VOLUME 2:
National Operational Plan (NOP) of the Multisectoral AIDS Response in Zambia 2011-2013

and

2011-2013 NATIONAL MULTISECTORAL AIDS PROGRAMME WORKPLAN

IN COLLABORATION WITH

THE DISTRICT AND PROVINCIAL TASKFORCES,
NAC THEMATIC GROUPS,
CIVIL SOCIETY ORGANIZATIONS, COOPERATING PARTNERS AND LINE MINISTRIES

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Table of Contents

1.0 Introduction 1

2.0 NASF Outcomes, Outputs And Impact 3

3.0 National Operational Plan 2011-2013 8
- 3.1 Purpose of the National Operational Plan (NOP) 2011-2013 8
- 3.2 Nop Stakeholders and Partners 8
- 3.3 Development of the NOP 8
- 3.4 Organization of the NOP 8
- 3.5 Key Operational Gaps Identified In The 2006-2010 National Response 8

4.0 Programmes, Interventions and Activities for NASF Implementation 9
- 4.1 Prevention 9
- 4.2 Treatment, Care and Support 19
- 4.3 Impact Mitigation 22
- 4.4 National Response Coordination and Management 24

5. Stakeholder Roles and Responsibilities and Division of Labour in Next Five Years of the National Response 44

6. National Three Years Multisectoral Costed Work Plan of the NASF 49

7. Item Costs 107

1.0 INTRODUCTION

1.1 Background

The prevalence of HIV in adults reduced from 16.9 percent in 2002 to 14.3 percent in 2007. Females aged 15-49 are more likely to be HIV positive (16.1 percent) than males (12.3 percent) in the same age group and on average become infected earlier. Urban areas have higher prevalence (20 percent) than rural areas (10 percent)[1]. An estimated 1.6% of the adult population becomes newly infected each year, and an estimated 10 percent of HIV transmission occurs during pregnancy, birth or breastfeeding. However, with effective treatment and follow-up, pediatric HIV could be virtually eliminated. The treatment coverage of ART increased significantly with over 300,000 receiving anti-retroviral treatment by 2010, allowing them to live longer and more productive lives. Significant progress has been made in access to treatment, blood safety and injection safety.

Among the many challenges to allaying the epidemic is changing sexual behavior in the general population; increasing treatment access for AIDS patients; and improving impact mitigation especially for orphans and vulnerable children (OVCs). Of the estimated 1.3 million OVC in Zambia only 19.1 percent of rural and 11.6 percent of urban OVC reported receiving external basic assistance from sources outside of the household and kinship network. In addition, resource tracking and monitoring of HIV programme outputs and overall impacts require strengthening.

The six key drivers of new infections in Zambia are: multiple and concurrent sexual partners; low and inconsistent condom use; low levels of male circumcision; mobility and labour migration; vulnerable groups with high risk behaviours; and mother to child transmission.

Major changes in sexual behaviour and improvements in prevention efforts, such as large scale provision of male circumcision, will significantly reduce the number of new HIV infections and bring the epidemic under control. Higher overall demand and initial costs are expected to continue rising during the SNDP, which will require rationalization of available resources in the medium and long term to priority areas of need for the country.

1.2 Fundamentals of the National HIV and AIDS Strategic Framework (2011-2015)

The Government of Zambia (GRZ) and the global AIDS community have recognized the need to do more to effectively tackle AIDS. Zambia is a signatory to many important commitments related to AIDS, including the 'Three Ones' principles which provides a useful framework for development of the Zambian AIDS response by ensuring that there is:

A. One Agreed HIV and Aids Strategic Framework that Provides the Basis for Coordinating the Work of all Partners

The Sixth National Development Plan (FNDP 2011–2015) and a related National HIV and AIDS Strategic Framework (NASF 2011–2015) have been developed with broad participation of key stakeholders, including civil society to ensure ownership and commitment to implementation. Both documents are now finalized and approved for dissemination.

B. One National AIDS Coordinating Authority, with a Broad-Based Multi-Sectoral Mandate

The National HIV/AIDS/STI/TB Council (NAC) was established through an Act of Parliament and is comprised of broad representation from several government ministries and civil society. The strength of the NAC Board and Secretariat to oversee, drive and convene a multi-sectoral national response is at the heart of Zambia's ability to turn the tide of the HIV crisis.

C. One Agreed Country-Level Monitoring and Evaluation System

In tandem with the NASF 2011-2015, the NAC developed a Monitoring and Evaluation (M&E) Plan aimed at determining what programmes works or do not work; programmes with cost effectiveness and sustainability. Through collective partners, the M&E system is expected to generate sustainable, high quality, affordable and timely information for decision making and accountability reporting by programme managers, policy makers and donors.

The NASF is the national multi-sectoral framework for HIV and AIDS that provides strategic and policy orientation to the response for the period 2011-2015, and was developed through an intensive and extensive consultation process with stakeholders.. The framework marks a shift from business as usual to a focus on evidence and results-based planning and management of the response. The current NASF succeeds the NASF 2006-2010.

[1]Central Statistical Office Zambia Demographic and Health Survey, 2007

The framework takes cognizance of the following: decentralization of the implementation of the HIV and AIDS response by sectors (including civil society and private), provinces, districts and communities; and incorporation of gender and human rights dimensions to ensure accelerated implementation of Universal Access to prevention, treatment, care and support of HIV and AIDS services. The framework takes a gender-based approach to analysis of the drivers of infection, planning, programming and monitoring and evaluation to ensure a sustained gender sensitive HIV and AIDS response. The rights-based approach promotes the rights of individuals living with or affected by HIV.

Among the key issues are: protection from stigmatization and discrimination; right to privacy (protecting people from mandatory testing, confidentiality of information); the right to education and information; and access to services. The NASF also considers the rights of OVC in the context of the Convention of the Rights of the Child.

The programmes and strategies in the NASF were identified based on available evidence of their efficacy and alignment with the National Vision 2030, Sixth National Development Plan (SNDP), the Poverty Reduction Strategy, the Millennium Development Goals (MDG), and the National HIV/AIDS/STI/TB policy.

The NASF articulates national priorities[2], impact level results, expected programme outcomes and outputs; and revolves around four pillars (prevention; treatment, care and support; impact mitigation; and response management) of the national multi-sectoral response. Within each of the thematic pillars, specific service delivery areas (SDA) are identified based on their potential to contribute to output, outcome, and impact results. These results are detailed in Annex 1. The NASF further identifies and articulates the specific strategies within each service delivery area that will be implemented to achieve results.

[2]These are priorities set out in the 6th National Development Plan Cross cutting section on HIV and AIDS, 11th June 2010.

2.0 NASF Outcomes, Outputs and Impact

A.Prevention
See below table 1 showing the expected prevention results

Table 1: Prevention results

Impact Result	Outcome Result	Output result
By 2015, the rate of annual HIV new infections reduced from 1.6% to below 0.8% (82,000 annual new infections to 40,000) The number of infants born of HIV positive mothers who are infected has reduced to less than 5%[3] by 2015	Social and Behaviour Change [OC1] More people have comprehensive knowledge[4] of HIV: Female and Male aged 15- 49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15 – 24 years to 51% in 2013 and 70% by 2015	[OP1] Females and males aged 15-25 with knowledge of HIV prevention increased 39% to 50% by 2013 and to 80% by 2015 [OP2] Females and males aged 15-24 accessing social and behaviour change programmes is increased from 30% to 50% by 2013 and to 80% by 2015 [OP3] Most at risk population and vulnerable groups reached with HIV prevention programmes has increased from 15% to 25% by 2013 and to 50% by 2015 [disaggregated by MARP and vulnerability category) [OP4] In and out of school OVC aged 5-17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015 [OP5] Young females and males aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV increased from 35% in 2007 to 50% in 2013 and 65% by 2015
	[OC2] Fewer persons have multiple and concurrent partnerships: Female and male aged 15-49 in the general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2015.	[OP6] Communities reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015 [OP7] Female and Male aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50%[5] for Male in 2008 to 65 % in 2013 and to 75% for both Female and Male by 2015 [OP8] Couples (stable and semi-stable relationships) reached with small group or individual social and behaviour change programmes increased to 35% in 2013 and to 70% by 2015
	[OC3] Among Females aged 15-49, HIV infection is reduced from 16% in 2009 to 10% in 2013 and to below 8% by 2015	[OP9] Female aged 15-49 reached with interventions that empower them to address gender inequality and gender based violence that predispose Female and girls to HIV infection increased to 40% by 2013 and to 75% by 2015 [OP10] Female rape survivors accessing post rape care services (counselling, treatment, and legal support) increased from 20.2% in 2007 to 50% in 2013 and 80% by 2015.
	HIV Counselling and Testing [OC4] More people test for HIV and know their results: Females and Males aged 15-49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4% in 2008 to 30% in 2013 and 50% by 2015	[OP11] Female and male aged 15-49 who received an HIV test in the last 12 months and know their results has increased from 28% (1910253/6822332) in 2009 to 41% (3,023,728/7330249) in 2013 and 50% (3,816,765/7633530) by 2015 [OP12] Couples who were counselled and tested in the last 12 months increased to 20% in 2013 and to 50% by 2015 [OP13] Most at risk population who received an HIV test in the last 12 months and know their status has increased from 20% to 35% by 2013 and to70% by 2015 [disaggregated by MARP category [OP14] Health and non-health facilities with adequate capacity to provide either provider initiated and client Testing and counselling and or client initiated counselling and testing increased from 60% in 2008 to 80% in 2013 and to 100% by 2015
	Condom Marketing and Distribution [OC5] More people consistently and correctly use condoms in their last sex intercourse: Female and Male aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 37% for female and 50% for male in 2007 to 45% for female and to 60% for male in 2013 and 55% for female and 70% for male by 2015	[OP15] MOH increase free condoms distribution per year for Male from 40 million in 2009 to 80million in 2013 and 100 million in 2015 and for Female from 450,000 in 2009 and 650,000 in 2013 and 1,000,000 in 2015 [OP16] MOH Condom retail outlets[7] and service centres that reported no condom stock out increased 40% in 2008 to 60% in 2013 and to 100% by 2015 [OP17] Male and Females age 15-49 years have Condom use increased from 37% in 2007 to 55% in 2013 and 73% by 2015
	Medical Male Circumcision [OC6] More male are circumcised by a health professional: male aged 15-49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015	[Op18] Male aged 15-49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015.[8] [OP19] At least 50% of all infants born in a health facility are circumcised in the first week of life [OP20] MOH have 50% and 80% of all PMTCT centres integrated with male circumcision service in 2013 and 2015. [OP21] Traditional leaders promote MC as an HIV prevention strategy as part of community mobilization efforts in 50% and 100% of communities with low MC practices by 2015 and 2015.

	Prevention of Mother to Child Transmission [OC7] More HIV positive pregnant female receiving ARVs to reduce risk of transmission to child: HIV positive pregnant Female who receive ART to reduce the risk of mother to child transmission is increased from 61%[9] (47,175) in 2009 to 85% (72,828) and to 95% (85,655) in 2015	[Op22] Pregnant women who were counselled during the ANC for their most recent pregnancy, who were offered and accepted a HIV test and received their test results in the last twelve months increased from 67%[10] in 2009 to 80% in 2013 and 95% by 2015 [OP23] Female aged 15-49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015 OP24] HIV-infected pregnant females who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission increased from 61% (47175/79498) in 2009 to 85% (72828/85708)in 2013 and 95% (85655/90163) by 2015 [OP25] HIV positive mothers, their children and families who have received at least two categories of care at home /community increased from 40% in 2009 to 75% in 2013 and to 100% by 2015 [OP26] Male participation in PMTCT programming increase from 30% to 50% (equivalent of 50% of women on PMTCT) by 2013 and 80% by 2015.
	[OC8] More infants born from HIV-positive mothers are not infected: Infants born to HIV-infected mothers who are infected has reduced from 7%[11] in 2009 to 5% in 2013 and to less than 2% by 2015	[OP27] Infants born to HIV-infected females (HIV-exposed infants) receiving ARV prophylaxis to reduce the risk of MTCT has increased from 62%[12] (21050/36215) in 2009 to 50% (31110,39469) in 2013 and 95% 36140/38042)by 2015 [OP28] Infants born to HIV-infected mothers (HIV-exposed infants) started on Cotrimoxazole prophylaxis within two months of birth has increased from 34%[13] in 2009 to 50% by 2013 and to 100% by 2015
	PLHIV – Promoting Positive Health, Dignity and HIV Prevention [OC09] PLHIV aged15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased to X% by 2015	[OP29] People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards increased from 30% in 2010 to 60% in 2013 and 80% in 2015
	[OC10] PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015	[OP30] Females and males who received counseling and testing services for HIV and received their test results increase from 15% in 2007 to 50% in 2013 and 80% in 2015
	Post Exposure Prophylaxis [OC11] All persons who have been accidentally or forcebly exposed to HIV are given drugs to reduce the risk of primary infection: People in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)	[Op31] Health facilities with PEP services available on site and being provided according to the national guidelines has increased from 43% in 2008 to 100% by 2015 [OP32] Health Workers with reported needle prick injuries in health facilities has reduced from 6.7%[14] in 2008 in 4% by 2013 and to less than 2 % by 2015 [OP33] People in need of PEP receiving PEP in accordance with the national guidelines in the last 12 months increased to 100% (all in need) and remain that way by 2015
	Sexually Transmitted Infections [OC12] Fewer Females and males have STIs: Female and Male who report having STI in the past 12 months has reduced for Female from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for Male from 26%% 2007 to 13% in 2013 and5% in 2015	[Op34] MOH Primary Health facilities offers comprehensive STI treatment maintains its current 100% of STI services by 2013 and remains at the same level by 2015[6]
	Blood Safety [OC13] Donated blood units are screened for HIV and other TTIs in a quality assured manner: Donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100%[15] between 2010 and 2015	[Op35] MOH meet national demand of 100% of need using the r national blood transfusion of centrally collected blood screened for transfusion transmissible infections .

B. Treatment, Care and Support

The treatment, care and support results for the next five years are as shown on table 2 below:

Table 2: Treatment, Care and support results

Impact Result	Outcome Result	Output result
PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased from 65% in 2009 to 85% by 2015	Antiretroviral Therapy [OC14] More PLHIV survive longer on ART: Adults (15 and older, and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015	[OP36] Adults enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to 2015 [OP37] Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis increased from 34% to 60% in 2013 and 100% up to 2015 [OP38] Female and Male with advanced HIV infection receiving ART has increased from 68%[16] in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015 [OP39] Children (aged 0-14) eligible for HIV receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015 [OP40] Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015
	TB/HIV co-infection: [OC15] More PLHIV with TB/HIV co-infection are successfully treated: PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 and 60 % in 2013 and to 75% by 2015	[OP41] The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 40.6 %[17] in 2007 to 60% 2013 and to 80% by 2015. [OP42] HIV-positive TB patients who are started on ART has increased from 41% (6595) in 2007 to 60% in 2013 and to 75% in 2015.
	Community Home Based Care and Palliative Care [OC16] Male and Female children 0-17 yrs orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and to 50% by 2015	[Op43] People receiving palliative care increased from 157,712 in 2007 to 200,000 in 2013 and 250,000 in 2015

[3] This is in line with the concept of Virtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT – presentation to funders, May 10th 2010, UNAIDS]

[4] Comprehensive knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission and prevention

[5] Baselines are from Zambia UNGASS National Report 2008/2009

[6] Baseline data for male and female condoms is derived Mode of Transmission report, while projection targets are based on the targets proposed in 6th NDP Chapter for HIV and AIDS i.e. 40% for 2013 and 50% for 2015.

[7] According to the MOT report (2009) in 2008, there were 15,252 condom outlets

[8] The targets for MC are set out in the Zambia National Male Circumcision Strategy 2010-2020

[9] NDP 6 – Chapter on HIV and AIDS (draft), 2010

[10] Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID / not targets have been taken from the 6th NDP Cross Cutting Section paper

[11] Zambia UNGASS National Report 2008/2009

[12] SNDP cross-cutting section on HIV and AIDS, June 2010

[13] Zambia UNGASS National Report 2008/2009

[14] Joint MID TERM Review of NASF report- Technical Report, January 2009, NAC

[15] Joint Mid – Term Review of NASF report- Technical Report, January 2009, NAC

[16] Zambia UNGASS National Report 2008/2009 / and 6th NDP Cross-cutting section on HIV and AIDS, 2010 (draft) paper

[17] Joint Mid Term Review of NASF report- Technical Report, January 2009, NAC

C. Impact Mitigation

The expected results for achievement for mitigation services in the country are as shown below:

Table 3: Mitigation results

Impact Result	Outcome Result	Output result
Fewer households[18] are vulnerable: The number of vulnerable households is reduced by 50% by 2015	Vulnerable Households and Food Security [OC17] More people receive comprehensive and quality care at home and in the community: Female and male aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41%[19] in 2009 to 50% in 2013 and 60% by 2015.. Orphans and Vulnerable Children [OC18] More OVC receive free external basic support: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16%[21] in 2009 to 25% in 2013 and to 40% by 2015	[Op44] Households[20] with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015 [OP45] Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from 15% in 2007 to 25% in 2013 and to 50% in 2015. [Op46] A national framework for the protection, care and support of OVC developed [OP47] Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%[22] in 2009 to 40% in 2013 and 60% by 2015 [OP48] Orphans and vulnerable children under age 18 years whose household had not received any basic external support to care for the child in the last 12 months has decreased from 84% in 2007, to 50% in 2013 and 25% by 2015 [OP49] OVC aged 5-17 possessing three minimum basic material needs[23] increased from 49%[24] in 2007 to 60% in 2013 and to 85% in 2015 [OP50] The ratio of OVC and non-OVC currently attending school is increased from 0.93[25] in 2009 to 1:1 in 2013 and remains that way by 2015.

[18] It is estimated that there are 8000 vulnerable households (2010) - Source: A Supplement to NASF 2006-2010 Based on the Joint MTR held in 2008, NAC
[19] Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID
[20] Households will be disaggregated by type, Child, Female and or male headed, rural and urban
[21] Zambia Demographic and Health Survey 2007
[22] Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID
[23] These needs are defined as a pair of shoes, two sets of clothing and a blanket.
[24] Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID
[25] Zambia UNGASS Report 2010
[26] Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID
[27] The baseline and the targets are set out in the 6th NDP Cross Cutting Section on HIV and AIDS,
[28] Including Parastatals
[29] This will include DHS, AIDS Indicator Survey (AIS), Quality of Impact Mitigations Services (QUIMS), Sentinel Surveillance, Behavioural Surveys and Studies (various), TB and STI prevalence surveys among others

D. Response Management of the National Multi-sectoral HIV and AIDS

The expected results for coordination and management of the response are as shown on table 4 below:

Table 4: Coordination and management results

Impact Result	Outcome Result	Output result
4. The national response is effectively and efficiently managed and coordinated: The total NASF service coverage targets (output level results) that have been met in all four pillars has increased to 50% by 2013 and 90% by 2015	Enabling Policy and Legal Environment [OC19] The enabling policy and legal environment is improved: Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened	[OP51] Social and legal protection of vulnerable people and most at risk populations is strengthened: % of national policies and legal instruments reviewed and incorporated human and legal rights. [OP52] Reduction stigma and discrimination: Female and Male aged 15-49 expressing accepting attitudes towards people living with HIV and AIDS increased from 34%[26] in 2009 to 45% by 2013 and by 60% by 2015
	Coordination and Management: [OC20] Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework	[Op53] National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response.
	HIV and AIDS, Gender and Human Rights Mainstreaming [OC21] Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015	[Op54] 75% of sectors and private sector institutions by 2013 and 100% by 2015 have reviewed their policies and programmes, and mainstreamed HIV and AIDS, gender and human rights in their internal (HIV workplace) and external (development) programmes [OP55] Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015 [OP56] Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 12015. [OP57] Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015[27] [OP58] The national action plan on gender and HIV is fully implemented, monitored and periodically reviewed
	Capacity Development and Systems Strengthening [OC22] Stakeholders capacity to implement NASF strengthened by 2013 and remains the same by 2015	[OP59] HIV and AIDS implementing partners capacity developed / strengthened in the areas of programme planning, resource mobilization, service delivery, community mobilization, monitoring, evaluation and reporting for 75% by 2015 [Op60] Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013 [OP61] Communities systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013 [OP62] Local Authorities' have good governance and leadership of HIV and AIDS programmes at district level by 2013 [OP63] Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes increased from 20 in 2009 to 73 by 2013 and remain at that level by 2015
	Resource Mobilisation and Management [OC23] By 2015, NASF financial resource needs that have been mobilised, and used efficiently increased to 100% by 2015	[OP64] Public[28] and private sectors that have developed annual HIV and AIDS operational plans that are aligned and harmonised with the national operational plan has increased to 100% for public and 75% for private sectors.
	Monitoring and Evaluation, and HIV Research [OC24] The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NSF results framework by 2013 and 100% by 2015.	[OP65] Government funding spent on health has increased from X% in 2010 to 15% in 2015 [OP66] Key planned research[29] studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015
	[OCC25] The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF	[OP67] NAC has a framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011. [OP68] The key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015 [OP69] NAC coordinate the implementation of 80% of the planned research studies and surveys and results disseminated. [Op70] Stakeholders capacity for applied research is assessed and strengthened

3.0 NATIONAL OPERATIONAL PLAN 2011-2013

3.1 Purpose of the National Operational Plan (NOP) 2011-2013

The purpose of the NOP is to provide a simplified guide for the implementation of the NASF 2011-2013. It enables stakeholders to identify and utilize their comparative advantage to collectively contribute to NASF implementation. This will accelerate the achievement of Universal Access (UA) to prevention, treatment care and support services and eventually contribute to Zambia's attainment of the Millennium Development Goals (MDG). The NOP identifies key strategies and sufficient activities that will enable Zambia to achieve the intended output, outcome and impact results.

