counted and reported. This indicator – “the number of the priority populations reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake” (known as “PP_PREV”) – is a critical measure of the reach of Z-CHPP’s SBCC activities to its intended target populations. Examples of IPC activities in the project include:
• Safe spaces group discussions with out-of-school adolescent girls on sexual and reproductive health
• One-on-one conversations with mobile men to encourage HIV testing
• Door-to-door outreach to sensitize families/couples and connect them to Z-CHPP program and services
• Counseling of HIV-positive men and women on how to disclose their status to their partner
• Dialogue with cultural and religious leaders on harmful social-cultural and gender norms
• Peer to peer support among PLHIV on adherence to ART

III. The Purpose
The purpose of this document is to provide operational guidance for Z-CHPP sub-partners on the scope and content of individual and group-level HIV prevention interventions that will be carried out by trained peer educators, community change agents and lay counsellors in the community settings. This guidance will in turn assist partners in building the knowledge and skills of the community providers and supervising IPC activities in their target districts and communities, while ensuring quality, compliance to reporting requirements and alignment with the Government of Zambia’s national HIV and AIDS communication strategy.

This paper is a living document that will be reviewed periodically and revised/updated as necessary throughout the life of the Z-CHPP project to ensure that feedback, lessons learned and best practices are incorporated. In addition, it is intended to supplement and not replicate Z-CHPP’s comprehensive SBCC strategy, a separate document which outlines the technical framework and behavior change objectives for the project’s SBCC interventions using a broad range of mutually reinforcing communications channels, including community radio, community leaders and gatekeepers, peer educators, service providers, and IEC materials.

III. IPC Package of Interventions
Z-CHPP employs a targeted approach to IPC using local information on the HIV epidemic, including the findings of Z-CHPP’s formative assessment on the vulnerabilities and risks of priority populations and community mapping conducted by local partners, to ensure that the project is reaching individuals and families who are most-at-risk/most vulnerable to HIV infection (also referred to as “clients”) and contribute to achieving epidemic control and UNAIDS goal of 90, 90, 90.

Under this approach, the project has instituted a standardized package of IPC prevention interventions for youth (10-24 years) and adults (25 years and above) in accordance with PEPFAR guidelines. Peer educators tailor these interventions and select those that are most appropriate for addressing the specific needs and concerns of clients, their stage in life and their risk circumstances.

The intervention packages for adults and youth are summarized in the following tables:

**Prevention Packages for youth:**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td><strong>Uptake of high impact, youth-friendly services</strong>&lt;br&gt;Promotion of relevant youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability and uptake of these services</td>
</tr>
<tr>
<td>2</td>
<td><strong>HIV risk reduction</strong></td>
</tr>
</tbody>
</table>
Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain behavior change; and promote gender equity and supportive norms

<table>
<thead>
<tr>
<th></th>
<th>Prevention Packages for adults:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Uptake of high impact services</strong></td>
</tr>
<tr>
<td></td>
<td>Promotion of relevant prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services</td>
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<td><strong>HIV risk reduction</strong></td>
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<tr>
<td></td>
<td>Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain behavior change; and promote gender equity and supportive norms</td>
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<tr>
<td>3</td>
<td><strong>Continuum of HIV testing and care</strong></td>
</tr>
<tr>
<td></td>
<td><em>Referral to or provision of HIV testing;</em> facilitated linkages to care and prevention services; and/or support services to promote use of, retention in, and adherence to care</td>
</tr>
<tr>
<td>4</td>
<td><strong>Condoms</strong></td>
</tr>
<tr>
<td></td>
<td>Condom and lubricant (where feasible)- promotion, skills building and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets</td>
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</tbody>
</table>

This standardized package plays an important role in setting the focus for and prioritizing Z-CHPP prevention activities. In districts where the PEPFAR DREAMS Initiative is being implemented, namely Lusaka, Ndola and Chingola, Z-CHPP is providing an expanded package of prevention interventions for AGYW (10-24 years) to address their multiple vulnerabilities to HIV. This package is described in detail in Z-CHPP’s *Safe Spaces Manual* and USAID’s *Operational Guide for DREAMS*.