The NOP describes how the National HIV and AIDS Strategic Framework will be implemented, and highlights the flow of work from input to impacts. It has a detailed action plan for achieving the objectives articulated in the NASF. Strategies are described in detail,, how they will be operationalised, and the basis and justification for annual operational budgets. The 2011-2013 NOP comprises a three rolling plan with three annual operational steps.

3.2 NOP Stakeholders and Partners

The NOP provides for easy buy-in by all stakeholders at the national, provincial, district and community levels respectively. These partners include those in the public and private sector, civil society, faith based organizations and traditional leaders.

3.3 Development of the NOP

The NOP was developed in consultation with national partners, civil society, development partners and other key stakeholders. Guidance and support to the process was provided by a core technical team comprised of multi-disciplinary technical staff from NAC, development partners, international partners, and civil society organizations. The process involved:

- Extensive review and analysis of the new NASF, relevant operational documents of sectors and thematic programmes and partnership plans;
- Participatory mechanisms involving consultative meetings, validation and internal peer review sessions involving all partners on the selected activities that will deliver the results;
- Consensus on co-stable items, unit cost and validation of the cost of the plan; and
- Calculating and aggregating the cost using Microsoft Office Excel

3.4 Organization of the NOP

The NOP is organized around the four pillars in the NASF 2011-2015 and sub-divided into service delivery areas (SDA). Each pillar covers core components, priority strategies, programme objectives and administrative settings, target populations, and quality assurance criteria. Partnerships and accountabilities are covered under the fourth pillar “Response Coordination and Management”. The fourth pillar, also, includes a description of organizational arrangements to promote the effective implementation of the five-year NASF; roles and responsibilities of implementing partners at national and decentralized levels; and performance monitoring criteria for the five year NASF.

3.5 KEY OPERATIONAL GAPS IDENTIFIED IN THE 2006-2010 NATIONAL RESPONSE.

Based on the situation and response analysis process used to support development of the NASF, several operational gaps were identified and are applicable to support the implementation of the national operational plan. These operational gaps are described in detail in the NASF by programmatic area. During implementation of the NASF 2006-2010, several capacity gaps were identified that are likely to influence the performance of the NASF 2011-2015.

The NOP draws on the operational and capacity gap descriptions detailed in the NASF to identify key interventions that will ensure that these barriers are addressed as part of strategies to remove implementation bottle necks affecting the national response.

4.0 Programmes, Interventions and Activities for NASF Implementation

4.1 Prevention

Prevention is the priority strategy in the fight against HIV and AIDS during NASF 2011-2015 as result of resolutions adopted during the 2009 Prevention Convention. One of the resolutions was to implement a "combination prevention" strategy, which offers the best prospects for addressing documented weaknesses in past HIV prevention programming, and for generating significant sustained reductions in HIV incidence in diverse settings. As Table xx below illustrates, there is no single "magic bullet" for HIV prevention but each strategy discretely applied has varying degrees of effectiveness.

Combination prevention relies on evidence-based strategic information, and the simultaneous use of complementary behavioural, biomedical and structural prevention strategies. Combination prevention programmes operate on different levels (e.g., individual, relationship, community, societal) to address the specific, but diverse needs of the populations at risk to HIV infection.

Table 5: Cost-effectiveness of Illustrative HIV Prevention Measures

HIV Prevention Measures	Effectiveness	Cost, per person	Cost-effectiveness per HIV inf averted
Behavioral Change Interventions			
VCT	Moderate to Mixed	$1.5 Russia to $668 Mexico	$1,315 in SSA to $672 in S.E.As
Treatment for addictions	90% reduction in IUDs	$10.21 in Ukraine	$97 in Ukraine
School-based interventions	Mixed to Moderate	$10 in Tanzania	$8,076 in SSA to $10,307 in S.E.
Biomedical Interventions			
ARTs	Moderate to High	$200 /year	$212 per DALY averted in India
Microbicides	High potential		
PMTCT	High		$857per pg woman in SSA
Treating STIs	Moderate	$118 for STI cured in Nicaragua	$2,093 in South Africa
Male Circumcision	High	$69 in Uganda to $55 in S.Africa	$181 in South Africa
Vaccines	Moderate to High		
Structural/Environmental Interventions			
100% Condom	Moderate to High		$58 in SSA
Conditional economic incentives	Moderate		$136 in rural Malawi
Women empowerment	Low to moderate		

Source: UNAIDS Global report, 2010

Social and Behaviour Change

The objectives of the social and behaviour change intervention are to improve comprehensive knowledge about HIV and AIDS (including the impact of gender) so that people are able to assess personal risk and vulnerability to infection; and promotion of social and behavioural changes that contribute to risk reduction. The SDAs in this section comprises of multiple activities that can be carried out discretely, in tandem, and/or sequentially by programme implementers. Some of the interventions overlap with activities in other pillars, e.g. treatment, care and support and impact mitigation. For instance, policy and law reform particularly in the context of promoting gender-responsive interventions cut across all pillars and SDAs.

Social Mobilisation and Communication

The objective of the comprehensive communications and community mobilisation programme is to ensure that administrators of all relevant government programmes, health care providers, people living with HIV and AIDS and their families, and caregivers, are fully knowledgeable about all key provisions and requirements of this plan, as well as their respective roles and responsibilities. The communications focuses on educating people who will be initiating antiretroviral drugs and their families on what to expect from the treatment and what they must do to make it successful. Finally, and of equal importance, the plan integrates prevention messages into programme communications. It also proposes significant investments in community support programmes for those being treated for AIDS.

The media is another important partner in this initiative as it has the potential to communicate a message of hope to the nation and to keep the public informed about the achievements and challenges experienced in implementing the programme.

Table 6: Performance framework of Social mobilization and communication

Objective	Target Population	Settings	Quality Criteria
To influence decision- makers to adopt a certain perspective and/or support a policy, law, regulation, guidelines, and/or resource allocation or mobilization strategy	Stakeholders in all sectors (e.g. public, private and civil society)	National, regional and international decision-making arenas	Clarity of issues to which advocacy campaigns address Advocacy plan Monitoring and evaluation of the advocacy process

Advocacy and Lobbying

Advocacy is a set of targeted actions directed at decision-makers in support of a specific policy issue[30]. HIV advocacy includes promoting the scaling-up of national and regional HIV programmes by national governments working with key partners such as civil society, the private sector, and .bilateral and multilateral donors.

Advocates use a wide variety of methods and communication channels such as letters, meetings, face-to-face interactions, media communication, forums and newspaper articles to deliver their messages.

Media communication

Media communication often is a tool in a broader advocacy campaign and should be strategic, e.g. developed to achieve specific and measurable outcomes. Critical components to a programme's success include understanding the target population; using the most appropriate channel; having specific and clear messages; pre-testing messages and revising messages/programmes based on results, and measuring the programme's effectiveness. Media communication examples include:

- edutainment,
- social marketing (communication portion of programme), and
- radio and television dramas).

Table 7: Performance framework of Media communication

Objective	Target Population	Settings	Quality Criteria
To promote positive changes in cognitive and behavioral outcomes such as increasing knowledge of modes of HIV transmission, increasing perceived risk of contracting HIV, reducing high-risk sexual behaviors such as having multiple concurrent partners, increasing positive protective behaviors such as condom use, and increasing the utilization of health care services.	Gender population and specific sub-groups within such as young women and men, most at risk populations, and PLHIV.	International, national, regional, and community levels	• Consensus on issues • Clear and specific messages • Monitoring and evaluation of media plan

Other programs that could be implemented in conjunction with media communication include: interpersonal communication, community mobilisation generating community-wide events, advocacy, commodity (e.g. male and female condom) distribution, and service delivery.

Community Mobilisation

A community becomes mobilized when a particular group of people become aware of a shared concern or common need, and decide together to take action in order to create shared benefits. This action may be helped by the participation of an external facilitator—either a person or organization. However, momentum for continued mobilization must come from within the concerned group or it will not be sustained over time. Also, inclusiveness of community members based on age, gender, and other social characteristics contribute to sustainability of efforts. Examples of community mobilization include:

- self-help activities,
- empowerment and solidarity activities,
- social-capital building, and
- Partnership and network building.

[30]The Futures Group Networking for Policy Change: An Advocacy Training Manual for the POLICY Project, 1999.

Table 8: Performance framework of Community mobilization

Objective	Target Population	Settings	Quality Criteria
To change individual attitudes and behaviors, and social and cultural norms.	Any group of people with a shared vision	Groups of individuals in a geographical setting and/or sharing an identity through common norms and values[31]	• Clarity of issues and desired outcomes • Mobilization strategy Monitoring and evaluation plan

Community mobilization interventions should be employed with advocacy, mass media, local activism, training, and interpersonal communications to support both individual- and social-level behavior change.

Interpersonal Communication

Interpersonal communication refers to face-to-face communication. Examples of interpersonal communication are:

- Interactive dialogue,
- Peer education,
- Psychosocial support,
- Individual outreach, and
- Client-provider prevention discussions.

Interpersonal communication should be based on participatory and non-judgmental interactions; factual and evidence-based information sharing; and encourage exchanges that extend beyond raising awareness and knowledge building. The ultimate aim is to change perceptions and values in order to facilitate behaviour change.

Table 9: Performance framework of Interpersonal Communication

Objective	Target Population	Settings	Quality Criteria
To address barriers to adopting healthier behaviors, focus on increasing risk perception, increasing use of available services, and improve skills and self-efficacy to enable individuals to be responsible for and protect their own health by making healthier behavioral choices.	Gender population but often used with young people and marginalized groups	Variety	Linkage and referrals to other care, support and treatment

Interpersonal communication programmes are often implemented in conjunction with other behavior change strategies such as media campaigns, community mobilization efforts, community-wide events, advocacy, and communication material and commodity (male and female condom and needle and syringe) distribution.

Education and Training

Education is a structured approach to HIV prevention that facilitates development of knowledge, attitudes, values and skills to create or maintain a healthy lifestyle. A few critical components to successful HIV-related education programmes include availability of a formal HIV-related education policy, curriculum guidelines, and educators trained in the delivery of the HIV prevention education programmes. Examples of HIV-related education include:

- Sexuality education,
- Life skills education,
- HIV and gender education, and
- Legal rights education

[31]For example, a FBO may consist of a non-residential community of believers.

Training forms the cornerstone for developing competent and professional individuals to deliver effective HIV programmes and services. Training should not be viewed as a one-time activity but a continued experience designed to address arising issues and changing situations. Training can take place in formal and informal settings. Examples of training include:

- Pre-service training
- In-service training
- Peer education
- Organizational development

Table 10: Performance framework of Education and training

Objective	Target Population	Settings	Quality Criteria
To build the knowledge and skills of individuals and groups to reduce risk and vulnerability to infection.	General population but particularly young males and females	In and out of school sites, formal and informal learning situations	Linkage and referrals to other care, support and treatment

Complementary interventions include media communication, interpersonal communication peer education, male and female condom provision, counseling and testing, PMTCT and treatment..

Sexual Reproductive Health Services

Sexual reproductive health services include Family planning services includes counseling and provision of FP methods such as male and female condoms. Media communication, interpersonal communication, community mobilization and education are complementary activities to increase demand for family planning and support services. FP counseling on personal risk to HIV exposure should be accompanied by referral to voluntary testing and counseling and to diagnostic and treatment of STI. In addition to safe delivery practices, the third and fourth components of the PMTCT strategy focus on the provision of antiretroviral treatment and antiretroviral prophylaxis for PMTCT to pregnant women who are infected with HIV and infant feeding counseling and support. Standard guidelines and laws should be strictly adhered to perform sterilization and termination or pregnancy. Advocacy for change in laws and existing norms may be needed to make these services accessible and safe.

Table 11: Performance framework of Sexual reproductive and health services

Objective	Target Population	Settings	Quality Criteria
To reduce risk of HIV sexual and vertical transmission and prevent unintended pregnancy among HIV+ females	Females and males of reproductive age, particularly adolescents	Health facilities, particularly family planning and maternal and child health clinics, antenatal care, STI clinics, adolescent sexual reproductive health services, and community-based reproductive health services	• Comprehensive package of services, including system for referrals • Gender sensitive to attract both male and females beneficiaries • Trained service providers • System of supervision and M&E in place • Widespread availability and accessibility

Combination prevention interventions should include: media communication, interpersonal communication, community mobilization and education to promote safer sexual behaviour and create demand for related services.

HIV Counselling and Testing

The underpinning principles for conducting HIV testing of individuals are:

- Confidentiality
- Counseling
- Voluntary and informed consent.[32]

[32]Voluntary counseling may not be possible in some context, e.g. in the context of rape and criminal assault where it is necessary to establish culpability for willful transmission, or for diagnostic purposes for accessing appropriate medical treatment.

Counseling for HIV testing consists of pre-test counseling, post-test counseling, and follow-up counseling, if needed. Follow-up counseling after post-test counseling helps clients identify their concerns and support them to address them. Follow up counseling is of particular importance to discordant couples, particularly in the context of prevention of mother-to-child transmission.

Table 12: Performance framework of HIV Counseling and Testing

Objective	Target Population	Settings	Quality Criteria
• To enable individuals to know their HIV status and adopt risk reduction measures . • To serve as an entry point for HIV treatment, care and support and prevention of mother-to-child transmission services. • To contribute to reduction of stigma and discrimination.	• General population, particularly women considering pregnancy or who are already pregnant, and young people. • Sub-populations at higher risk to HIV infection and transmission, and their regular sexual partners	Health facilities, stand-alone facilities outside health institutions, mobile services, community-based initiatives, and even in people's homes.	• Training and supervision for health care providers • Close monitoring and evaluation of provider-initiated HIV testing and counseling. • Referral system for additional treatment and safety needs (GBV)

Support activities to counseling include development and dissemination of education materials, provision of male and female condoms including lubricants, non medical needles and syringes for IDUs, and referrals for GBV. Support activities to testing and counseling include development of protocols for testing and counseling, appropriate storage facilities, supply management, staff training for HIV testing and quality counseling, including standard appropriate selection of staff for counseling (clinic staff, peer educators, volunteers, PLHIV), ensuring privacy in counseling setting and supervision and support to counselors.

In the context of combination prevention, advocacy can contribute to the creation of a supportive legal and policy framework to maximize positive outcomes of HIV testing and minimize potential harms. Media communication, community mobilization and community education can be used to develop a better understanding of HIV, increase awareness of the benefits of VCT and normalize its uptake, hence reducing fear of discrimination and rejection associated with HIV positive status. In low HIV prevalence areas, interpersonal communication and, in particular, peer education outreach and peer counselling should be utilized.

Condom Promotion

The male latex condom is the most efficient available technology to reduce sexual transmission of HIV and other STIs. Male condoms are usually supplied with a lubricant coating to facilitate penetration. Male condoms lubricated with spermicidal Nonoxynol-9 should no longer be promoted and distributed as they can increase the risk of HIV transmission.

The female condom is pre-lubricated and, when used consistently and correctly, also provides protection. Female condoms are the only existing effective female-controlled preventive tool against HIV and other STIs. Male and female latex condoms should only be used with water-based lubricants, and reapplication of lubricant or application of water is often sufficient to re-activate them. Female condoms made from polyurethane or artificial latex (such as FC2) can be used with water-based or oil-based lubricants.

Table 13: Performance framework of Condom Promotion

Objective	Target Population	Settings	Quality Criteria
To enhance condom use, particularly when having sex with a partner whose HIV status is unknown or when partners are of a discordant HIV status.	Sexually active populations, particularly people at higher risk to HIV exposure such as sex workers and their clients, injecting drug users, and men who have sex with men	Multiple sites and distribution channels inside and outside health care settings such as commercial sales sites, community-based distribution settings and workplace sites	• An efficient and effective logistical system that includes distribution channels inside and outside health care settings, commercial sales and social marketing, community-based distribution, workplace promotion and outreach services to target population • Capacitated policy-makers, programme managers, service providers and procurement officers who know how to apply the essential elements of condom quality assurance to guarantee that a quality product is purchased, promoted and distributed to the consumer.

Advocacy, media communication and interpersonal communication can help place condom provision and promotion on the political agenda and address religious and gender norms, stigma associated with condom use and cultural norms and practices that impede access to information, skills, condom and their consistent and correct use. Mass media campaigns, peer education outreach, community education, facility-based education, school-based education, life skills education and peer counseling or counseling by a trained counselor are all behaviour change communication approaches that can be utilized to promote condom use. Consistent and correct use of condoms should be promoted together with delay of sexual initiation, abstinence, being consistently faithful to one's partner when both partners are uninfected, reducing the number of partners, avoidance of penetrative sex, diagnostic and treatment of STI, HIV testing and counseling and male circumcision. Orientation, sensitization and training for media people, health care providers and outreach workers should be part of communication efforts to equip them with accurate information and reduce bias towards female condoms or sub-population groups who need them.

Male circumcision

Male circumcision (MC) is the surgical procedure for removal of the foreskin of the penis and langerhans cells on the underside, which are specific target cells for HIV. It causes keratinization (hardening) of the skin surface, and promotes more rapid drying. MC reduces the likelihood of bacterial sexual infections (like chancroid), which in turn reduces the risk to HIV.

Pre-counseling should focus on the benefits of male circumcision for the prevention of HIV and other diseases; and address concerns such as fear of pain, complications, or a decrease in sexual pleasure. Post counseling should emphasize the following: circumcised men can still become infected with the virus and infect their sexual partners; safe male circumcision reduces the risk of HIV infection through vaginal sex but not anal sex; and sexual relations before wound healing increases the risk of HIV infection among recently circumcised HIV-negative men. Men should be advised to come back to the health facility to verify that the wound is healed and to seek immediate treatment if there is evidence of complications.

Table 14: Performance framework of Male Circumcision

Objective	Target Population	Settings	Quality Criteria
To provide partial protection against the risk of HIV sexual transmission from women to men.	HIV-negative males of any age but particularly younger men and infants[33]	Surgical male circumcision should be performed by trained medical practitioners in a safe and adequately equipped sanitary setting.	• Traditional practitioners comply with standards of safety for prevention and management of complications • Services are accessible, available and affordable • Integration of MC with other HIV and sexual health services[34] • Promotion of other methods of protection[35]

In the context of combination prevention, MC should be promoted and delivered with other methods such as media communication, interpersonal communication, education, diagnostic and treatment of sexually transmitted infections, and HIV counseling and testing. Introducing and scaling up male circumcision services

that are accessible, acceptable, and provided safely to all men may also require advocacy for development of appropriate law, regulation and policy and partnerships.

Prevention of Mother to Child Transmission

Biomedical prophylaxis refers to the use of ARV drugs to reduce the likelihood that a pregnant woman living with HIV will transmit the virus to her child during labour and delivery. While ARV drugs can be harmful to the child during the first three months of pregnancy, women who are on ART should not interrupt their treatment if they become pregnant as this will put their own health at risk and endanger their infant's future. Short courses of ARV drugs started late in pregnancy or during labour reduce the risk of in utero and peripartum HIV transmission. For HIV-infected pregnant women who do not have access to treatment, the recommended antiretroviral prophylactic regimens are based on AZT (from 28 weeks of pregnancy or as soon as possible thereafter), single-dose nevirapine during labour, maternal 7-day tail of AZT and 3 TC plus one-week AZT for the infant.

Prophylaxis dosing with cotrimoxazole is a key intervention that should be offered to HIV exposed children until infection has been definitively ruled out and the mother is no longer breastfeeding. To HIV infected children it should be given indefinitely where ARV treatment is not yet available. Where ARV treatment is being given, cotrimoxazole can be stopped only once clinical or immunological indicators confirm restoration of the immune system for 6 months or more.

Table 15: Performance framework of PMTCT Services

Objective	Target Population	Settings	Quality Criteria
To reduce the likelihood of HIV transmission to infants exposed to HIV infection during birth to an HIV positive mother.	Pregnant women who test HIV positive	Public and private health sector facilities that provide antenatal and delivery services	• Protocols and guidelines for case assessment and response. • Trained health facility managers and health care providers on the PEP policy and protocols. • Widespread accessibility and 24-hour availability. • Counselling and follow-up support services

Counselling and Services Related to Infant Feeding Options

Because breastfeeding of infants by mothers is the expected norm throughout Zambia, very little information about how it should be done and optional feeding practices are available. Family and community social norms, values and practices interact to reinforce breastfeeding practices by the majority of mothers. For instance, grandmothers are the primary source of information about infant feeding practices. Therefore, interventions to provide feeding options to HIV+ women should include the broad spectrum of people who influence a woman's choice in selecting an infant-feeding practice, e.g. spouse, neighbours, and family members.

Table 16: Performance framework of Infant feeding options

Objective	Target Population	Settings	Quality Criteria
To enable HIV+ women to make an informed choice about infant-feeding options and reduce the dual burdens of HIV and reproduction	General population but particularly pregnant and lactating mothers, and infants born from HIV+ women	Variety, particularly health facilities providing ante and post-natal care services	• Protocols and guidelines for infant feeding options • Trained health facility managers and health care providers on the infant feeding options • Counselling and follow-up support services

Complementary services include: regular growth monitoring of infants living with HIV to follow the progression of the virus and the response to treatment, including antiretroviral therapy. Provision of family

[33] Male circumcision is not recommended for men who are already infected with HIV as there is no demonstrable public health benefit for reduced HIV transmission to partners and men with severe immunodeficiency.
[34] Vertical stand-alone services may be useful in the short term to introduce and expand access to safe male circumcision, especially where demand is high and health systems are weak.
[35] All stakeholders and individuals should know that safe MC does not provide complete protection against HIV and does not offer an alternative. It is an additional risk reduction measure. It should be clear to all that male circumcision is different from female genital mutilation which has serious adverse effects on the health of women and has no demonstrated medical benefits.

planning counseling and support services is especially important during the postpartum period for women living with HIV who choose not to breastfeed or who stop breastfeeding early.

Because the evidence base for policy-making on this issue is still accumulating, advocacy is required to communicate emerging information to decision-makers. Media communication and community mobilization are helpful to creating an enabling environment for improving nutrition for all lactating women, regardless of their HIV status. Self help groups can provide nutrition education to HIV-positive mothers and help them sustain their infant feeding option.

PLHIV-Promoting Positive Health, Dignity and HIV Prevention (Prevention with the Positives):

Provision of Safe Virtual or Physical Spaces for Vulnerable Populations

The creation of safe spaces, either virtual or physical, can relieve the isolation that vulnerable populations have in societies where their rights and/or lifestyles are not protected, and where there are few places to express their health concerns. Examples of safe space interventions are:

- Interactive online communities
- Telephone hotlines
- Drop-in centers
- Women's shelters
- Youth friendly corners
- Support groups
- Text messaging

Table 17: Performance framework of Vulnerable Groups

Objective	Target Population	Settings	Quality Criteria
To increase access and use of friendly and confidential HIV and AIDS information, referrals, and support services;	General population , and particularly vulnerable groups such as women and youth	Virtual and physical spaces	• Confidentiality • Trained personnel • Widespread availability and accessibility

Complementary interventions to safe space programmes include: diagnosis and treatment for sexually transmitted infections, HIV testing and counseling, risk reduction support, needle and syringe exchange, male and female condom distribution, counseling, peer education and outreach, and referrals to other non-stigmatizing care and treatment services. Other interventions are: advocacy for more equable treatment and support for vulnerable populations, vocational training, literary classes, and legal services.

Post-Exposure Prophylaxis

Post-exposure prophylaxis (PEP) is a set of services that are provided to prevent and manage specific aspects of exposure to HIV and reduce the risk of becoming infected. The PEP core package includes:

- Reporting assistance and possible referral capacity;
- Risk assessment;
- Counseling services (providing consent to PEP; pre- and post-HIV test counseling for both the exposed person and the source person); drug adherence and managing side effects; preventing the risk of transmission
- HIV testing (initial testing of exposed individuals and testing of the source person, when possible)
- Providing PEP medication (the initial dose as soon as possible preferably within 72 hours; and the full course of 28 days of treatment);
- Support and follow-up; and
- Appropriate record-keeping and documentation

Table 18: Performance framework of PEP

Objective	Target Population	Settings	Quality Criteria
To reduce the likelihood of HIV transmission by providing a course of antiretroviral therapy to those exposed to HIV infection through occupational or non-occupational hazards	Health care workers, law enforcement personnel, emergency rescue staff, waste disposal workers and fire fighters exposed to HIV infection through blood and other potentially infectious body fluids whilst performing official duty. Non-occupational exposure through sexual assault and other forms of GBV	All health facilities and non-occupational settings where there is a high risk to HIV exposure, e.g. health clinics, rape crisis centres and police stations.	• Standard precautions for risk reduction • Protocols and guidelines for case assessment and emergency response. • Trained health facility managers and health care providers on the PEP policy and protocols. • Widespread accessibility and 24-hour availability. • Counselling and follow-up support services

Support activities for HIV PEP include advocacy for the development of a post-exposure prophylaxis policy or protocol covering both occupational and non occupational exposure and legal changes for protection of occupational exposure and its consequences

Standard Precautions and Safe Medical Injections

Individual and social behaviour in the context of treatment, care and support and general interaction with the public can minimise risk and vulnerability to infection. A number of standard precautions should be adopted by medical and other care facilities to promote positive social behaviour in the context of health care provision. These include:

- Hand hygiene and use of gloves
- Facial protection to protect the mucous membranes of the eyes, nose, and mouth.
- Protective clothing to protect skin and prevent soiling by blood, body fluids, secretions, or excretions.
- Standard procedures to prevent needle stick and injuries from other sharp instruments
- Respiratory hygiene and cough etiquette should be practiced with persons demonstrating respiratory symptoms.
- Source control measures should be applied. Patients with acute febrile respiratory symptomatic patients should be placed at least one meter away from others in common wait¬ ing areas.
- Guidelines for environmental cleaning should be implemented, e.g. routine cleaning and disinfection of the environment and frequently touched surfaces.
- Patient care equipment should be handled in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
- Apply procedures for safe medical injections and disposal of used needles.

Table 19: Performance framework of Universal safety Precautions

Objective	Target Population	Settings	Quality Criteria
To institutionalize standard precautions and safe medical infection procedures	All health workers and care-givers	All health care facilities	• Procedures for reporting and treating exposure to HIV infection • Protocols and guidelines on the use of PEP • Training in infection control and precautionary measures

To prevent injection overuse, advocacy may be required to ensure that national drug policies promote the rational use of therapeutic injections, including removing unnecessary inject able medicines from the national essential medicines list. Medical waste should be disposed in a safe and environmentally responsible way, which may require advocacy for developing a policy of health care waste management.

Drug treatment including drug substitution therapy

Drug treatment, including drug substitution therapy, consists of providing medical and/or psycho-social support to Injecting Drug Users (IDUs). Drug treatment options include detoxification with or without medication,

abstinence-oriented treatment to assist IDUs to develop drug-free lifestyles and prevent relapse, and drug substitution therapy. Drug substitution therapy entails the administration of oral medicine, with simi¬ lar action to the drug of dependence, under medical supervision. Relapse following detoxification alone is common. Detoxifications with subsequent abstinence-oriented treatment or substitution treatment are more effective than detoxification alone.

Table 20: Performance framework of Drug Treatment

Objective	Target Pop	Settings	Quality Criteria
To reduce the risk of HIV infection and transmission through use of contaminated drug injecting equipment.	IDUs who inject illicit drugs	Long and/or short-term institutions for treatment and care, out-patient facilities, and community-based sites with trained medical and paramedical staff.	• Good practice guidelines are available and widely disseminated • Trained personnel • Services available and accessible

Drug treatments should also provide prevention education to reduce injecting risk: using single use needles and syringes, injecting less often, or stopping needle use by moving on to non-injecting drugs. Drug substitution therapy can be used as an entry point for offering complementary services such as voluntary testing and counseling, referral for medical care (HIV) and antiretroviral treatment, education on HIV sexual transmission, diagnostic and treatment of STIs and provision of male and female condoms including lubricants.

Non-medical needle and syringe provision

Non-medical needle and syringe provision consists of ensuring easy, consistent and safe access to single use needles and syringes to injecting drug users (IDUs). Modalities for non-medical needle and syringe supply include provision of needles and syringes free or for cost; one-for-one exchange; and secondary distribution. Non- medical needle and syringe provision should ensure that used injecting instruments are disposed of safely.

Table 21: Performance framework of Needle and syringe provision

Objective	Target Population	Settings	Quality Criteria
To reduce the risk of blood borne HIV infection and transmission associated with using contaminated drug injecting equipment	Drug users who inject illicit drugs. IDUs might consist of a series of sub-population groups such as prisoners, male or female/transgendered sex workers and clients of sex workers.	Community outreach programmes, distribution points, vans, drop-in centres, and pharmacies	• Training of key law enforcement personnel and community workers • Community mobilization interventions in place • Referral services for counselling and testing, treatment care and support and impact mitigation

Non-medical needle and syringe provision to IDUs remains a neglected and sometimes controversial issue in Zambia, and advocacy and media communication can help reassure stakeholders and the community that providing access to safe injecting equipment will not lead to increased number of drug users. Legal reforms may be required to permit legal purchase of needles and syringes and change legislation that supports arrest and harassment of IDUs. Advocacy, also, might be needed for the Government and partners to provide sufficient funding.

Outreach to IDUs usually include complementary activities, such as peer education on HIV transmission and risk reduction strategies, delivery of primary health care (e.g., abscess management) HIV testing and counseling and drug treatment. Activities targeting IDUs may also include education on HIV sexual transmission and risk reduction strategies, provision of female and male condom including lubricants, and referral for diagnosis and treatment of Sexually Transmitted Infections.

Sexually Transmitted Infections

Sexually transmitted infection (STI) treatment is an important HIV prevention strategy in the general population,and syndromic management a key cost-effective strategy[36]. Support activities to diagnosis and treatment of STIs include development and dissemination of standard STD diagnostic and treatment protocols and guidelines and training of health care providers in their use, including the needs of specific sub-population groups such as asymptomatic STI in women and asymptomatic rectal STIs in MSM/transgender.

STI case management also includes counseling on issues including compliance in treatment, problems associated with self medication, ways to avoid or reduce risk of infection with sexually transmitted pathogens, including HIV, and partner notification to prevent re-infection of the index patient and reduce the spread of

infections. Epidemiological treatment (treatment for the same infection or syndrome as in the index patient) should be given to all recent sexual partners.

Table 22: Performance framework of STI

Objective	Target Population	Settings	Quality Criteria
To identify and treat curable STIs as a primary prevention strategy for HIV control.	General and most at risk sub-populations such as female, male and transgender sex workers and their clients who also might have sex with their regular partner, MSM, IDUs involved in commercial sex, and PLHIV	Public, private , FBO and NGO first-level health care facilities, either within or to complement primary health care services or as a stand alone STI clinic.	Regular supervision of clinicians treating STIs, availability of protocols and guidelines, equipment , and a continuous supply of drugs and commodities

Integrated services should be made "user friendly" to attract and make accessible to sub-population groups at higher risk to HIV infection and young people. Clinics specializing in STI (categorical clinics) can provide STI case management to sub-population groups that are marginalized or hard-to-reach.

Advocacy may be required to place STI control high on the political agenda and ensure funding for evidence-based scaling up. Media communication, interpersonal communication and community mobilization have a crucial role to play in creating a supportive environment for/and increasing demand for diagnosis and treatment of STIs. Diagnosis and treatment of STIs should be promoted together with provision of male and female condoms including lubricants, preventive education and male circumcision. Referral from STI clinics to HIV testing and counseling is essential.

Blood Safety

Blood safety is the most effective strategy for prevention of transfusion transmissible infections, Blood safety interventions include creating a conducive environment for safe blood donations through non-remunerative voluntary efforts, institutionalisation of efficient and effective screening procedures in all health care settings, and referral of HIV+ donors to counselling and testing and treatment services.

Table 23: Performance framework of blood safety

Objective	Target Population	Settings	Quality Criteria
To reduce the risk of HIV transmission and other transmissible infections through transfusion of contaminated blood or blood products.	Non-remunerated blood donors from low-risk populations; recipients of donated blood and blood products; anonymous sperm donors and directed reproductive donors and reproductive recipients.	Health service settings and mobile blood collection teams at various sites.	• HIV tests are highly sensitive and reliable. • Comprehensive referral system in place for donors requiring treatment, care and support

Combination measures for ensuring drug safety include strengthening the screening of blood and blood-products and rationalizing the use of blood and blood products to reduce unnecessary transfusions. Ccommunity mobilization for voluntary paid or non-remunerated blood donation, staff training for quality assurance and quality control in HIV testing methodology and blood banking and in use or rational use of blood and blood products, standard precautions, including safe disposal of laboratory waste and HIV-positive blood. Blood donors who are confirmed positive should be referred to counseling and testing services so that they can be notified of their infection status and referred for clinical management of HIV and psycho-social support.

4.2 Treatment, Care and Support

Zambia is committed to improving the quality of life for PLHIV through comprehensive and quality treatment, care and support services. HIV counseling and testing (HCT), particularly that which is provider-initiated, will be intensified as an entry point for treatment and care. The referral system will be improved and service providers will be trained in maximizing the use of the referral system.

[36]Syndromic management is based on using a flowchart to diagnose etiological agents giving rise to a particular clinical condition.to reach a diagnosis and decide on treatment. This approach is based on identifying consistent groups of symptoms and easily recognizable signs, and providing treatment that will deal with most of, or the most serious organisms responsible for each syndrome.

The national treatment, care and support programme will be scaled-up based on the following principles:

- Universal access, equitable and quality care
- Emphasis on prevention
- Strengthened national health system, including the safe use of medicines and provisions for controlling multi-drug resistance
- Comprehensive and sustainable programmes
- Promotion of individual choice and responsibility for adopting a healthy lifestyles

Care and treatment protocols will be based on international best practice. Accreditation procedures will help to ensure that all facilities that are approved to provide antiretroviral treatment are of good quality and observe the highest standards of care. In addition, extensive training and certification of health professionals will be carried out on an ongoing basis to support treatment interventions.

The NOP also provides for extensive investments in monitoring and research to facilitate continual evaluation and improvement in the quality of care. A robust monitoring system will ensure an early warning system to detect drug resistant strains of the virus, adverse drug events and drug-to-drug interactions between Western, traditional and complementary medicines. These efforts will ensure that the best information is available for the benefit of Zambians undergoing care and treatment.

Antiretroviral Therapy

The following strategies will be implemented to achieve the stipulated outcome result and outputs:

Universal Care and Equitable Implementation

Zambia will endeavour to provide universal access to care and treatment for all, irrespective of race, colour, gender and economic status. The programme attempts to address the challenge of providing services in rural and urban settings without compromising the quality of care. Therefore, the operational plan aims to accomplish a balance between areas that can readily implement ART and those that need additional resources and investment to upgrade their general capacity to do so. Specific attention will be focused on historically disadvantaged populations and underserved health districts.

Table 24: Performance framework of Universal care and equity

Objective	Target Population	Settings	Quality Criteria
To ensure universal access to treatment, care and support	PLHIV who eligible in terms of national protocols and guidelines	Public and private health facilities	• Confidentiality • Trained personnel • Widespread availability and accessibility

Continuum of Care Package

In the absence of a cure, prevention remains the cornerstone of the country's response to HIV and AIDS. The current range of prevention strategies are articulated in section 4.1. A comprehensive HIV and AIDS programme will build on testing programmes to diagnose HIV infection and measure disease progression so that proper care and treatment regimens can be implemented. The continuum of care and treatment includes:

- On-going medical services to provide treatment for opportunistic infections associated with HIV and, when necessary, antiretroviral treatment to arrest the progression to AIDS.
- Nutrition interventions, and
- programmes to integrate the provision of medical care with traditional methods of healing.

Table 25: Performance framework of Continuum of care

Objective	Target Population	Settings	Quality Criteria
To deliver improved integrated quality and comprehensive HIV treatment, care and support services	Health sector inclusive of public and private providers	Public and private health facilities and community	• Comprehensive referral system in place for clients requiring treatment, care and support • Trained personnel

Laboratory Services

The guiding principles of the laboratory services component of the antiretroviral treatment programme are:

- Monitor patient safety for toxicity, adverse events and drug resistance
- Establish evidence-based, cost-effective and sustainable laboratory services
- Provide high quality laboratory services in all parts of the country

Table 26: Performance framework of laboratory services

Objective	Target Population	Settings	Quality Criteria
To support best practices of patient care	Health care facilities	Public and private health sectors in all areas of the country, however the National Health Laboratory Service will validate laboratory tests	• Capacity to perform CD4 and viral load tests • Supervisory system • M&E for quality assurance

Safe Use of Medicines

Prescribing of antiretroviral drugs is a relatively new practice, and if not administered and monitored properly can become less effective as drug-resistant strains of the virus develop. The drugs also have toxic side effects for some patients. Therefore, monitoring the impact of the drug regime and a patient's safety is critical to the safe use of medicines and adherence to treatment.

Promotion of Personal Healthy Lifestyles

Ultimately, any health care programme should begin with the promotion of a healthy lifestyle. Good nutrition, safer sex practices, and effective prophylactic medical care are fundamental to good health. This remains true for all people – both to prevent the spread of HIV to those uninfected, and to sustain the immune systems of PLHIV for as long as possible.

This programme will be integrated with existing efforts to promote healthy lifestyles, and will include advice on general health maintenance strategies, positive living, exercise, nutrition, traditional and complementary medicines, and antiretroviral therapy. . It will enhance these efforts through additional investments in nutrition and traditional and complementary medicines; promoting regular exercise; supporting community-based initiatives; monitoring and evaluating the impact of health promoting activities; and intensifying information, education and communication campaigns.

A wide range of interventions and options will be provided through the comprehensive package of care. All potential clients will be informed about their care and treatment options and encouraged to make informed choices to enhance their circumstances of living and personal lifestyle.

Food and Nutrition

Good nutrition is essential to good health. This is particularly true for PLHIV. The Zambian government has in place programmes to improve nutrition and food fortification among PLHIV, TB, and/or other chronic debilitating diseases. Interventions to improve food intake and nutritional status will be fully integrated into the continuum of care.

The next five years advocacy will be prioritized for a significant increase in nutritional programmes available to people who are HIV-positive or who have developed AIDS. All persons attending service points for HIV and AIDS care and treatment will receive counseling and information on healthy eating and lifestyle, food preparation and coping with HIV-related disease. Nutritionists, where available at the service points, will provide regular assessments of patients' nutritional needs and evaluate their food and supplement needs, and, where necessary, refer patients to appropriate food security programmes in the Ministry of Health.

Specifically, two nutritional interventions are included in the operational plan: Provision of food support (composite meals) for members of defined patient groups who are malnourished and do not have access to secure food supply; and high-dose vitamin supplementation for defined patient groups such as HIV-positive pregnant women, people with active tuberculosis and/or TB/HIV co-infection and HIV-positive children under 14 years of age.

TB/HIV Co-Infection

Tuberculosis is the major cause of death among PLHIV. TB services have been rolled out to all health facilities and many community-based programmes. Under the NOP the “Three Is” strategy (intensified case finding, provision of Isoniazid Prevention Therapy, and TB infection control) will be accelerated and the national capacity

for treating TB and monitoring the emergence of multi-drug resistance (MDR) and extensive drug resistance (XDR) will be intensified.