Per PEPFAR requirements, in order for a client to be counted and reported as reached, the following requisites must be met:

<table>
<thead>
<tr>
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<th>For individuals that have NOT previously been diagnosed as HIV positive:</th>
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<tbody>
<tr>
<td></td>
<td>• Referral to or provision of HIV testing <strong>must</strong> be offered, at least once every 12 months</td>
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<tr>
<td></td>
<td>• At least one additional intervention <strong>must</strong> be offered</td>
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<td></td>
<td>• Minimum of two interventions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>For individuals who self-identify as HIV positive:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• At least one intervention <strong>must</strong> be offered</td>
</tr>
<tr>
<td></td>
<td>• Minimum of one intervention</td>
</tr>
</tbody>
</table>

HTS is a focal intervention in this package. Requiring the referral to or provision of HIV testing to individuals who are not known as diagnosed HIV positive is intended to ensure that they have the
opportunity to get tested for HIV. Key SBCC messages to be conveyed to clients as part of the delivery of these interventions are segmented by priority population group in Z-CHPP’s SBCC strategy document.

IV. Role of Peer Educators (PEs)

Peer education is an approach that empowers people to work with people of similar characteristics, such as age, sex, social group or status, health status, occupation or other factors. It helps to break down barriers by allowing people to discuss sensitive matters with others whom they can trust and relate to. Multiple studies in various contexts over the past two decades indicate that behavioral interventions can best impact behaviors if they, among many other factors, utilize channels (such as peer education) that can effectively reach the target audiences. Community level interventions through peer education model has been documented to increase service utilization and acceptance, change in attitudes and norms. Cost-effectiveness studies have shown that interpersonal communication (through peer education) has the ability to reach hard-to-reach population groups in a cost-effective manner. And beyond its direct effects upon behavior, there is increasing consensus that interpersonal communication interventions may have important secondary or indirect effects through the diffusion of program messages through social networks.

Z-CHPP will use one of the combination HIV prevention package intervention; peer led outreach services to reach its target population. The trained priority population (PP) members will link their peers to program services. This will enable Z-CHPP, through its sub-partners, to engage directly with priority populations and build their capacity to protect themselves and others from HIV.

The primary roles of peer educators in IPC is to:

1. Motivate priority population (PP) for HIV prevention discussions and service utilization
2. Transfer knowledge and skills to priority populations to be better able to reduce risk behaviors and address other barriers to health and well-being
3. Support priority populations to access and demand necessary HIV prevention, care and treatment services and other services that are important to them
4. Support priority populations to access necessary peer and social support to reduce risk behaviors

Additionally, Z-CHPP peer educators will participate in mapping and/or validating of priority populations and identifying priority hotspots for interventions. They will also conduct programmatic mapping to determine where the greatest concentrations of population members are located and the available services.

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Recruitment, selection and Training
The process for selecting PEs is critical and will be taken up as an important process for the project success, sustainability and community ownership. Z-CHPP will recruit PEs using a set and tested criteria. The following attributes will be considered:

- Shares demographic characteristics with the clients (peers)
- Committed to the goals and objectives of the program
- Knowledgeable about the local context and setting and especially their peer networks
- Committed to gender equality and ready to challenge one’s own negative gender attitudes and values
- Being prepared to explore one’s own attitude and beliefs and to change own behavior
- Able to maintain confidentiality
- Good listening, communication and interpersonal skills
- Potential to be/or a strong role model for the behavior she/he seeks to promote with peers

Z-CHPP and its sub-partners will ensure that peer educators receive training designed to prepare them to increase their knowledge and skills for prevention of HIV, GBV and other sexual and reproductive health outcomes. The training will enable them to deliver targeted SBCC interventions and demand creation for biomedical, structural and social services both at individual and group level. PEs will also be capacitated to facilitate individual and group education sessions for their peers using a specific curricula and promote discussion and critical reflection rather than merely giving messages. They will also conduct personal risk assessment that informs the tailored services and referrals to be provided.

Basic skills such as strong planning skills, ability to manage conflicts, basic knowledge of HIV and AIDS, demonstrating ease in talking about sexual, personal and taboo topics; and ability to read and right will be considered paramount in recruiting the Peer educators.

V. Service Delivery through Peer Education
The provision of combination prevention services to priority populations (PP) through peer educators (PE) will include programmatic mapping to determine where the greatest concentration of PP are, conducting risk assessment, providing individual and small group education, distribution of targeted SBCC materials to increase awareness for regular service utilization and sensitization of stakeholders on the significance of counseling and testing for PP.

Since PEs are knowledgeable about the local context and settings especially on their networks, they will actively participate in mapping the geographic areas of operation so as to identify all hotspots relevant to the program, define the type of hotspots and characterize the type and size of the PP accessing them (e.g. migrant labors, AGYW or a combination of both). The identification of the hotspots will guide the development of the route plan, describing locations and target population for the demand creation as well as the SBCC education and the delivery of services. They will also promote the use of static and mobile HTS by informing beneficiaries on days and time of service.

With the exception of migrant workers, peer educators will ensure at least two contacts with individuals or groups reached from priority populations, with a recommended interval of 10-20 days between initial contacts. Given the mobility of migrant workers, peer educators may use one-off sessions to reach these
groups as they may not be easily located again due to the nature of their occupation. The idea is to make
the best possible use of each opportunity to interact with individuals from priority populations and
provide them with HIV information and services, particularly HIV testing as the entry point to care and
treatment.

In each contact, peer educators will use dialogue-based approaches to focus on understanding the
individual or group’s risks to HIV and discussing or solving problems and concerns. These discussions will
provide direction for the kind of SBCC topics to cover. During early or initial contact with a client or group,
peer educators will offer the minimum one or two interventions to clients per the Z-CHPP prevention
package to count the individual as having been reached. Depending on the rapport and relationship
established with an individual and his/her needs, peer educators should complete this requirement by the
second contact.

In general, this process entails these steps:

1. Identify and engage a peer education client
2. Assess risks and needs (information and behavior support) of the client
3. Counsel/motivate client to adopt positive behaviors or minimize risk practices
4. Provide HTS or refer to HTS if client has not previously tested positive
5. Ensure accessibility and usage of condoms
6. Provide referrals to needed services
7. Encourage client to take prevention messages and activities to their friends, partners and family
   members as appropriate
8. Monitor client’s progress and check on referral completion (during follow-up contact)
9. Monitor and report on session (using Z-CHPP peer education register)

To illustrate this sequence, the following flowchart highlights these steps for three different categories of
clients. The method of delivery used to stimulate IPC with the client may vary based on the different
contexts and project settings where the interaction may occur, for example during a community-wide
outreach, in a home, church, youth club or workplace setting. What is most important is that the IPC
interaction is adapted to each situation and always promotes discussion and problem solving within a safe
environment. After a client’s personal risk factors have been identified, follow-up encounters should focus
on motivating the client to make healthy decisions that will protect them, filling knowledge gaps
concerning HIV prevention and risk behaviors, assessing any progress made on adopting HIV prevention
methods and any new needs, and seeking feedback on any referrals made.
Identify and engage client

Build rapport with client and introduce HIV prevention as topic of conversation

Assess basic HIV knowledge and risk status of client

Client has not been diagnosed as HIV positive

Client identified as not at risk

Refer to or provide HIV testing and counseling to ensure client knows his/her status

Promote and provide condoms

Encourage client to maintain positive health behaviors

Encourage client to seek support if their situation changes

Client identified as at risk (at least one risk behavior)

Refer to or provide HIV testing and counseling to ensure client knows his/her status