Containment of resistance to antimicrobial agents requires the establishment of appropriate early warning systems overseen by a dedicated team of experts. Key elements in a containment strategy include the prudent use of antimicrobial agents, educational intervention, integrated surveillance and monitoring systems in all areas as well as good infection control practice. In addition, risk assessment and management strategies within a regulatory framework play an important role in containing antimicrobial resistance.

Community and Home Based Care and Palliative Care Services

A full range of community support services is required for home-base and palliative care, treatment adherence, support groups, and elimination of stigma and discrimination that deter treatment and support regimens.

Table 27: Performance framework for CHBC and Palliative care

Objective	Target Population	Settings	Quality Criteria
To deliver improved CHBC and palliative care and support services	Health sector inclusive of public, community and private providers	Public and private health facilities and community	• Comprehensive referral system in place for clients requiring treatment, care and support • Trained personnel • Functioning community based organisations

4.3 Impact Mitigation

The NASF priority in impact mitigation is to strengthen the capacity of vulnerable households and individuals to cope with the socio-economic impacts of HIV and AIDS within the context of social protection. This will entail development and implementation of sustainable livelihoods, improving household food security, strengthening systems that provide social security and reducing risks and vulnerability.

Among the key vulnerable groups are: PLHIV, OVC, the elderly, people living with disabilities, and care-givers. Provision of care for OVC and PLHIV remain the greatest challenge for vulnerable households given their limited resources. The NOP will support interventions that address the basic needs of food, shelter, education, clothing, social protection, access to health care, water and sanitation in addition to the challenges of psychosocial needs and gender-based violence (physical, emotional and sexual).

Policy Environment and Institutional Reform

Governance and Human Rights

Many issues that support social protection and development of mitigation strategies are related to governance and policy reform, particularly protection of children. The duty of the state is to respect, protect and fulfill citizens' rights, and many failures in this regard are challenges in governance.

i) Complete Domestication into National Law of the Provisions of the Convention on the Rights of the Child (CRC)

   Although ratified in 1991, the CRC has not been completely domesticated into Zambia Laws. Most recently, Parliament ratified laws that increase penalties for people who sexually abuse children, and provide greater controls on the participation of young children in paid employment. This process requires further support and progress.

ii) Implement Free and Compulsory Universal Birth Registration

   The CRC establishes that all children should be registered at birth and have a name. Zambian law also requires that all births must be notified within one month, and registered within twelve months. There are registration offices in each district. However, compliance is very low, and many children remain unregistered. This can cause problems at different stages of their lives, and deprive them of a demonstrable identity.

iii) Increase Awareness of Rights and Laws Governing Inheritance

   Property-grabbing from widows, widowers, children and other legal dependents remain a major problem because of conflicts between Statutory and Customary Laws; and many people lack of knowledge on how to seek redress when property has been unfairly appropriated.

Livelihood and Financial Security for Vulnerable Communities, Households and Individuals

The objectives of the livelihood and financial security activities are intended to provide vulnerable populations with the economic resources needed to meet their basic needs, support asset-building, and address HIV risks

associated with financial insecurity. Although an aim of many livelihood interventions is to improve household income and viability, it is important to build in processes that ensure equitable access and benefits from the intervention, particularly along gender and age categorisations. Research has shown that a rise in household income does not automatically translate in equal benefits to household members. Examples of Livelihood Activities:

- Income generation activities
- Support services such as access to micro-credit, saving and credit loans, grants
- In-kind sustenance support
- Business training
- Financial literacy training

Table 28: Performance framework of livelihood and financial security

Objective	Target Population	Settings	Quality Criteria
To enable individuals to better meet their basic needs and, therefore make healthier sexual decisions to prevent HIV infection.	Vulnerable populations, particularly women and girls, OVC and PLHIV	Variety	knowledge, skills and Commitment to achieve policy and institutional reform at all administrative levels and in all sectors

Other activities that could be implemented to support financial security programmes with women include interactive drama to learn how to defuse potential conflicts with partners, and providing self-defense and family law classes. Additional activities could include interpersonal communication, media communication, advocacy, and community mobilization.

i) Agriculture

Proposed strategies in the Agricultural sector that can contribute to improve individual and household functioning are:

- Provide extension services and development programmes to low capacity households, e.g. female or child-headed households, households with a high dependency ratio, and households headed by people incapacitated by a disability.
- Reduce exploitation of vulnerable workers (women, children, people living with a disability, and PLHIV by requiring commercial farmers and agricultural exporters to adhere to the labour laws and international codes of conduct for employment in the agricultural sector.

ii) Education and Training for Income-Generation

Skills-building and technical training is expanded to capacitate vulnerable groups to generate income for self sufficiency.

iii) Social Protection[37]

The key concern in planning the Social Protection Strategy is to identify priorities for the core target group – the most vulnerable - rather than designing interventions to address the needs of “the poor”.The social protection strategy has six objectives of which five directly impact on the target groups (vulnerable households and individuals), whilst the sixth is directed at improving national and local capacity to implement the programme. The social protection objectives are:

- To increase the ability of low capacity households to meet their basic needs
- To reduce extreme poverty in incapacitated households
- To reduce the vulnerability and numbers of street children
- Improve access to health & education for people from incapacitated and low capacity households
- Reduce the vulnerability of SP target groups to the violation of their legal rights
- Strengthen capacity at local and national level to deliver an effective social protection programme

[37]Social protection refers to policies and practices that protect and promote the livelihoods and welfare of people suffering from critical levels of deprivation, and/or vulnerable to risks and shocks.

Table 29: Performance framework of social protection services

Objective	Target Population	Settings	Quality Criteria
To ensure that incapacitated and low capacity households and people have sufficient income security to meet basic needs, and protection from the worst impacts of risks and shocks.	Vulnerable populations, particularly women and girls, OVC and PLHIV	Variety	knowledge, skills and Commitment to achieve policy and institutional reform at all administrative levels and in all sectors

Orphans and Vulnerable Children

Education

Arguably, the Education Sector provides the most critical essential service for children. Through the Education Strategic Plan (ESP) 2003-2007, the Zambian Government has identified key priorities for the provision of basic and post-basic education for all children, including OVC and non-OVC. These provisions include the following:

- Implement the National Plan of Action for Children, particular interventions for OVC
- Support households and individual girls to facilitate their completion of a basic education programme
- Provide resources, monitoring and training support to upgrade standards in 500 community schools
- Support for the continuing education of out-of-school children and youths
- Increase provision of relevant information on HIV/AIDS and skills for the prevention of transmission to all pupils and teachers
- Strengthen the life skills curriculum for use in and out of school programmes for children
- Promote services that address early childhood development, school health services, sport, play and culture
- Expand membership, retention and capacity amongst school-based Anti-AIDS Clubs, training the teachers who lead the clubs and providing a greater range of materials, and ideas for activities to make the clubs more interesting and relevant to the needs of members of all ages.
- Deliver in-service training to all teachers to build their skills as local leaders and to promote capacity as role models in communities[38]

Health

Strategies in the health sector contribute to improving access to essential services through the Basic Health Care Package (BHCP). The package includes preventive and curative services, and key environmental health activities such as spraying residential areas for mosquitoes. This integrated approach supports improved service delivery through the BHCP rather than through individual projects or programmes.

Health sector interventions are targeted to eliminating MTCT, facilitating access to reproductive services for adolescents and treatment for children living with HIV, reducing the burden of care for members of households caring for a PLHIV.

- Expand and strengthen the provision of psychosocial support at community level
- Facilitate accessibility to the universal ARV programme by HIV+ single parents/caregivers and children

Table 30: Performance framework for OVC

Objective	Target Population	Settings	Quality Criteria
To deliver improved material, spiritual and psychosocial support services for the vulnerable groups and care givers	Community public and private providers	Public and private facilities and community	• Comprehensive referral system in place for clients requiring social support • Trained personnel

4.4 National Response Coordination and Management

The national response to HIV and AIDS will be coordinated and managed according to an integrated structure and the following principles:

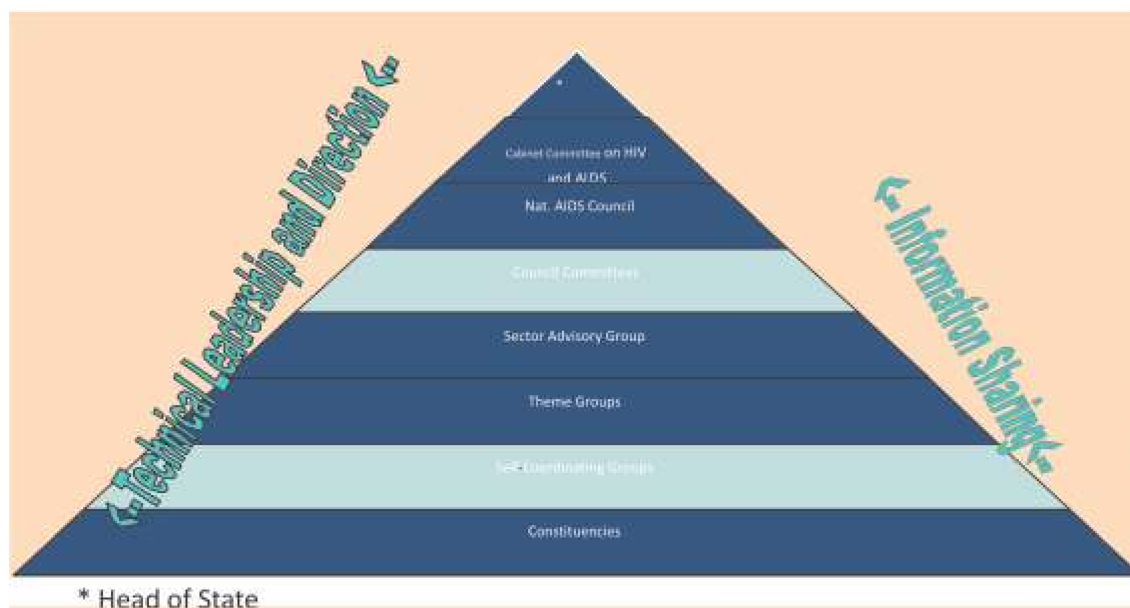
- Mainstreaming into existing programme delivery systems
- Utilization of an integrated approach providing a comprehensive prevention, treatment and care, and impact mitigation programme must integrate with prevention and education programmes.
- Coordinated within a national framework to ensure uniform quality, an equitable implementation and efficiencies that can come with scale of operation.

[38] In most communities (particularly rural areas), teachers are amongst the best educated residents, and are very likely to be held in high regard. In this position, they have an opportunity to contribute significantly to development in their areas, in education and beyond.

The NASF 2011-2015 will be implemented within the context of the National Decentralisation Programme and Implementation Plan. Coordination of the national multi-sectoral response takes place at four levels, i.e. national, provincial, district and community levels. Coordinating structures are in place to orchestrate and harmonise the multi-sectoral response into a set of broad but cohesive and focused interventions at the various levels of implementation.

Figure 1 illustrates, provides a foundation for effective coordination, information sharing and leadership. The general principle of the Institutional Structure is the flow of information and technical leadership and guidance through all levels of the national response.

Figure 1: Conceptual Framework



Policy and Institutional Reform

A supportive policy environment is required for the effective implementation of gender-responsive and human-rights based HIV programmes. This may require policy and institutional reform to ensure that populations in need can access programmes and services; that government and non-governmental organisations can operate effectively; and that stigma and discrimination can be addressed. Policy and institutional reform, also, may require amendments to policies, laws, and institutional practices that restrict access to prevention and treatment services. For instance, removing barriers to universal access to services emanating from criminalizing consensual sex between males, prohibiting condom and needle access for prisoners, and prohibiting drug substitution or criminalizing those who consume drugs.

Table 31: Performance framework of Policy and institutional reforms

Objective	Target Population	Settings	Quality Criteria
To create a supportive and enabling environment to remove barriers to accessing HIV prevention, care, treatment and support services	General population and institutions with emphasis on MARP	Multiple levels, e.g. national, provincial, district and community	knowledge, skills and commitment to achieve policy and institutional reform at all administrative levels and in all sectors

Changes in traditions and customs present particular challenges as a purely legalistic approach without adequate education and enforcement is unlikely to result in rapid abandonment of traditional norms and values. Societal norms and policy often reflect one another. Therefore, complementary activities are required to encourage gatekeepers of societal norms and values to promote the type of behaviour that reduces risk and vulnerability. Mass media, public debates, and community theatre are means to stimulate national and community dialogue about sensitive topics.

Legal Services

Legal services in the context of HIV takes many forms including legal information and advice; formal litigation; mediation and other forms of dispute resolution; assistance with negotiating informal or traditional legal

systems (e.g. local courts); cost of legal consultancy; legal representation of individuals in court and related expenditures; and community legal education. In addition to lawyers, legal service providers can include paralegals, volunteers, students and peer educators trained in legal issues. It is important that all legal service providers (either staff or volunteers) are trained in gender, human rights and discrimination issues.

Table 32: Performance framework of legal services

Objective	Target Population	Settings	Quality Criteria
To promote access to HIV prevention, care and treatment services through promotion and protection of the human rights of PLHIV and other vulnerable populations, and to provide an avenue for redress by people who are discriminated against because of their sero-positive status.	General population, especially those vulnerable to stigma and discrimination or denial of their human rights	HIV treatment and counseling centers, mainstream legal aid centers, prisons and community settings.	Training schemes to develop capacity of organizations to provide in-house para-legal advice and counseling services

Complementary services include counseling and information dissemination to improve service accessibility.

Levels of Responsibility For Coordination And Management

A. National

Table 28: Performance framework of Response management

Cabinet

Table 33: Performance framework of Cabinet

Objective	Target Population	Settings	Quality Criteria
To provide policy direction and guidance to the National AIDS Council and inform the Head of State on important matters concerning HIV and AIDS in the country.	Head of State and Cabinet	Cabinet	knowledge, skills and commitment to achieve policy reform in all sectors

Council

Table 34: Performance framework of Council

Objective	Target Population	Settings	Quality Criteria
To support the development and coordination of policies, plans and strategies for the prevention and combating of HIV, AIDS, STI and TB.	• PS in Ministries of Health, Community Development and Social Welfare, Youth, Sport and Child Development and Education. • The Attorney-General's Office; • Network of People Living with HIV and AIDS (NZP+); • Zambia National AIDS Network (ZNAN); • Forum of Youth Organisations (FYO); • Traditional Healers Association of Zambia (THAZ) • Medical Council of Zambia (MCZ); • General Nursing Council of Zambia; and the • Media.	Different sectors and constituencies	knowledge, skills and commitment to achieve policy and institutional reform at all administrative levels and in all sectors

Legislature

Table 35: Performance framework of Parliamentarians

Objective	Target Population	Settings	Quality Criteria
Oversight function on the Executive and representative role for their Constituents at the National Assembly of Zambia (NAZ). In Councils where they sit as Councillors contributing to planning, implementing and accounting for development activities at the local level. Advocating against the stigma of HIV and AIDS and promoting greater awareness of the disease	MPs and communities	Constituencies National Assembly (Parliament)	Enacting legislation to protect the rights of those affected and infected by HIV and AIDS; Supervising the proper allocation of resources to national HIV and AIDS programmes; and Overseeing the proper implementation of programmes;

Provincial

At the provincial level, the HIV/AIDS institutional framework consists of a Provincial AIDS Task Force, (PATF) which is a sub-committee of the Provincial Development Coordinating Committee (PDCC) as shown in Figure 2. The role of the PATF is to coordinate, supervise and monitor the implementation of HIV/AIDS policies and programs in the province.

Figure 2: PDCC Organisational Structure Showing Some Sub committees

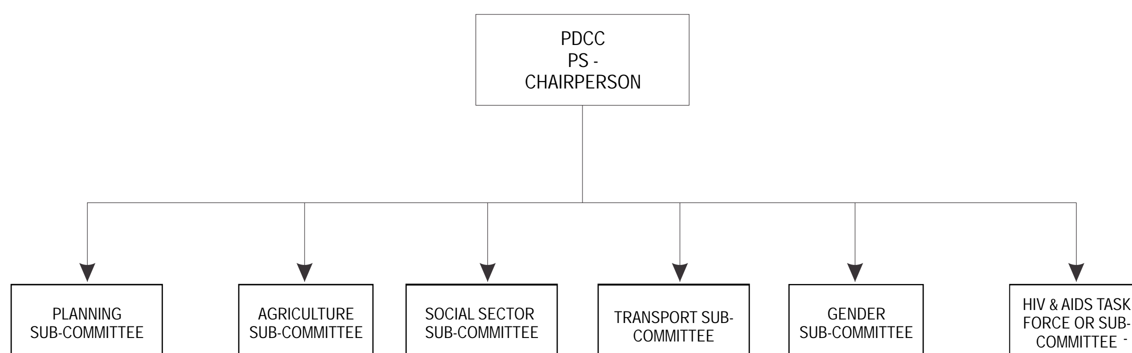


Table 36: Performance framework PDCC

Objective	Target Population	Settings	Quality Criteria
• Oversee district-level project implementation • Provide technical support to the district through the PDCC • Develop a capacity-building team • Facilitate district interaction, information exchange, and promote inter-district learning • Coordinate and monitor disbursements of human, financial and material resources to districts • Interpret national policies and action plans • Monitoring and evaluation.	• HIV & AIDS focal point persons from at least four line ministries including security wing • At least one member from the group of people living with HIV/AIDS • Local government representation • At least four NGOs One female and one male youth representative • Representation from Faith Based Organizations • Representation from Traditional Healers • Media representation, .Private Sector representation • Legal representation where possible • Representation from the Health Boards	Different sectors and constituencies	Functioning of Public Sector Private Sector (Umbrella Organisations and self-coordinating platform, Individual companies/private sector members, Coordinating organisations ZFE) Civil Society (NGO FBO CBOs)

District

The district level decentralized structures include both the locally elected Government, i.e., Local Authority and the deconcentrated government ministries and departments headed by the District Commissioner. The Local Development Planning Manual issued by the MoFNP in 2005 provides that all development plans at the district level be approved by the Council of that district. It is in this vein that all HIV/AIDS activities at district level should be incorporated into the district development plan that is approved by the Council. This will ensure a harmonized and coordinated response to the epidemic and improve the tracking of resources channeled to the sector.

One other window for improving coherence in the sector at the local level is the requirement for all the institutions working in the sector to enter a memorandum of understanding with the Councils in the district they are working in. The Alliance of Mayors and Municipal Leaders against HIV and AIDS (AMICAAL) adopted this provision in the declaration of their 4th General Assembly held in 2007. This declaration is attached as Annex 1. In support of this declaration, AMICALL provides capacity building for Mayors and other municipal leaders on the decentralized multisectoral response to HIV/AIDS. This makes it possible for the leaders at district level to screen their district plans for the mainstreaming of HIV/AIDS.

The above institutions at the district level are supported by the District Development Coordinating Committee (DDCC) that is chaired by the District Commissioner (DC). The DDCC is a multisectoral and multi stakeholders forum composed of representatives of all the major stakeholders in each district. It helps improve coordination of all development activities in the districts. The HIV/AIDS institutional framework at district level consists of the District AIDS Task Force (DATF), which is a sub-committee of the DDCC. The role of the DATF is to coordinate, supervise and monitor the implementation of HIV/AIDS policies and programs in the district. The DDCC and its sub-committees is illustrated in Figure 3.