If HTS is delivered directly, provide post-test counseling and support based on test result - if HIV positive, ensure immediate linkage to care

Prioritize one risk behavior (per each session) and counsel client on risk reduction strategies

Promote and provide condoms

Provide referrals to other services based on needs

Client self-identifies as HIV positive

Ensure client is:
- Enrolled in care & treatment
- Practicing Positive Health, Dignity and Prevention
- Using condoms consistently
- Linked to PLHIV support group

Promote and provide condoms

Provide referrals to other services based on needs

Encourage HIV testing and counseling for partner and family members

Set up follow-up contact within 10-20 days, as feasible

Complete M&E form to document and report on session

VI. Identification of Peer Education Clients

There are a number of ways in which Z-CHPP peer educators will identify and enlist clients from priority population groups. In general, peer educators will reach peers in the communities where they reside, near where they live, from their networks, work or in schools. This approach maximizes the frequency of interaction with peers and reduces the time and travel burden on peer educators to find clients, which helps peer educators to balance volunteering and their daily life.

- Peer educators will go to sites and venues where their peers are known to gather or be located, such as the local market and shopping malls, youth and social clubs, schools, churches, workplaces, and health facilities.
- Peer educators will provide one-on-one or small group sessions as a complement to community outreach events, community conversations and insakas (gatherings), sports activities, music and entertainment shows, and other events.
- Peer educators will receive clients referred to them by health care workers, teachers, community leaders, church leaders, and/or other peers.
- Peer educators will find clients in their homes as part of the door-to-door outreach or home visits.

Based on field experience and feedback from implementing partners, a one-on-one peer education session may take anywhere between 20-45 minutes or more, whereas a small group peer education session that involves up to 25 individuals may last anywhere from 60 to 90 minutes. These are not specific and required time durations for peer education sessions as this factor depends considerably on the client or group’s availability and the setting for the session. However, for a one-on-one “entry” session where there is opportunity for more individualized education and support, the basic guideline is 15 minutes for the personal risk assessment and 15 minutes for peer education support without HTS provision and 30 minutes with HTS. If the client is not available at the time of initial contact and expresses interest, the peer educator will arrange for another day and time to meet with the client and get his/her contact information for follow-up.

VI. Personal risk assessment and risk reduction

The purpose of conducting a personal risk assessment is to raise the client’s awareness of his/her own risk to HIV infection and to identify areas of concern or need to guide the provision of HIV education, counseling, and services. This is not intended to be a formal assessment, but rather a guided conversation with the client that encourages reflection on how his/her behavior choices may render them vulnerable to HIV infection. The risk assessment questions (annexed below) will determine whether the client has one of the risk factors prevalent in the Zambian context (and validated by Z-CHPP’s formative research) or not.

Risk factors in Zambia include but not limited to:
- Unprotected sex
- Multiple and concurrent sexual partners
- Transactional sex
- Alcohol consumption and drug use
- History of STIs
- Client has not tested for HIV
- Partner has not tested for HIV
The risk assessment will focus on asking some or all of the questions as shown in annex 1. Depending on the responses provided by the client, they may be found to be at no risk, at moderate risk (1-2 risk behaviors/factors), or at high risk (3 or more risk behaviors/factors). Those with moderate and high risk should be counseled on having an HIV test and on specific risk reduction strategies that address their high-risk behaviors. It is important to explain to clients and reflect with them why their specific risk behavior puts them at risk for contracting HIV as it will help to motivate them to decide to change their behavior and lifestyle. It is natural for this process to take more than one encounter, depending on the client’s readiness and confidence to make a change.

Below is an example of potential risk reduction strategies to discuss with clients. The aim is to be as practical as possible in understanding and helping the client address the barriers they face in real life, not just in theory, and emphasizing the benefits of making the change and using available HIV services.