Figure 3: DDCC Organisational Structure Showing Some Sub-Committees

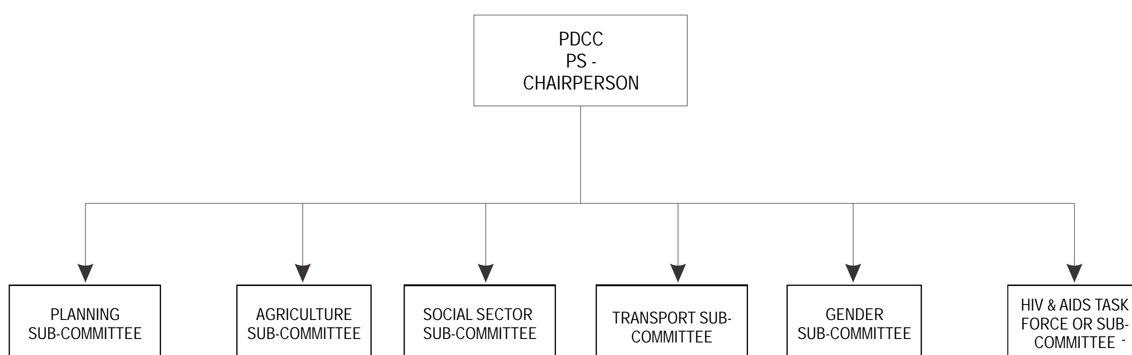


Table 37: Performance framework District DCC focal points

Objective	Target Population	Settings	Quality Criteria
• Interpreting national policies to guide the district response • Developing district-level strategic action and implementation plans • Documenting and maintaining a database of HIV/AIDS activities in the district • Monitoring and documenting activities in the district • Compiling reports for submission to the DDCC • Facilitating the formation of village/community AIDS task forces (CATF) • Building capacity of community AIDS task forces • Foster linkages between the CATF, DATF and PATF. • Adapt IEC materials and guidelines to suit needs, language and geographical location • Resource mobilization (human, material and financial) to support technical interventions • Identifying and disseminating examples of best practices • Promote basic and operational research	HIV & AIDS focal point persons from at least four line ministries including security wing At least one member from the group of people living with HIV/AIDS Local government representation At least four NGOs One female and one male youth representative Representation from Faith Based Organizations Representation from Traditional Healers Media representation, Private Sector representation Legal representation where possible Representation from the Health Boards	Different sectors and constituencies	Functioning of Public Sector Private Sector (Umbrella Organisations and self-coordinating platform, Individual companies/private sector members, Coordinating organisations ZFE) Civil Society (NGO FBO CBOs)

Ward level

Sub-district level implementation of HIV/AIDS programmes and coordination, supervision, monitoring and implementation have been undertaken by various structures, e.g. Neighborhood Health Committees organised under the Ministry of Health (NHCs), Area/Resident Development Committees organised under the local authorities, and other CBOs. The allegiance of these CBOs would be to different funders but expected to be coordinated at district level through the DATF.

The National Decentralization Policy, adopted in 2002, states that Area Development Committees (ADCs) shall be established in each ward. The Policy further stipulates that the functions to be performed by the sub-district structures will include promotion of community participation in decision making, development planning and implementation.

Local authorities have not been adequately supported in establishing sub district structures. This is mainly because the various line ministries are currently also able to set up their own community structures outside the Area/Resident Development Committees of the Councils.

Table 38: Performance framework of Ward Level services

Objective	Target Population	Settings	Quality Criteria
• To provide an efficient and effective administrative tool for the population in the ward. • To coordinate and monitor the various activities of groups, committees and associations in the ward. • To organize and motivate the population of the ward for the effective utilization of the ward's natural, human and other resources towards the end of improving the quality of life in the ward. • To create and spearhead schemes through which the population can assume increasing responsibility for the resolution of their local problems. • To support and facilitate overall district planning by the district level. • To encourage individual as well as family investments and savings. • To encourage co-operation in schemes of communal interest with other wards. • To facilitate the acquisition of external resources by the ward. • To coordinate the programmes of Development Agencies and provide them a link with the communities. • To collect specified levies for and on behalf of District Councils. • To provide a developmental link between the ward and district (more specifically, the District Development Coordinating Committee – DDCC).	General population, especially those vulnerable to stigma and discrimination or denial of their human rights	Community settings.	Functioning local communities

The functions of ADCs as further detailed by the Ministry of Local Government and Housing have been defined as follows:

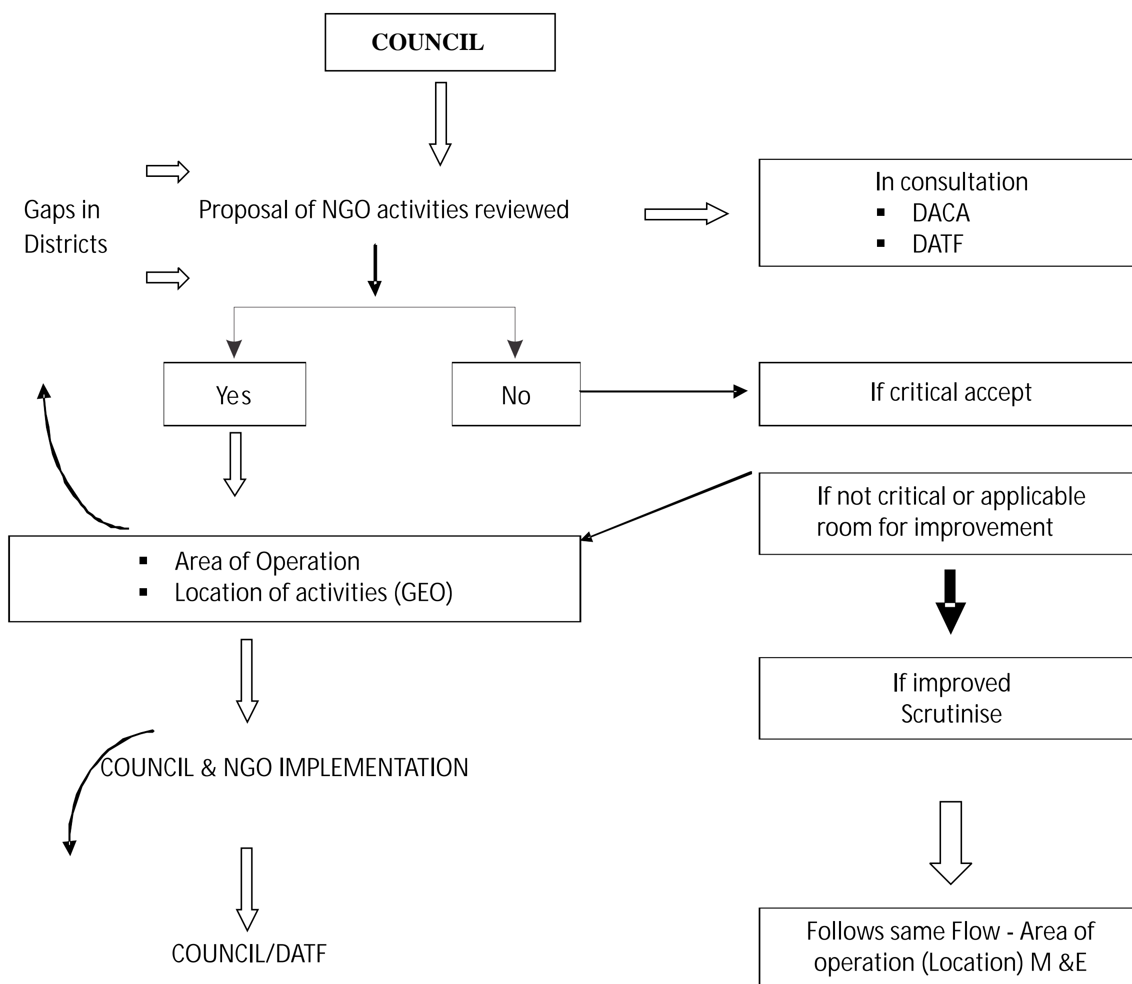
Community/Village AIDS Task Forces

Given the above functions, it is clear that there is no need for line Ministries and other development agencies to organize their own community structures outside the established ADCs. Similarly, NAC's CATFs should fit within this existing coordinating mechanism at the Community Level Coordination of HIV and AIDS Interventions

District Coordination Flow Chart

The District Coordination Flowchart in Figure 4 shows how the HIV and AIDS related activities implemented at the district level should be coordinated. This Figure also provides greater detail on how the "implementation" of District Plans and Sector/Partners Plans will be undertaken at district level.

Figure 4: District Coordination Flow Chart



HIV and AIDS, Gender and Human Rights Mainstreaming

Gender disparities are a structural factor driving the HIV and AIDS epidemic in Zambia. NAC will collaborate with the Gender in Development Division (GIDD) to guide and monitor the implementation of gender and HIV interventions. This will be guided, primarily, by the National Gender and HIV Plan of Action.

Priority Indicators:

- Gender issues mainstreamed in all relevant NDP SAGs
- Women's literacy rate increases
- Legal framework strengthened to address disparities affecting women

Table 39: Performance framework of Gender

Objective	Target Population	Settings	Quality Criteria
To guide and monitor the implementation of gender and HIV interventions	All sectors	Variety	Existence gender sensitive programmes

Capacity Development and Systems Strengthening

Strengthening the National Health System

Comprehensive care and treatment for HIV and AIDS should be delivered in an integrated fashion within a coherent overarching public health policy framework for the provision of basic social services as part of the continuum of care. Government is currently pursuing plans to upgrade public hospitals, consolidate the

National Health Laboratory Service, refurbish and build health facilities, upgrade patient and health information systems, improve drug procurement and distribution, and enhance management systems. The NOP calls for significant additional investments to improve the capacity and capabilities of the national health care system, in particular the strengthening of human resource capacity, and providing incentives to recruit and retain health professionals in historically underserved areas.

Table 40: Performance framework of Strengthening Health systems

Objective	Target Population	Settings	Quality Criteria
To ensure the effective delivery of comprehensive HIV and AIDS care and treatment.	Health sector	Public and private providers of ART and other HIV-related health care services	Functioning training institutions and improved conditions of service

Human Resources

Human resource capacity will be strengthened by retaining and recruiting additional health professionals to strengthen the healthcare delivery system. The gap between current and essential staffing levels has been calculated based on potential workloads per health professional. Numbers and categories of staff needed have been estimated for service points in each health district.

A training programme for health professionals and traditional health practitioners will be implemented as part of the service point accreditation process for the purpose of preparing Zambian clinicians, nurses, counselors, pharmacists and other health professionals to deliver high quality care. The training programme will be extended progressively throughout the country and certification will be provided to professionals who successfully complete training. Training modalities will involve a short intensive formal module as well as ongoing mentoring. Zambians and international experts will be mobilized to assist in the planning, designing, and delivering the training at national and provincial levels.

Under the NOP, the following strategies are proposed to increase human capacity to provide treatment, care and support. The plan proposes strategies for increasing the number of health professionals in order to successfully implement the programme, and indicates the financial resources necessary to do so. It advocates increasing the utilization of private sector health professionals in the national health system, additional incentives to attract health professionals to underserved areas, and measures to retain health professionals in the public health sector.

Table 41: Performance framework of HR

Objective	Target Population	Settings	Quality Criteria
Retaining and recruiting additional health professionals to strengthen the healthcare delivery system	Health sector	Public and private providers of ART and other HIV-related health care services	Functioning training institutions and improved conditions of service

Drug Procurement and Distribution

Drug procurement and distribution will be fully integrated into the treatment, care and support system and will involve multiple competing suppliers and multiple production locations to ensure adequate and sustainable supplies. To support the operational plan, the procurement system for these medicines must achieve the following objectives:

- The medicines must be of the highest quality and licensed by the Zambian pharmaceutical regulatory authority.
- The medicines must be appropriate for the treatment regimens according to international standards and adopted by the Ministry of Health
- The supply of medicines must be secure and sustainable at a volume large enough to meet the demand envisioned.
- Medicines must be purchased at the lowest possible price.
- Procurement of drugs will follow the following options by which this tender process could be put into operation:
    - A regular government tender using local suppliers.
    - A private-public partnership/initiative and International tendering.

Drug distribution will be accomplished by …

- Improving inventory management, patient prescription information and financial management systems;
- Investing in more secured storage facilities
- Ensuring efficient and secure transportation
- Training pharmacy personnel, and
- Improving packaging to support inventory control and ease of use by patients.

Table 42: Performance framework of Procurement system

Objective	Target Population	Settings	Quality Criteria
To support an adequate and sustainable supply of ART and other drugs to control opportunistic infections	Health care sector	Public and private providers of ART and other HIV-related health care services	• Capacity to perform logistic system • Supervisory system • M&E for quality assurance

Pharmacovigilance

A pharmacovigilance programme is critical to developing systems to assess the risks and benefits of treatments commonly used in patients with HIV, STI and TB. It includes monitoring over the counter medication for phyto-therapeutic agents as well as antiretrovirals. NOP interventions in this area will include:

- Identifying, assessing and communicating safety concerns associated with the use of antiretrovirals and other HIV medicines
- Support to regulatory and public health decision-making through an efficient, national post-marketing surveillance system, and
- Monitoring the quality, benefits and risk or harm associated with ARVs and other medicines currently used in the health sector

Table 43: Performance framework of Pharmacovigilance

Objective	Target Population	Settings	Quality Criteria
To determine the burden of drug-related morbidity and mortality in patients with HIV and AIDS, particularly associated with ARV use, and develop measures to minimize their impact	Health care sector	Public and private providers of ART and other HIV-related health care services	• Supervisory system • M&E for quality assurance

Patient Information Systems

The NOP proposes to upgrade patient information systems in the national health system using the SMARTCARE platform approved by the MOH. Effective patient information systems are necessary to ensure that a standardized, effective and efficient system for data collection, collation, monitoring, and feedback is in place to facilitate programme implementation, ensure good quality care, and achieve good patient/programme outcomes.

The specific functions of the patient information system are to:

- Register patients utilising a standard Patient Record
- Collect relevant clinical care information at baseline and subsequent follow-up visits to monitor treatment progress
- Monitor adherence to treatment
- Monitor adverse drug events, and
- Collect other clinical, laboratory, and non-clinical data that will be useful for programme monitoring at local, provincial and national levels.

Table 44: Performance framework of PIS

Objective	Target Population	Settings	Quality Criteria
To improve patient care through establishment of a comprehensive	Health care sector	Public and private providers of ART and other HIV-related health care services	• Supervisory system • M&E for quality assurance

The patient information system will be developed as an integral part of the existing health information system. Information technology upgrades will occur to enable a standard electronic and paper-based patient information system to meet patient care objectives.

Resource Mobilization and Management

Resource Mobilisation

The National HIV/AIDS/STI/TB Policy that was adopted in 2005 recognizes that the implementation of national and sectoral HIV/AIDS/STI/TB interventions have heavy financial implications. In order to meet more than normal budgetary demands that the implementation of this Policy will require, Government will need to scale up its domestic and international resource mobilization. In this regard, Government shall:

a) Establish the National HIV Fund

b) Make annual allocation in the National Budget

c) Raise funds from other sources including bilateral, multilateral cooperating partners and other stakeholders

a. Five (5) Year Estimates of Resource needs-National Strategic Framework (NASF)

In order to establish the actual resource needs a comprehensive resource mapping will be conducted annually to establish how much funding is available and the financial gap that will require additional resource mobilization. The NASF presents the estimates of resource available by donor/ cooperating partner and funds are committed.

Table 45: Performance framework of Resource management

Objective	Target Population	Settings	Quality Criteria
To establish resource needs, available funds and financial gap	CPs, Government	Variety	knowledge, skills and commitment to mobilise resources at all administrative levels and in all sectors

b. Three (3) Year Detailed Cost Needs-National Operational Plan (NOP)

An activity based costing approach was used to cost all the activities agreed in the national operational plan of the NASF. This was because this approach is an essential for strategic as well as an operational planning tool. It was a single exercise, rather than multiple parallel efforts. The methodology assessed the true financial gaps of the national HIV multisectoral plan. It has an improved transparency for the internal management and budgeting purposes, as well as for external resource mobilization efforts in line with Global Fund proposals development requirement. This exercise does not preclude the use of other tools to validate and cross-check the final numbers.

The following considerations were made in carryout the costing:

- Ensuring transparency of the underlying assumption and unit costs
- The ability to easily change assumptions and unit costs, therefore, using formulas that are linked to a specific assumptions table and a unit-cost table, and not hard-coding any formulas
- The ability to view the data from many different perspectives. This requires setting up the detailed costing sheet in columns with only one specific type of information by column in order to use the pivot function in excel. This allows to cross-check the costing information, and more easily identify potential errors, gaps, outliers, relative costs amongst categories.

The methodology involved wide scale consultation with key stakeholders, four technical working meetings using the theme groups, development of comprehensive list of unit cost for sub activities, setting of sub activity targets and costing o and validation meeting of the products.

Table 46: Annual cost of the four pillars of NASF.

Pillar	2011 Cost for year One	2012 Cost for year Two	2013 Cost for year Three	2011-2013 Total Cost	Percentage
Prevention	147,348,145.34	176,263,067.83	148,141,472.78	469,913,827.83	34%
Treatment, Care and Support	172,550,103.06	192,115,005.60	187,450,465.50	551,017,536.67	40%
Impact Mitigation	77,973,894.35	72,956,184.50	79,397,501.49	230,327,580.34	17%
Response Management	43,645,617.77	42,294,861.33	51,466,860.93	137,462,975.40	10%
Grand Total	441,517,760.53	483,629,119.26	466,456,300.71	1,388,721,920.23	100%

Table 47: Total Cost of Service Delivery Areas of the four Pillars

SDA	Total	Percentage
Antiretroviral treatment (ARV) and monitoring	430,791,564	31%
Vulnerable Households and Individuals	121,157,851	9%
Support for orphans and vulnerable children	109,169,729	8%
Social and Behaviour Change	95,051,024	7%
TB/HIV	86,684,958	6%
PMTCT	74,281,335	5%
Post-exposure prophylaxis (PEP)	64,073,994	5%
HCT	58,166,689	4%
Male Circumcision	58,763,246	4%
Community and Home Based Care (CHBC)	33,541,014	2%
Condom	42,810,142	3%
STI diagnosis and treatment	41,018,932	3%
Capacity Development and Systems Strengthening	37,836,165	3%
Blood safety	35,748,464	3%
Monitoring Evaluation and HIV Research	27,652,612	2%
HIV and AIDS, Gender and Human Rights Mainstreaming	30,932,939	2%
Coordination and Management	17,834,078	1%
Enabling Policy and Legal Environment	18,226,132	1%
Resource Mobilisation	4,981,050	0%
Grand Total	1,388,721,920	100%

Table 48: Cost of Other major categories of the NASF

Cost Category	Total	Percentage
Communication materials	73,371,809	5%
Training, meetings and Workshops	223,917,263	16%
Planning, Monitoring & Evaluation	79,408,746	6%
Running costs - fuel, electricity, communication, office supplies	22,268,257	2%
Personnel	262,018,193	19%
Health Equipment	9,959,847	1%
Lab supplies	32,169,255	2%
Other Medical supplies	78,957,727	6%
Non-health Equipment	23,594,995	2%
Infrastructure	79,664,016	6%
INDIRECT - TA / In-country Program Staff	1,897,002	0%
Drugs	313,409,153	23%
Socio-economic support	96,229,850	7%
Budget Support	91,855,807	7%
Grand Total	1,388,721,920	100%

Resource allocation

The allocation of resources to the HIV/AIDS multisectoral response is based on the principles of allocation by institution or allocation by intervention. Allocation by institution refers to allocation of resources to those institutions that have a role in the HIV/AIDS multisectoral response. Allocation by intervention refers to the four NASF thematic areas or pillars .

In addressing the allocation of resources, it is reiterated here that NAC does not have the sole mandate for allocating and disbursing funds to the institutions. The allocation referred to is allocation formulas arrived at in consultation with all institutions supporting the HIV and AIDS multisectoral response. This consultation was informed by the historical experiences in the allocation of resources to the sector. The source of funds for the response is therefore not the primary criteria for resources allocation. The primary driver of the resource allocation is the efficient and effective implementation of "three ones". This means that all the partners have to be alive to both how they reinforce each other's activities in the sector and how the implementation of each thematic area complements the others.

Given the above, it is expected that the allocation of resources mobilized for the sector from diverse sources will be harmonized by using the allocations provided below in Tables 49 and 50 below.

Table 49: Allocation of resources by institution

	Institution	% Allocation
I	80% National Scale-up Activities	45
II	All Districts and Provinces	30
III	Line Ministries	7
IV	Private Sector	4
V	CSOs	9
VI	NAC	5

Table 50: Allocation of estimated funding by Theme of NASF 2011-15

	Theme	% Allocation
I	Intensifying Prevention	26
II	Expanding Treatment, Care, Support	40
III	Mitigating S/E Impact	23
IV	Response Management	11

Disbursement

The allocation of resources to the sector can also be expressed in terms of how the resources are disbursed. This is termed allocation through implementation mechanisms. The allocation through implementation mechanisms can be through two modalities, i.e., allocation through an umbrella organization or directly to implementers.

- Umbrella organizations: This applies to a situation where resources allocated to the sector are disbursed to one principal recipient in the country. The principal recipient is legally responsible for distributing or using the funds for the HIV, Malaria or TB response. An example in Zambia is that the CSOs nominated the Zambia National AIDS Network (ZNAN) to be the principal recipient of funds from the GFTAM for non faith based sector and private sector. Its role is to distribute these funds as per agreement and also ensure that proper accountability. The Churches Health Association of Zambia (CHAZ) is the principal recipient for the faith based sector. Both these institutions are represented on the CCM and some of the Thematic Groups.
- Direct funding to implementers: This is where support to the sector is disbursed directly to the implementing institutions at national, provincial, district or community levels. An example is PEPFAR funds that can be accessed directly by, for example, international NGOs and FBOs.