<table>
<thead>
<tr>
<th>High risk behavior</th>
<th>Risk reduction strategy and actions</th>
</tr>
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<tbody>
<tr>
<td>Unprotected sex</td>
<td>Use a condom in every sexual intercourse</td>
</tr>
<tr>
<td><strong>Potential actions:</strong></td>
<td></td>
</tr>
<tr>
<td>- Get information on where condoms are available</td>
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<tr>
<td>- Get condoms from peer educators</td>
<td></td>
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<tr>
<td>- Carry a condom at all times and keep condoms at home</td>
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</tr>
<tr>
<td>- Learn skills from peer educator for how to talk with partner about safe sex and negotiate use with partner; practice these skills with a close friend</td>
<td></td>
</tr>
<tr>
<td>- Learn how to use condoms correctly from the peer educator</td>
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</tbody>
</table>

VII. HIV Testing Services

Both facility and community-based HIV testing serve as a critical entry point for life-saving care and treatment. Some trained peer educators may also be trained lay counselors for community-based HTS. In this case, these peer educators/lay counselors may offer HTS directly to the client, if the situation and setting of the session with the client permit for private counseling and adherence to national standards for rapid HIV testing, for example, during door-to-door HIV testing outreaches when peer educators/lay counselors are equipped with appropriate materials and supplies for conducting HIV testing. Otherwise, peer educators play a supportive role, in referring individuals to HTS provided in the community by Z-CHPP sub-partners and other service providers and in health facilities. Peer educators can play an especially important role in bringing partners or family members of clients for HIV testing and counseling. They can help individuals understand their results and provide post-test support, including encouraging people to enroll into care as early as possible if they are HIV positive.

Z-CHPP sub-partners will provide community-based HTS, in adherence to national HIV testing standard guidelines, through several approaches: mobile, door-to-door, community outreach and family centered/index testing. Children and adolescents below the age of 16 may only be tested by Z-CHPP sub-partners after obtaining consent from the parent or guardian. Adolescents above the age of 16 can consent for HIV testing on their own. Z-CHPP sub-partners will follow the national testing algorithm and standard operating procedures (SOPs) when providing HIV testing and pre and post-test counseling. If the client prefers to access facility-based HTS, peer educators will provide referrals.

Key points about HTS to cover during peer education:
✓ It is not possible to say whether a person is HIV positive or not based on physical appearance
✓ HIV can be detected only through HIV testing
✓ Explain the benefits of early HIV testing and not waiting until one is sick
✓ Refer client to HTS services that are easily accessible and convenient
✓ Ask about partners and children and encourage them to seek HTS – home visits are a good place to talk about family testing
✓ Promote couples testing and counseling to identify discordant couples
✓ For pregnant women, discuss the importance of PMTCT and refer them to ANC/PMTCT services
✓ For adolescents and youth, refer them to adolescent-friendly health services and/or youth clubs/drop-in centers for HTS
✓ Emphasize that the test is confidential and not revealed to anyone but the person who tested
✓ Explain the HIV care, treatment and support services that are available and the post-test provided by health facilities and community-based service providers, if diagnosed as HIV positive.

VIII. Continuum of HIV care and treatment

With mounting evidence on the benefits of early ART and “treatment as prevention”, peer educators have an important role to play in linking individuals diagnosed as HIV positive to immediate care and treatment, particularly as Zambia plans to scale-up the “test and start” strategy. Peer educators are also a critical community resource for ongoing adherence and other social support services. Peer Educators should counsel all PLHIV to enroll in care and treatment services at a facility, even if they feel healthy but are not on ART.