The institutions providing resources using either of the above implementation mechanisms have been engaged and actively encouraged to use the resources allocation principles outlined in Tables 49 and 50above.

Criteria for funding of sub-national structures for coordination of the decentralized response

In order to facilitate the operationalisation of the decentralized multisectoral HIV/AIDS response, an equitable system of funding the sub-national structures has been included in this manual and a matrix with factors determining funding levels provided as Table 51 below.

The following factors, that comprise the criteria for funding, relating to demography, geographical disposition, HIV prevalence, availability of essential social services such as banks, fuel station and infrastructure such as roads, transport and telecommunications were considered. Table 51 shows the matrix of these factors and the weights that can be assigned to each factor. The weights are scored numerically from 1 to 5. 1 is the lowest score whilst 5 is the highest.

The maximum score that can be assigned for each District and Province is 25. This means that the higher the total score that is assigned for a District or Province, the higher the resources that will be allocated and remitted to it.

Table 51: Criteria for funding sub-national structures

Provincial Factors		District Factors	
A. Distance from Lusaka	Weight	A. Distance from Lusaka	Weight
1300 - 2000 KM	5	1300 - 2000 KM	5
1000 - 1300 KM	4	1000 - 1300 KM	4
700 - 1000 KM	3	700 - 1000 KM	3
400 - 700 KM	2	400 - 700 KM	2
Less 400 KM	1	Less 400 KM	1
B. Lack of Essential Services		B. Lack of Essential Services	
Lack of a bank	5	Lack of a bank	5
Lack of a fuel station	5	Lack of a fuel station	5
With fuel station	3	With fuel station	3
C. Size of Province		C. Size of District	
Over 140000 km2	5	Over 1000 km2	5
120000 - 140000 km2	4	600 - 1000 km2	4
100000 - 120000 km2	3	300 - 600 km2	3
80000 - 100000km2	2	100 - 300km2	2
Less than 80000km2	1	Less than 100km2	1
D. Population		D. Population	
1 500 000 - 2 000 000	5	1 500 000 - 2 000 000	5
1 000 000 - 1 500 000	4	1 000 000 - 1 500 000	4
800 000 - 1 000 000	3	800 000 - 1 000 000	3
600 000 - 800 000	2	600 000 - 800 000	2
Below 600 000	1	Below 600 000	1
E. Terrain of countryside		E. Terrain of countryside	
Water/ hard to reach	Districts	Water/ hard to reach	5
Mountains/swamps	Averages for	Mountains/swamps	4
Plateau/ dirty roads	Each Province	Plateau/dirty roads	3
F. HIV - Prevalence		F. HIV – Prevalence %	
Above 25		Above 25	5
20 – 25		20 – 25	4
15 – 20	Districts	15 – 20	3
5 to 10	Averages for	5 to 10	2
Less than 5	Each Province	Less than 5	1

It is emphasized here that Table 22 should be applied in conjunction with Tables 20 and 21 above. Table 20 shows that 22 percent of HIV/AIDS funds will be allocated to all Districts and Provinces. Table 21 shows how the Districts and Provinces should allocate funds set aside for their HIV/AIDS activities to each of the NASF themes. Table 22 above shows how the 22 percent of the funds should be allocated between the individual Provinces and Districts.

Resource tracking

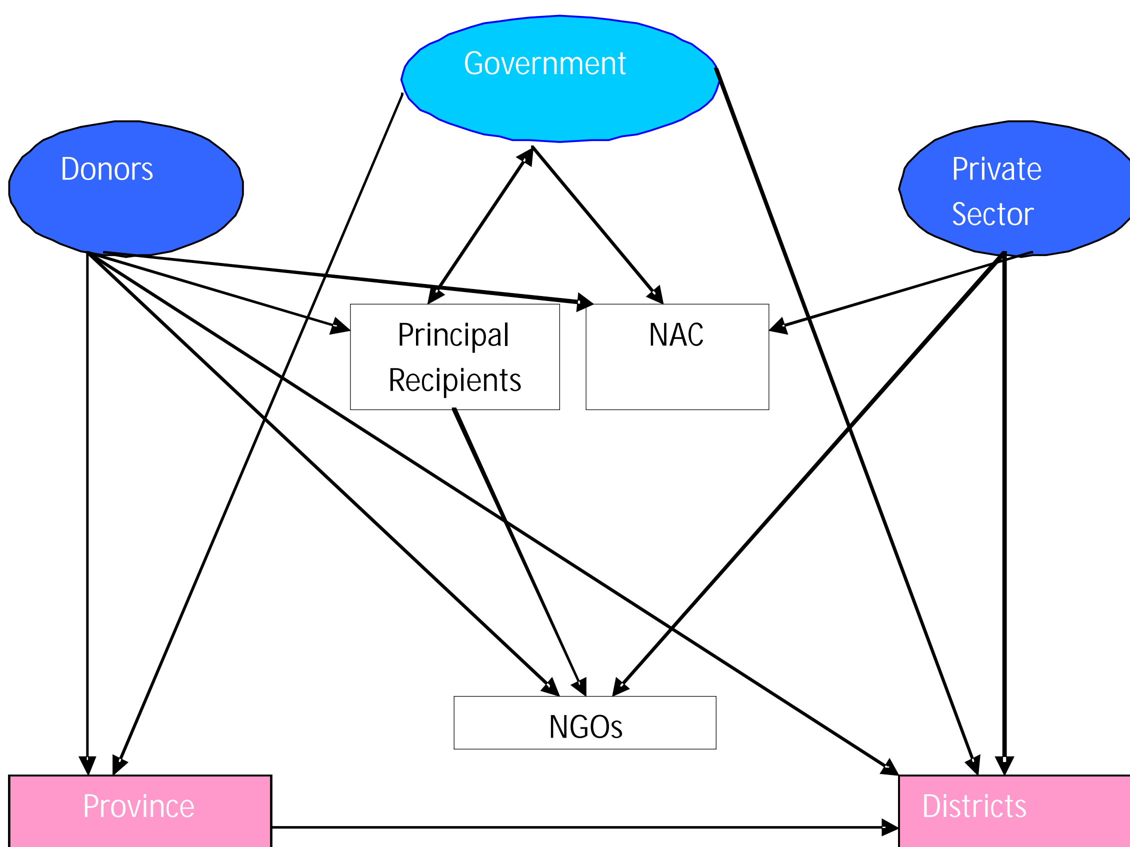
The tools available for tracking funds budgeted for and disbursed to the HIV/AIDS multisectoral response in Zambia include:

- Joint Annual Programme Review Process;
- The reports rendered by districts and provinces, principal recipients of CPs support to the HIV/AIDS multisectoral response
- The NAC national and sub-structures at provincial and district levels, i.e., PATFs, DATFs, CATFs, compilation of HIV/AIDS programme expenditure
- Data collection from funding agencies and programme implementers
- The national budget
- Specific studies such as NASA

The resources addressed in this section include pooled funds, direct support and technical assistance. The resource mobilization, allocation and disbursement mechanisms for HIV and AIDS is still evolving as most programmatic funds are channeled directly from source to the principal recipients, NGOs, Provinces and Districts. The programme resources are currently not channeled through NAC. Figure 7, below, shows the flow of resources to the HIV and AIDS multisectoral response in Zambia. The arrow from donors to NAC shows the resources channeled to it for coordination, and not programmatic, purposes. Coordination resources are those that the Government of the Republic of Zambia and some donors all contribute to the NAC basket fund referred to as the Joint Financing Agreement (JFA).

While some sources of resources such as the Global Fund can be relatively easily traced given the centralized disbursement system, there is a plurality of other resources flows, which create tracking and auditing difficulties.

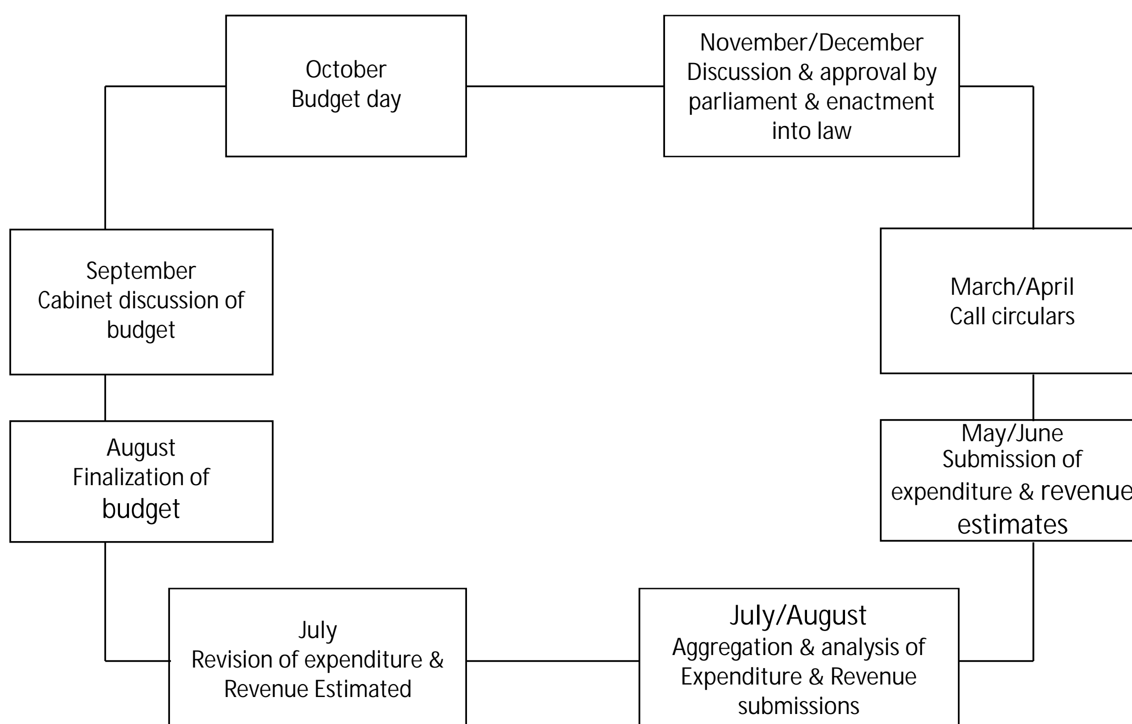
Figure 5: Flow of HIV and AIDS funds



National Budget process

The NAC work planning and budgeting cycle and timetable of this NOP respectively, is synchronised with that of the National budget illustrated by Figure 8 below. The national budget cycle is elaborated in detail here so that a broader context is provided as background to the NAC planning and budgeting cycle.

Figure 6: The National Budget Cycle



Monitoring and Evaluation, and HIV Research

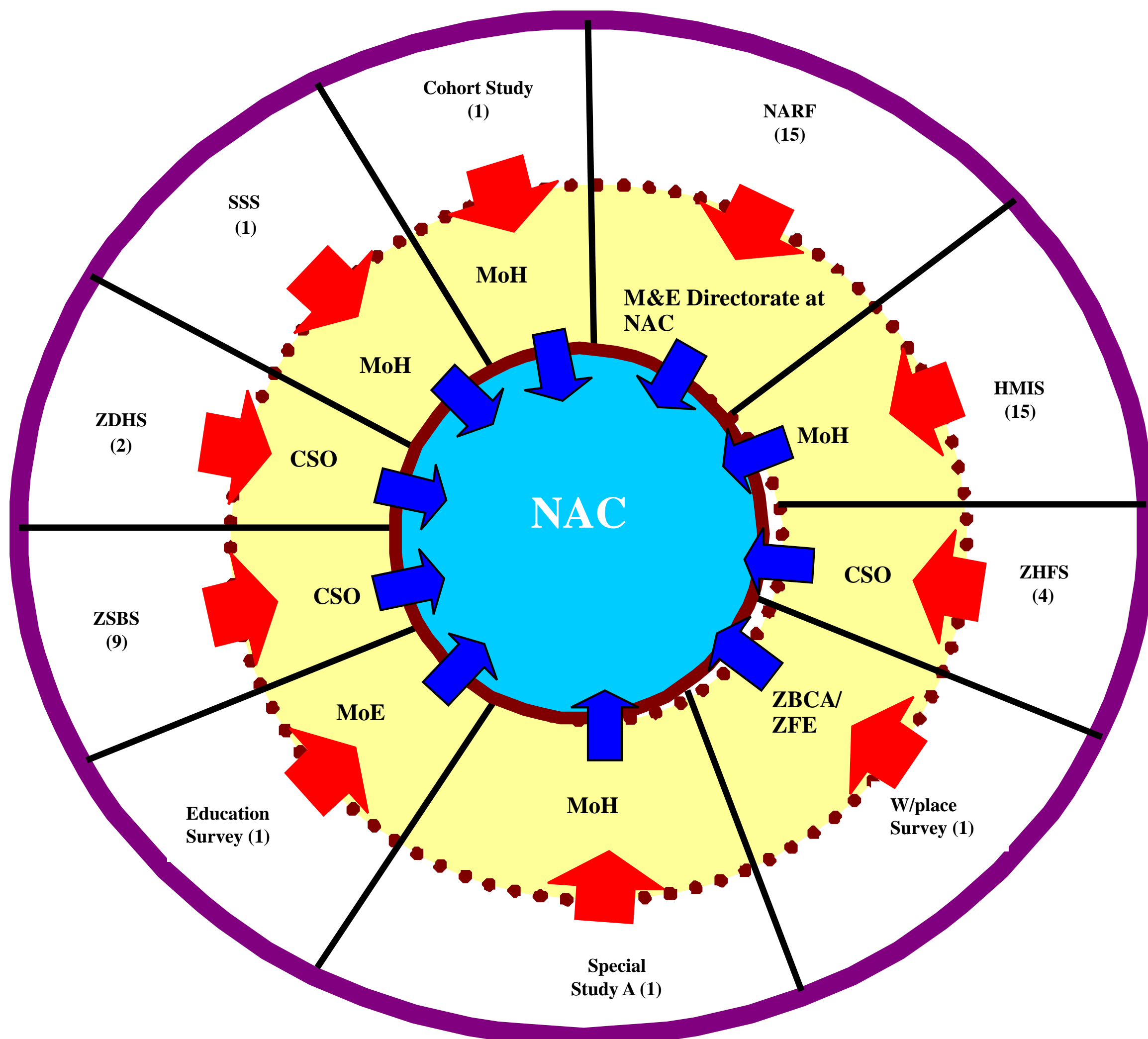
The plan defines monitoring as the routine, regular assessment of ongoing activities and progress. In contrast, it defines evaluation is the episodic assessment of overall achievements and the extent to which they can be attributed to specific interventions.

NAC has a specialized department, the "Monitoring & Evaluation Unit", which strives to create and maintain a well managed and functional monitoring and evaluation system. The Unit is supported by the Monitoring and Evaluation (M & E) Theme Group. The M & E Group provides overall technical guidance on the following:

- Implementation of the National HIV and AIDS Monitoring and Evaluation Plan 2011 to 2015
- Operationalisation of the NAC Activity Reporting Form System
- The national HIV and AIDS research agenda
- Strategic input into the annual review process.

Figure 7, below provides a conceptual framework for monitoring the HIV/AIDS multisectoral response. The outermost circle shows how the data will be collected. These data collection methods are elaborated upon further below. The next circle shows the institutions that will have the primary responsibility for managing the data collection methods. The inner circle shows NAC a primary recipient and user of this information.

Figure: Conceptual Framework for Monitoring the Response



Data collection tools.

The data collection for monitoring and evaluation will be undertaken through the following;

Activity Report Form: The NAC Program Activity Report System refers to a generation of information from standard forms received by NAC on a regular basis from NAC grantees, non grantees, including Government Line Ministries, implementing HIV/AIDS interventions. The form summarises the coverage achieved by organisations implementing HIV/AIDS interventions in the area of prevention, care, support and impact mitigation. These forms are collated at District, Provincial and National levels on a quarterly basis.

Cohort study: The cohort studies are conducted for various purposes to monitor a group of individuals with similar characteristics to monitoring the effectiveness of a service delivery programme or behaviours that may occur to particular group of individuals when exposed to a particular event or situation. Cohort studies will be undertaken as and when required.

Education Management Information System (EMIS) The Ministry of Education has an Education Management Information System that collects information on a regular basis. The Ministry will also collect HIV/AIDS information through this system. The primary output is percentage of teachers who have been trained in life skills education and taught it during the previous academic year.

Special Education Survey: This special survey by the Ministry of Education will collect information on percentage of children aged 10-18 years who report receiving life skills education in school. The information on this indicator will be collected through the EMIS.

Health Management Information System (HMIS): The HMIS is a database of nationally aggregated health data intended for programme management and policy decision making. This data is collected, and collated, from the clinics in the districts by the District Health Management Teams that submit it electronically to the Provincial level on a quarterly basis. The Provinces further clean this data, collate it and submit it to the Ministry of Health.

The Provinces also use this data for programmatic decisions.

National Composite Policy Index (NDCPI): The composite index covers four broad areas of policy, strategic plan, prevention, human rights and care and support. A separate index is calculated for each policy area using specific policy indicators and calculating the overall percentage score.

Sentinel survey: Biological surveillance of HIV has been primarily tracked through surveillance of sentinel populations. Surveillance data is collected from a sample of urban, rural and transitional rural sentinel sites in the country distributed throughout the nine provinces. Specified minimum samples for each type of site are set in advance and vary from year to year. Blood samples are drawn and testing for syphilis is done on site whilst the rest of the samples are sent to UTH and TDRC for HIV testing.

Financial Resource Flows Survey: This financial resource flow survey is recommended by the UNAIDS on biennial basis in order to collect financial data to inform the UNGASS indicator about national government expenditures on HIV programmes. As such all other costs from any multilateral or bilateral international donor or NGO funded government programmes are excluded.

Workplace survey: These surveys provide information on the extent to which the workplaces are developing policies to protect and mitigate the impact of HIV/AIDS on their respective employees. This survey is conducted annually.

Zambia Demographic Health Survey (ZDHS): The ZDHS is a robust instrument for tracking changes in knowledge and behaviour at a national level. It is conducted every 4-5 years. The Zambian DHS includes a household, female and male questionnaire. It is applied to a nationally representative sample of people ages 15-49.

Zambia Health Facility Survey (ZHFS): The ZHFS is conducted to better understand provider/household linkages, provider performance, costs, quality and effectiveness, links between providers and government-provider linkages.

Zambia Sexual Behaviour Survey (ZSBS): The ZSBS is carried out to monitor the extent to which the programmes to prevent HIV are succeeding.

Special studies: Special studies will be conducted to review some of the sub-strategies of the NASF. These studies will provide information on improving the quality of the HIV and AIDS response.

Information Products

Quarterly Monthly Service Coverage Report: The NAC will produce the above report to provide information on coverage statistics per HIV programme area. It will be based on the information provided by all stakeholders in the NAC Activity Report Form. The production of this report will also ensure that NAC meets the GFATM requirements in terms of minimum reporting standards as well as reporting to its other basket donors.

Annual HIV/AIDS M & E Report

This report will provide a comprehensive overview of Zambia's response to HIV/AIDS. It will be done by reporting all indicators in the NAC's National HIV/AIDS Monitoring and Evaluation System. It will provide key observations and guidance for future implementation.

Biennial UNGASS Report

This report will be prepared to report to the UNAIDS on a periodic basis in terms of Zambia's progress in the fight against HIV/AIDS, by reporting on 17 specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators. This report is one fulfillment of Zambia signatory status to the 2001 Declaration of Commitment on HIV/AIDS at the United Nations Special Assembly Session on HIV/AIDS (UNGASS).