Key points about care and treatment to cover during peer education:
✓ Highlight the benefits of early treatment
  o Starting ART as soon as possible reduces the chances that the person will become sick
  o Adhering to ART and achieving viral suppression reduces the risk of HIV transmission to others
✓ Promote treatment seeking behavior by making referrals and/or providing accompanied referrals
✓ Provide information to client on where and how to access ART at the health clinic or hospital
✓ Identify any potential barriers to accessing treatment and solutions for overcoming barriers
✓ Explain that important components of care that can help all PLHIV include: check-ups by health care workers, preventing and treating opportunistic infections, counseling on positive living, nutritional support and/or counseling, and linkages to support groups
✓ Emphasize the need to adhere daily to ART/care and treatment plan and discuss strategies for adherence support, including the concept of a treatment buddy or a group adherence club (GAC).
✓ Provide counseling on how to seek social support and disclose status to partner and/or family members
✓ Encourage referral of partner and/or family members for HIV testing

IX. Condoms

All peer educators must become skilled at handling, talking about, demonstrating and explaining the use of condoms. Since condoms are associated with sex, people may feel reserved and/or shy when talking about or handling them. Peer educators need to ensure that clients have the opportunity to feel safe and comfortable talking about their perceptions and practice of using condoms and any challenges that they face.
In addition, peer educators should have a consistent supply of condoms (both male and female) and lubricants (where feasible) and other materials for demonstration, discussion and distribution purposes. They should have visual aids or anatomic models to help them demonstrate the correct use of condoms and to use as a focus for discussion on condom use.

Key points about condoms to cover during peer education:

✓ Emphasize the benefits of consistent and correct condom use
  o Condoms (along with a water-based lubricant) are the safest means for protecting oneself from HIV infection
  o Condoms provide dual protection – from HIV/STIs and unwanted pregnancies
✓ Promote condom use with all partners, especially with non-regular partners or partners who do not know their HIV status
✓ Address any myths or misconceptions about condoms
✓ Identify any potential challenges that the client may be facing related to condom use, such as peer pressure, alcohol consumption or partner reluctance, and help them think through how to overcome the identified challenges
✓ Counsel clients on ways to talk about safe sex and negotiate condom use with their partner and help them to practice what they are going to say to their partners
✓ Demonstrate the proper steps for using male and female condoms using visual aids and/or anatomic models
✓ Observe the client practicing how to properly put on a condom using the anatomic models and provide feedback as necessary
✓ Distribute condoms and lubricants (if available)
✓ Provide information on where condoms are available for free or at minimal costs in the community, from NGOs and social marketing programs
✓ Provide information on how best to store condoms in a cool, dry place and away from sunlight and heat

X. Sensitization of Parents/Caregivers of Adolescents and Youth

Parents/guardians of adolescents and youth in the DREAMS sites will be referred to the Family Matters program to enhance AGYW-parent communication and parenting skills, among others. The Families Matter Program (FMP) is an evidence-based intervention for parents and caregivers of 10-19 year-olds that promotes positive parenting practices and effective parent-child communication about sex-related issues and sexual risk reduction. Subjects addressed include open discussion on sexual and reproductive health issues, child sexual abuse (CSA) and gender based violence (GBV). The ultimate goal of FMP is the reduction of sexual risk behaviors among adolescents, including delayed onset of sexual debut. Hence, open and transparent parent-child discussion on the aforementioned issues will be highly encouraged under this prevention package in the three DREAMS districts.
Annex 1: Z-CHPP Personal Risk Assessment Form for Peer Educators

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Response</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you ever been tested for HIV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you had sex without a condom with someone who is not a stable partner?</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>If you are or were married, have you ever had sex without a condom with someone who was not your wife/husband?</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>If you are or were married or are in a stable relationship, do you know your spouse or partner’s HIV status?</td>
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<tr>
<td>5</td>
<td>Have you ever been so drunk that you did not remember having sex?</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Have you used alcohol in the past month?</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>Have you used drugs in the past month?</td>
<td></td>
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<tr>
<td>8</td>
<td>Have you ever had an STI, such as chlamydia, gonorrhea or syphilis?</td>
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<tr>
<td>9</td>
<td>Have you ever had one or more partners in the period of a month and not used a condom in each case?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Have you ever paid money for sex or traded sex for food, clothing, other material goods?</td>
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</tr>
<tr>
<td>11</td>
<td>Does the nature of your work require you to travel frequently and be separated from your spouse or regular partner?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assessment Summary:**