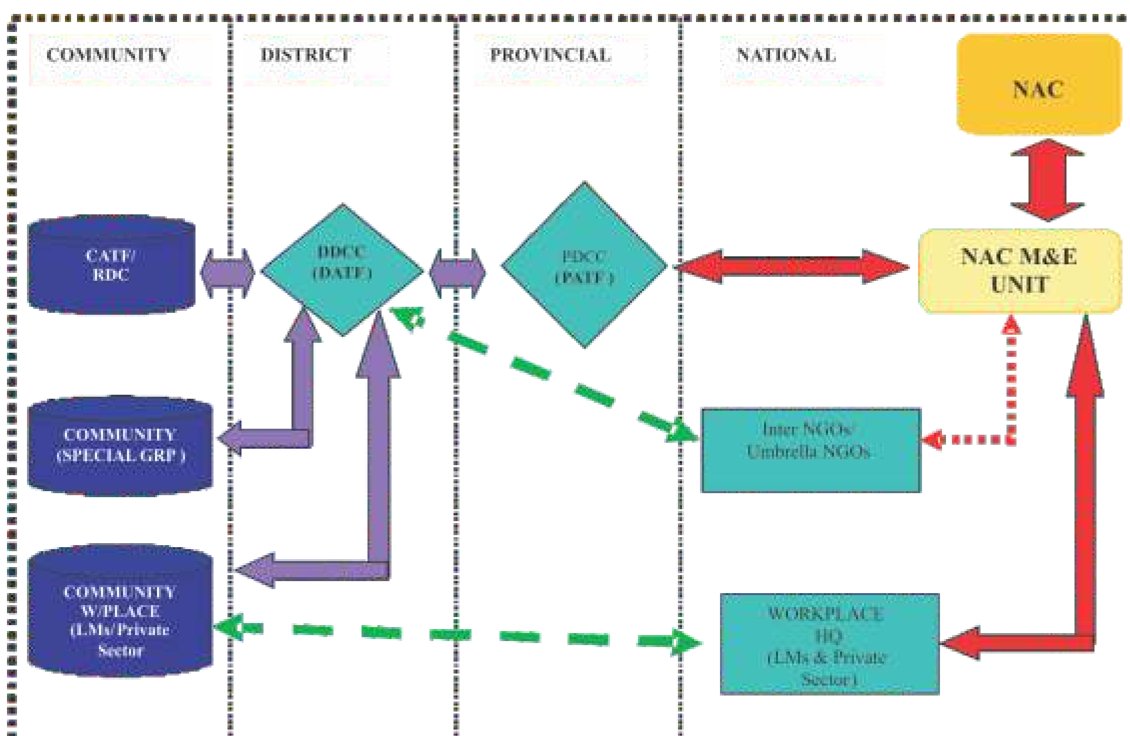
Adhoc information updates

NAC will post all monitoring and evaluation reports on its website making them available for electronic downloading. This will ensure that NAC stakeholders are able to access up-to-date information. Based on this readily available information, NAC will also make specific information available to stakeholders upon request in writing.

Lines of reporting

Figure 6 provides an illustration of how the information to be generated through the above means will be reported. Each of the data collection tools and the institutions shown in Figure 1 can be linked to this reporting structure. It should be clearly understood that all the outputs of the monitoring and evaluation system eventually inform the processes of the NAC.

Figure 8: Structure of NAC Data Reporting System



The Joint Annual Review Process

The JAPRs bring the Government of the Republic of Zambia, National AIDS Council and its partners together. The primary focus of JAPRs is to annually review the programme performance in light of the NASF goal and strategic objectives. The outputs of the reviews are recommendations on the priority interventions for successive years of the NASF. The JAPR will also support the process of linking the work on HIV and AIDS with other Government processes. The JAPRs help operationalise the mandate of NAC and its Secretariat, establish in Parliamentary Act No. 10 of 2002, to coordinate, monitoring and evaluate the implementation of the National HIV/AIDS actions.

The process of the Joint Annual Review process is comprised of a Technical review and consultative Meeting with key informants.

The technical review is undertaken by the Thematic Technical groups that assess the progress in meeting the outputs of the National Strategic Plan. It comprises a review of existing data (desk reviews, literature reviews and secondary data), review of data from the districts and field visits to validate the information gathered through the technical review process.

The main JAPR meeting is undertaken in two days. It includes representatives of all key stakeholders in the NASF. Besides the regular protocols for meetings, the substantive agenda sessions include the following;

- Review of agenda and meeting objectives
- Overview of the review process
- Prevention and advocacy
- Treatment, Care and support
- Coordination, management and institutional arrangements
- Monitoring and evaluation
- Planning, finance and budgeting

Table 53, below, shows the generic JAPR timetable. This timetable requires that all the stakeholders have their annual reports ready by February of every year so that they are used as inputs into the JAPR process. The JAPR timetable is consistent with the National Budget Cycle that is illustrated in Figure 8. The planned conclusion of the JAPR process at the end of June each year is intentionally targeted to coincide with the issue of the call circular by MoFNP initiating the national budget process. The sector, specifically NAC and line ministries, are integral components of this national budget cycle. Table 23 is also consistent with the Table XXX, i.e. Timetable for Local Level Planning. As such, the two tables complement each other and cater for all the twelve months of the year.

Table 52: JAPR timetable

ID	Task Name	Duration	Start Date Third week February	Finish Date
1	Send notification/invitation letter to all partners	1 day		
2	Convene stakeholder inception meeting	1 day		
3	Prepare material for JAPR – TORs, Budget, TAs, Tools, etc	14 days		
4	Selected Consultants notified	2 days		
5	Consultants mobilised	2 days		
6	Commence literature review for Joint Review	5 days		
7	Launching of the Joint Review Field Data Collection and project verifications, NAC, TWG	1 day		
8	Consultations	7 days		
9	Data analysis and report writing	10 days		
10	Report editing and consolidation	4 days		
11	Print and bind report in-house	2 days		
12	Distribute report to all stakeholders	4 days		
13	Stakeholder Meeting to review Joint Review Report	2 days		
14	Further work on report to incorporate comments	3 days		
15	Finalise, Sign Off and Print Report	4 days		
16	Disseminate Report to Stakeholders	1 day		30th June

Monitoring and Evaluating, and Reporting on the Performance of the Operational Plan

Zambia has developed a National M&E Framework in addition to an indicator description index. The Framework provides detailed information on the NASF results and explains how the results will be measured. The indicator description is intended to help the stakeholders what the indicators are and what they will measure over what periods.

Monitoring the NOP implementation

In the context of NOP monitoring will be an-going activity carried out at all levels of implementation. The monitoring will

i. Monitor progress in terms of the overall Implementation of NOP
ii. Monitor implementation to ascertain whether implementation is making progress towards attaining the set targets.
iii. Monitor the use of human, financial and material resources
iv. Monitor the involvement of and participation of communities, PLHIV, and other vulnerable people.
v. Monitor emerging barriers that are likely to compromise the implementation
vi. Monitor how the strategies contributing to capacity development, knowledge and skills transfer, the improvement of service delivery systems, health and community systems strengthening and strategic information management.

Evaluation of the NOP

The NOP will be reviewed annually for two years. A formal evaluation will be conducted in 2013. The evaluation will assess the extent to which the NOP has achieved its results. The evaluations results will be compared with against the baseline information available at the start of the NOP implementation or those that will be added during the annual review process having been established in the preceding year

Reporting of the NOP performance

Reporting on the NOP performance will be done quarterly using standardised tools. The diagram below illustrates how the reporting will be conducted.

Project reporting will be done quarterly and will include both narrative and financial reports. BONASO will compile a single report for submission to ACHAP based on individual quarterly project reports. The narrative reports will highlight among other issues the following:

- The status of implementation.
- Achievements made during the quarter in terms of targets and other outputs.
- Emerging challenges and how they were addressed, and not addressed.

The financial reports will be in form of balance sheet analysis indicating how much funds were received and how much has so far been used and for what purpose. The reports should also contain information on environment changes such as prices changes, availability or lack of availability of materials etc.

DESCRIPTION OF THE RESULTS GUIDING THE NOP 2011-2013

The NASF 2011-2015 identifies four pillars to the national response: prevention; treatment, care and support; impact mitigation; and response management and coordination.

Monitor interventions and funding directed to or affecting children, assessing the extent to which resources reach the base

Description: Over the past few years, there has been increasing resources coming into Zambia, directed at children. The majority of these resources do not pass through Government, and in many cases there is little or no dialogue in planning, implementation or reporting. These resources are derived from various public international funds, as well as large private international foundations, charities and NGOs.

With increasing resources available for HIV/AIDS, the NPA identifies the need for adequate information on resources, expenditure, performance, achievements and challenges. This is necessary to ensure coordination, and to ensure that funds are being spent efficiently and responsibly on the stated purposes. It is the duty of Government to protect Zambia's children, and this extends to ensuring that they benefit sufficiently from funds raised in their names. One key consideration here is to ensure that a reasonable proportion of funds raised actually reach the communities and children intended, rather than being absorbed by administration and other overheads.

Target: Government implements an effective and efficient monitoring scheme, tracking all resources being directed to the benefit of Zambian children. This monitoring will maintain an inventory on institutional responses to children, and report on resource flows, expenditure, performance, achievements and challenges.

Indicators:

Monitoring system designed, established and reporting by 2012.

5.0 Stakeholder Roles and Responsibilities and Division of labour in next five years of the national Response

SECTORAL RESPONSIBILITIES

All stakeholders are needed to bring together their comparative advantages and be involved in the national response given the complexity and multidimensional nature of HIV and AIDS. Therefore all Government Ministries must actively participate in the national response, with some Ministries playing a bigger role than others on account of their broad mandates. Below is a description of the specific roles that will be expected to be played by selected line Ministries.

a. Financial Sector

Since the national response to HIV and AIDS requires enormous fiscal implications, the financial sector shall be responsible for:

(a) Providing specific budget lines for HIV/AIDS/STI/TB prevention and control;

(b) Integration of HIV/AIDS awareness and counselling in all its in-house training programmes;

(c) Ensuring that HIV/AIDS is mainstreamed in all national development plans and programmes; and

(d) Spearheading resource mobilisation for HIV/AIDS/STI/TB interventions

b. Labour and Social Security and social safety net Sector

In order to effectively address outstanding issues with regard to HIV and employment, the Labour and Social Security sector shall:

(a) Make a statutory amendment to the Employment Act, Cap 512, so as to make illegal non-voluntary HIV pre-employment screening;

(b) Remove HIV/AIDS-related discriminatory barriers to joining any social security or pension scheme; and

(c) Collect, coordinate and disseminate HIV/AIDS-related information in regard to employment practices and labour force trends.

(d) Provide for social safety net to vulnerable groups like orphans, the aged, street children and the disabled.

c. Education Sector

In order to redress the HIV/AIDS challenges associated with the education sector, the Education sector shall:

(a) Fully transform to effectively prevent from the rapid spread of HIVAIDS in the sector;

(b) Ensure that the sector fosters and inculcates supportive behavioural change among the youth;

(c) Strengthen functional links between the educational sector, local communities and other relevant sectors;

(d) Support and strengthen the role of local educationists/teachers in mobilising their respective communities against HIV/AIDS;

(e) Review and enforce penalties against school pupils, teachers and other education personnel who engage in sexual abuse of school girls;

(f) Give priority to orphans and vulnerable children (OVCs) in awarding bursaries and scholarships;

(g) Integrate HIV/AIDS awareness in pre-service and in-service training programmes; and

(h) Introduce counselling in workplaces as one way of preventing HIV infection among its personnel, particularly teachers, pupils and students, and promoting positive living by those who are already infected and affected.

d. Health Sector

In order to resolve the challenges associated with the provision of health as well as enable the health sector to provide leadership in the fight against HIV/AIDS, the Health sector shall:

(a) Ensure that the health sector attaches highest priority to HIV/AIDS prevention, care, support and treatment at all levels;

(b) Strengthen overall capacity of the health sector to pro-actively respond to the challenges posed by HIV/AIDS;

(c) Promote and strengthen inter-sectoral networking at national, provincial and district levels; and

(d) Provide requisite technical backstopping to all stakeholders actively involved in the fight against the HIV/AIDS pandemic.

e. Agricultural Sector

The major portion of the Zambian population is engaged in agriculture either as a source of living or income. On its part, the agricultural sector employs hundreds upon hundreds of individuals some of whom are in the remotest parts of the country. In order to address the numerous health challenges associated with the sector, the agricultural sector shall:

(a) Promote the mainstreaming of HIV/AIDS in agricultural programme planning;

(b) Utilise its extensive agricultural extension network for purposes of HIV/AIDS prevention and support;

(c) Ensure that systematic efforts in support of improved national and household food security and nutritional standards for low-income groups are initiated and promoted;

(d) Promote the empowerment of rural women in order to reduce the negative impact of HIV/AIDS on production levels;

(e) Provide skills training facilities to PLWHAs as a means of ensuring their participation in HIV/AIDS prevention and care programmes; and

(f) Provide targeted food support as a component of HIV/AIDS care and support to families in need.

f. Sport, Youth and Child Development Sector

The incidence of HIV infections is particularly acute among the youth and adolescent population. As the line Ministry responsible for youth development shall:

(a) Strengthen human and organisational capacity within key agencies of the Government and communities in support of initiatives targeted at combating the spread of HIV/AIDS among children and youth;

(b) Mobilise resources for targeted programmes against the spread of HIV/AIDS among children and youth in the country;

(c) In conjunction with the Ministry of Justice (MoJ), formulate a more progressive penal code relating to sexual abuse of children;

(d) Develop mechanisms for protecting children against the effects of harmful practices and values that may subject them to dangers of HIV/AIDS;

(e) Systematically use sports as a conduit for HIV/AIDS social mobilisation and awareness creation; and

(f) Raise awareness of the dangers of drug and alcohol abuse.

g. Communications and Transport Sector

It is now common knowledge that social mobility, such as among long distance truck drivers and cross-border traders, is among the major vectors for HIV transmission. Mobility and transportation can, however, be positively employed to sensitise the public to the dangers of contracting HIV/AIDS and the Ministry responsible for Communications and Transport is suitably placed to provide the requisite leadership. In this regard, the Ministry shall:

(a) Produce and provide HIV/AIDS/STIs/TB information, education and communication (IEC) materials for display on public conveyances such as buses and trains, including stadia and other sports facilities. It will also lobby for the imprinting of HIV/AIDS/STI/TB messages on utility bills (telephones, power, water, etc), electronic messages, stamps and other media and channels;

(b) Support and encourage the marketing of condoms at railway stations, inter-city bus stations, Post Office counters and boarder and transit points; and

(c) Encourage the private transport sector to mainstream HIV/AIDS in their business plans.

h. Tourism Sector

The tourism sector is characterised by high mobility of people who come to Zambia to view its natural attractions. It is probable, therefore, that the rate of HIV infection might be high as tourists travel up and down the country. In order to contribute to the national fight against the rapid spread of HIV/AIDS in the tourism sector, the Ministry responsible for Tourism shall:

(a) Provide HIV/AIDS education to its employees, including those in Forestry and Wildlife Departments;

(b) Support efforts aimed at finding alternative remedies for dealing with HIV/AIDS-related conditions;

(c) Integrate HIV/AIDS topics into forestry and wildlife syllabi;

(d) Investigate environmentally-friendly means of disposing condoms, syringes, razor blades and other sharp instruments that may contribute to the spread of HIV;

(e) Ensure that all tourist operators and the hospitality industry incorporate HIV/AIDS prevention information in staff training programmes and in information packages offered to clients and patrons;

(f) Owners of hotels, motels, lodges, camping sites and other tourist facilities mainstream HIV/AIDS in the business promotion programmes; and

(g) Ensure that a person's HIV/AIDS status is not a criterion for admission to or accessing tourism services.

i. Information and Broadcasting Sector

The Ministry responsible for Information and Broadcasting Services is the official Government mouthpiece and, as such, plays a pivotal role in transmitting official positions on national issues. In this regard, the Ministry shall:

(a) Ensure that it effectively utilises the public print and electronic media to disseminate HIV/AIDS/STI/TB messages and information to the general public;

(b) In conjunction with the Ministry of Health, provide relevant HIV/AIDS/STI/TB information, education and communication (IEC) materials, including counselling services to other line Ministries and departments; and

(c) Integrate HIV/AIDS education in journalism and broadcasting courses.

j. Governance and Justice Sector

Like is the standard elsewhere in the world, the Zambian Cabinet is responsible for national policy formulation and implementation. Given this understanding, the Cabinet Office is expected to provide the requisite policy direction to the national fight against HIV/AIDS/STI/TB. In doing, this, it shall:

(a) Establish a mechanism for monitoring and evaluation of the implementation and impact of HIV/AIDS/STI/TB interventions by all line Ministries and other stakeholders;

(b) Develop strategies for the care and support of public service workers infected and affected by HIV/AIDS within the broad framework of the Public Service Reform Programme (PSRP);

(c) Integrate HIV/AIDS information, education and communication into curricula of public service training institutions such as the National Institute for Public Administration (NIPA) and National In-Service Training College (NISTC); and

(d) Closely work with and support the National HIV/AIDS/STI/TB Council.

(e) Support changes in pieces of legislation that disadvantage HIV infected and affected persons and that encourage stigma and discrimination;

k. Defence and Security Sector

Security and defence forces are highly mobile in the discharge of their daily calls of duty. Their mobility exposes them to the risk of contracting HIV/AIDS, STIs, TB and other opportunistic infections. In order to militate against the high risk of infection associated with the high mobility of security and defence forces, the Ministry responsible for Defence and security shall:

(a) Ensure that it plays a more pro-active role in HIV/AIDS/STI/TB prevention, care, treatment and support;

(b) Integrate HIV/AIDS education in all military training curricula;

(c) Provide enhanced counselling services and peer education programmes in all military bases;

(d) Provide VCT services in all military hospitals;

(e) Ensure that defence personnel on deployment in and outside the country are provided with the necessary information and means to guard themselves against HIV/AIDS, STIs, TB and other opportunistic infections;

l. Home Affairs

The sector is responsible for staff (uniformed and non uniformed officers) and groups (refugees, displaced communities) who are highly mobile in the discharge of their daily calls of duty and daily dealings. Their mobility exposes them to the risk of contracting HIV/AIDS, STIs, TB and other opportunistic infections. In order to militate against the high risk of infection associated with the high mobility of these groups, the Ministry responsible for Home Affairs shall:

(a) Ensure law enforcement

(b) Ensure that it plays a more pro-active role in HIV/AIDS/STI/TB prevention, care, treatment and support;

(c) Integrate HIV/AIDS education in all military training curricula;

(d) Provide enhanced counselling services and peer education programmes in all military bases;

(e) Provide VCT services in all military hospitals;

(f) Ensure that defence personnel on deployment in and outside the country are provided with the

necessary information and means to guard themselves against HIV/AIDS, STIs, TB and other opportunistic infections;

m. Private, Construction and industry Sector

In order to contribute to the national fight against the rapid spread of HIV/AIDS in the Private, construction and industry sector, the Ministry responsible for Private Construction and industry sector shall:

(a) Provide HIV/AIDS education to its employees, including those in the mining and private sector.

(b) Support efforts aimed at finding alternative remedies for dealing with HIV/AIDS-related conditions;

(c) Integrate HIV/AIDS topics into construction and Mining syllabi;

(d) Ensure that all Private, construction and mining companies incorporate HIV/AIDS prevention information in staff training programmes and in information packages offered to surrounding communities and workers;

n. National HIV/AIDS/STI/TB Council

An effective response to the HIV/AIDS epidemic requires a partnership approach,

involving government Ministries, local and international NGOs, CBOs, religious

Organisations, the private sector, UN agencies and bilateral donors. This partnership approach requires effective coordination of the policies and activities in each of these different sectors in order to ensure complimentarity in activities and avoid the inefficient use of limited financial and human resources. In order to coordinate and support the development, monitoring and evaluation of the multi-sectoral national response for the prevention and combating of the spread of HIV, AIDS, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB, the National HIV/AIDS Council shall:

(a) Support the development and coordination of policies, plans and strategies for the prevention and combating of HIV, AIDS, STI and TB;

(b) Advise the Government, health institutions and other organizations on the policies, strategies and plans to prevent and combat HIV, AIDS, STI and TB;

(c) Advise the Government, health institutions and other organizations on the policies, strategies and plans to prevent and combat HIV, AIDS, STI and TB;

(d) Ensure the provision and dissemination of information and education on HIV, AIDS, STI and TB;

(e) Develop a national HIV, AIDS, STI and TB research agenda and strategic plan which shall include the quest for a cure for HIV, AIDS as one of the research priorities;

(f) Support programmes relating to prevention, care, and treatment of HIV, AIDS, STI and TV;

(g) Mobilize resources to promote and support identified priority interventions including research in areas related to HIV, AIDS, STI and TB;

(h) Provide technical support and guidelines to health and other institutions involved;

(i) Prevention and treatment of HIV, AIDS, STI and TB; and

(j) Care and support of persons infected with or affected by HIV, AIDS, STI and TB; and

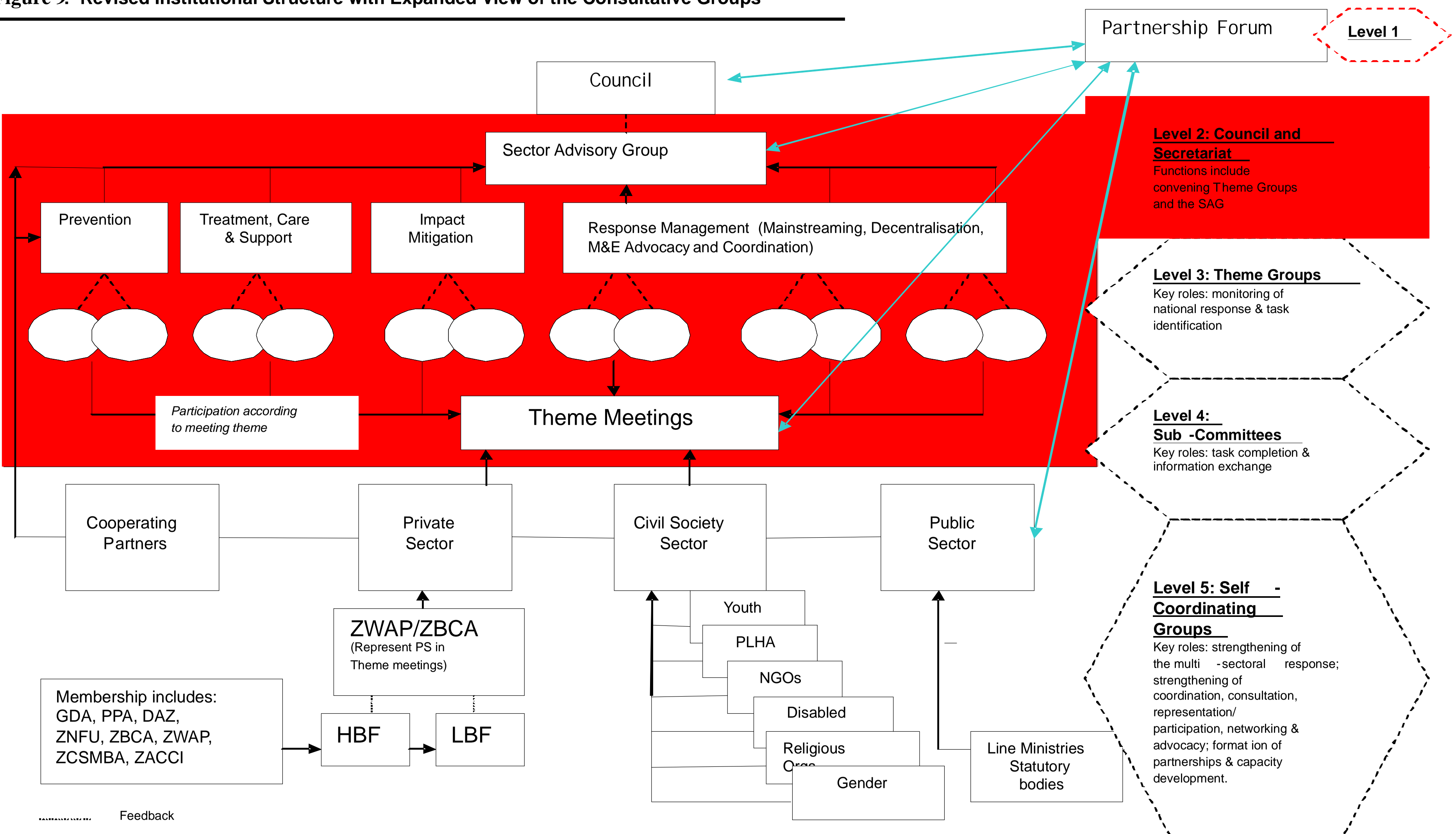
(k) Collaborate with other research institutions in relation to HIV, AIDS, STI and TB.

o. Cooperating partners in Zambia

As part of the Paris declaration, and in accordance with the comparative advantages of cooperating partners supporting the national response, the following division of labour guide their engagement.

I. Intensifying Prevention	II. Expanding Treatment, Care and Support	III. Mitigating the Socio -economic impact	IV Response management Strengthening the Decentralized Response and Mainstreaming HIV and AIDS Improving the Monitoring of the Response
(UNFPA) USG UNAIDS	WHO)	(Irish Aid) (UNICEF)	Integrating Advocacy and Coordination of the Multi-Sectoral Response (UNDP) (UNAIDS) Irish AIDS USG

Figure 9: Revised Institutional Structure with Expanded View of the Consultative Groups



6.0 National Three Years Multisectoral costed Work plan of the NASF

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
Outcome Results	Output Results	NASF Mid Term Target	Strategies	Activities	2011 Cost for year One	2012 Cost for year Two	2013 Cost for year Three	Total Cost	Target	Unit Cost	1	2	3		
				1.1 Support the implementation of the National Strategy for the Prevention of HIV and STIs	432,443	454,065	476,768	1,363,276	146 meetings	9,338	*	*	*	NAC; MOH, PEPFAR,UNAIDS	UN, SFH, GFATM,ZCCP.ZNAN,CHAZ
				1.2 Support the implementation o the National Plan of Action to Reduce HIV Infection women and girls 2011-2014	216,221	227,033	238,384	681,638	73	9,338	*	*	*	NAC; GIDD, PEPFAR,UN	
Cross cutting prevention Action [these prevention cross cutting issues will contribute to all the prevention outcome and output results)			Strengthen the capacity for Prevention	1.3 At Mid Term (2013 review and update the National Strategy for the Prevention of HIV and STIs [review strategy from a gender and human rights perspective and introduce changes in line with commitments in the NASF].			29,789	29,789	1	29,789				NAC, MOH, UNAIDS	All stakeholders involved in Joint review process
				1.4 Review and update the "National HIV and AIDS Communication Strategy (2005)	37,798	-	-	37,798	1	37,798	*	*		NAC, MOH, UNAIDS	
				1.5 Conduct orientation for key stakeholders on "combination prevention strategy"	56,697	59,532	62,508	178,737	3	59,579		*	*	NAC, UNAIDS	MOH, UN, PEPFAR
				1.6 Mobilise political leadership around prevention issues (e.g.. MC, PMTCT, MCP, gender inequality, GBV etc), as well as around reforming laws that hinder an effective AIDS response.	209,945	220,442	231,465	209,945	219	959		*	*	NAC,UNAIDS, MOH	SFH,ZPTC, ZCCP,UN;CCP,CHAZ,MOFNP
				1.7 Support and strengthen capacity of youth leaders, [including young women living with HIV] in spearheading prevention advocacy, championships and role modelling	39,620	41,601	43,681	62,451	27	2,313		*	*	NAC,UNAIDS, MOH	SFH,ZPTC, ZCCP,UN;CCP,CHAZ,MOFNP
				1.8 Develop a strategy for engaging Mass Media (Television, radio and print media) on prevention advocacy and, in particular, in engaging the media to support efforts to challenge harmful gender norms and/or laws that discriminate against women.	9,450			9,000	36	250	*	*	*	NAC,UNAIDS, MOH	SFH,ZPTC, ZCCP,UN;CCP,CHAZ,MOFNP

3.1 - Prevention

Zambia National Operational Plan (NOP) for NASF 2011-2013

3.1.1 - Social and Behaviour Change			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Implementation period Y 1	Y2	Y3	Lead agency	Collaborating partners
											1	2	3		
[OC1] More people have comprehensive knowledge of HIV: Female and Male aged 15-49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15 – 24 years to 51% in 2013 and 70% by 2015	**[OP1]** Females and males aged 25 and older reached with small group or individual social and behaviour change programmes is increased to 50% by 2013 and to 80% by 2015	50%	Intensify targeted HIV and AIDS education and awareness	1.1 Conduct community outreach / conversations on HIV and AIDS targeting specific groups	180,009	189,009	198,460	**567,478**	**146**	**3,887**	*	*	*	NAC, MOH,	CCP,SFH,ZCCP, ZHECT, UNFPA
				1.2 Develop a mass media campaign (billboards, radio, television, print media and interactive scenarios) to increase the level of comprehensive knowledge of HIV and AIDS	-	1,652,644	-	**1,652,644**	**9**	**183,627**			*	CHAZ,ZNAN,MOH,PEPFAR,UN	SFH,ZHECT,CCP
				1.3 Develop and produce IEC materials on HIV and AIDS for the general public	1,680,000	1,764,000	1,852,200	**5,296,200**	**120,000**	**44**	*	*	*	MOFNP,CHAZ, ZNAN,MOH,PEPFAR, UN	USG,UNFPA, SFH, ZHECT, CCP, HCP, CDC, JICA
				1.4 Expand coverage of a core package of comprehensive prevention interventions for mobile populations and vulnerable groups (persons living with disability, PLHIV and women)	571,265	599,828	629,820	**1,800,914**	**146**	**12,335**	*	*	*	NAC, MOH, UNAIDS	
		50%	Develop HIV prevention interventions that target priority epidemic drivers	2.1 Develop targeted social and behaviour change interventions focusing on mobile and migrant populations including cross- border traders	353,833	361,602	379,682	**1,095,116**	**90**	**12,168**			*	NAC,	PSMD, Ministry of Labour
				2.2 Conduct a national survey to establish the size and map out services being provided for MARPs (sex worker, IDU, MSM, and their clients), and mobile and migrant workers	1,645,682			**1,645,682**	**1**	**1,645,682**	*	*		NAC,MOH, MOHA	
				2.3 Conduct a nationwide survey to establish the size and magnitude of MARPS (MSM Sex workers, prisoners and IDU) in Zambia, and develop appropriate responses	1,645,682			**1,645,682**	**1**	**1,645,682**	*	*		NAC,MOH	
				2.4 Review the existing policies and legislation, including the specific effects of these on women and girls] and develop appropriate responses based on the national survey report results	28,348	29,766	-	**58,114**	**1**	**58,114**				NAC,	
				2.5 Develop targeted interventions to address alcohol and substance abuse	1,153,859	1,214,859	1,272,130	**3,640,848**	**17,600**	**207**			*	NAC,	
				2.6 Mobilise and sensitise community leaders to take action on alcohol and drug abuse	194,517	204,243	214,455	**613,215**	**32,400**	**19**			*	DATF, PATF, MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y 2	Y 3		
3.1.1 - Social and Behaviour Change			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	1	2	3		
		50%	Promote gender sensitive response to gender-based drivers of the epidemic.	3.1 Create community action oriented awareness on gender and HIV and AIDS,	1,035,253	1,090,323	1,141,367	3,266,943	108	30,249		*	*	GIDD, NAC	
				3.2 Develop and disseminate gender-cultural sensitive social and behaviour change materials	41,966	52,884	46,267	141,117	3	47,039	*	*	*	NAC, GIDD	UN (UNFPA, UNDP, UNICEF etc), ZNAN,
				3.3 Advocate for dual protection for women and girls by encouraging partner responsibilities	651,906	684,501	718,726	2,055,133	81	25,372			*	NAC, GIDD	USG,
				3.4 Develop and implement mass media campaigns on women and girls vulnerability to HIV infection and strategies to reduce such vulnerability	781,016	820,067	861,070	2,462,154	2,886	853			*	GIDD, NAC	UNFPA, ZNAN, Zambia Police, UN,
				3.5 Mobilise communities to participate in national events i.e. World AIDS Day,	1,367,230	1,435,591	1,507,371	4,310,192	81	53,212				NAC, GIDD	
				3.6 Develop mass media campaigns on gender issues and HIV and AIDS.	3,799,485	3,989,459	4,188,932	11,977,876	5,772	2,075			*	NAC, GIDD	
				3.7 Conduct targeted community based conversations with traditional marriage counsellors, initiators, traditional leaders and religious groups	202,830	212,972	223,620	639,422	18	35,523		*	*		
	[OP2] Females and males aged 15-24 reached with small group or individual social and behaviour change programmes is increased to 50% by 2013 and to 80% by 2015	50%	Intensify targeted HIV and AIDS education and awareness	4.1 Incorporate HIV and Education in the on-going health and education programmes in schools	573,158	601,816	631,907	1,806,882	7,300	248		*	*		
				4.2 Strengthen anti-AIDS Clubs in schools	518,305	650,706	571,431	1,740,441	1,000	1,740		*	*	MOE, MOH, NAC	
				4.3 Distribute educational materials on HIV and AIDS and develop learners' knowledge and understanding of risks and vulnerability.	878,850	906,255	948,095	2,733,200	515,000	5		*	*		
				4.4Train teachers and some students as peer educators	9,681	10,166	10,674	30,521	3	10,174		*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013										Implementation period			Lead agency	Collaborating partners
3.1.1 - Social and Behaviour Change		Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
										1	2	3		
	50%	Review and Strengthen integration of life skills based HIV education in schools	5.1 Train teachers during pre-service and in-service on life skills HIV and AIDS based education that incorporates gender, sexual and reproductive health issues.	259,577	272,556	286,184	818,318	73	11,210		*	*	MOE, GIDD	
			5.2 Implement life skills HIV and AIDS education in primary and secondary schools	418,077	438,981	460,930	1,317,988	2,920	451				MOE, GIDD	
			5.3 Intensify the teaching of sexual reproduction health in the context of HIV and AIDS lifeskills	190,466	-	-	190,466	450	423				MOE, GIDD	
	50%	Conduct a national KAPB on HIV and AIDS among young people aged 10-14 years	6.1 Establish a baseline on KAPB for young people aged 10-14 in the first two years of NOP implementation	-	110,250	-	110,250	1	110,250	*	*		MOE, GIDD	
			6.2 Develop and implement targeted social and behaviour change interventions focusing on the age group	194,073	203,777	213,965	611,815	162	3,777		*	*		
[OP3] Most at risk population and vulnerable groups reached with HIV prevention programmes has increased to 25% by 2013 and to 50% by 2015 [disaggregated by MARP and vulnerability category)	25%	Expand coverage of a core package of comprehensive prevention interventions for mobile populations and vulnerable groups (prisoners, persons living with disability and other vulnerable groups)	7.1 Develop social and behaviour change materials targeting most at risk and vulnerable groups	836,043	877,845	921,738	2,635,626	528,000	5		*	*	MOHA, NAC	
			7.2 Develop and support HIV prevention interventions in prisons including HCT)	213,624	224,305	235,521	673,450	45,000	15		*	*	MOHA, NAC	
			7.3 Train MARPs as peer educators and HCT counsellors	832,070	-	-	832,070	74	11,244	*	*	*		
			7.4 Provide HCT, diagnosis and treatment for STIs among MARPS including other vulnerable groups	107,612	112,992	118,642	339,246	1,200	283		*	*	MOHA, NAC	
[OP4] In and out of school youth aged 5 -17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015	50%	Review and strengthen current guidelines on life skills based HIV education [Ensure life skills education includes content that promotes gender equality and that addresses factors that increase women's vulnerability to HIV].	8.1 Train female and male teachers and out of school youth programme coordinators in skills and methodologies for teaching life skills based HIV education	217,302	228,167	239,575	685,044	900	761	*	*	*	MOHA, NAC	
			8.2 Integrate gender and sexual reproductive health issues in the lifeskills training	10,325	10,841	11,301	32,467	2,000	16	*	*		MOHA, NAC	
			8.3 Review the life skills based HIV education manual to incorporate gender and SRH	9,450	-	-	9,450	1	9,450	*	*		MOHA, NAC	
			8.4 Print and distribute revised manual on life skills	47,250	-	-	47,250	5,000	9		*	*	MOHA, NAC	

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.1 - Social and Behaviour Change			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	1	2	3		
				8.5 Train peer youth peer educators on life skills based HIV education and sexual reproductive health issues	216,221	227,033	238,384	681,638	1,460	467		*	*	MOYSCD	
				8.6 Develop and produce age and gender appropriate IEC materials targeting youth on life skills based HIV education	588,000	617,400	648,270	1,853,670	420,000	4	*	*	*	MOYSCD	
				8.7 Strengthen anti-AIDS Clubs in schools	433,223	454,884	477,628	1,365,734	21,900	62	*	*	*	MOYSCD	
		50%	Strengthen the capacity of youth centres to serve as resource centres for female and male youth on HIV and AIDS	9.1 Develop sporting and entertainment activities (procure a TV & Video; establish a volley ball, tennis, basket ball and reading clubs)	144,408	151,628	159,209	455,245	73	6,236	*	*	*	MOYSCD	
				9.2 Refurbish youth community centres to serve as HIV and AIDS resource centres and provide basic services (HCT, condomss, education, etc)	270,013	283,514	297,690	851,217	219	3,887	*	*	*	MOYSCD	
		50%	Scale-up evidence-based prevention interventions for young people	10.1 Intensify comprehensive and targeted HIV and AIDS education and awareness	270,013	283,514	297,690	851,217	219	3,887	*	*	*	MOYSCD	
				10.2 Promote and encourage through awareness and education abstinence among young people	54,003	56,703	59,538	170,243	219	777	*	*	*	MOYSCD MOE	
				10.3 Develop and produce HIV and AIDS youth targeted and engendered social and behaviour change materials	462,000	485,100	509,355	1,456,455	870,000	2	*	*	*	MOYSCD MOE	
				10.4 Strengthen partnership between schools and community based youth centres to expand the scope of coverage of HIV and AIDS interventions for young people	265,362	278,630	292,562	836,555	438	1,910				MOYSCD MOE	
[OC2] Females and males aged 15-49 who had multiple and concurrent partnerships in the last 12 months is reduced from 1.2% for female and 14% for male in 2007 to less than 1%% for female and remains that way by 2015, and to 10% by 2013 for Male and to 5% by2015.	**[OP5]** Households reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015	50%	Scale-up campaign for multiple and concurrent sexual partnerships	11.1 Conduct community based awareness campaigns on multiple and concurrent partnerships in collaboration with CSO, CBO and FBOs	378,000	396,900	416,745	1,191,645	270,000	4	*	*	*	PSMD,MIB S,NAC	
				11.2 Develop and implement mass media (television, radio and print media) campaigns on multiple and concurrent partnerships	1,350,295	1,417,810	1,488,700	4,256,805	36	118,245	*	*	*	PSMD,MIB S,NAC	
				11.3 Sensitise and mobilise traditional and religious leaders to speak on the risks of multiple and concurrent partnerships	202,830	212,972	223,620	639,422	438	1,460			*	PSMD,MIB S,NAC	
				11.4 Provide counselling and encourage HIV testing for people and couples in MCP relationships	33,805	35,495	37,270	106,570	73	1,460			*	PSMD,MIB S,NAC	
				11.5 Empower women with negotiating skills for safe sex	116,550	122,378	128,496	367,424	3	122,475		*	*	PSMD,MIB S,NAC	

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y 2	Y 3		
3.1.1 - Social and Behaviour Change			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	1	2	3		
	[OP6] Females and males aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50% for Male in 2008 to 65 % in 2013 and to 75% for both Female and Male by 2015	65% [for both women and men]	Intensify condom education and awareness	12.1 Develop mass media campaigns on consistent and correct use of condoms	19,425	20,396	21,416	**61,237**	**1**	**61,237**		*	*	PSMD,MIBS,NAC	
			Scale-up evidence-based prevention interventions for female and male young people	13.1 Intensify HIV and AIDS education and awareness	360,018	378,019	396,920	**1,134,957**	**292**	**3,887**		*	*	PSMD,MIBS,NAC	
	[OP7] Couples reached with small group or individual social and behaviour change programmes is increased to 35% in 2013 and to 70% by 2014	35%	Develop HIV prevention interventions that target couples	14.1 Conduct community conversations targeted to couples / stable unions and relationships including discordant couples on HIV prevention strategies	67,610	70,991	74,540	**213,141**	**146**	**1,460**		*	*	PSMD,MIBS,NAC	
				14.2 Provide couple counselling and testing services	5,809	6,100	6,405	**18,314**	**6**	**3,052**		*	*	PSMD,MIBS,NAC	
				14.3 Promote condom use in stable relationships through inter-personal communication	1,248,984	1,390,995	1,377,005	**4,016,985**	**515,000**	**8**		*	*	PSMD,MIBS,NAC	
[OC3] Among female aged 15-49, HIV infection is reduced from 16% in 2009 to 10% in 2013 and to below 8% by 2015	**OP8]** Female aged 15-49 reached with interventions that empower females to address gender inequality and gender based violence that predispose Female and girls to HIV infection is increased to 40% by 2013 and to 75% by 2015	40%	Scale up interventions to address gender inequalities and gender based violence	15.1 Implement the Gender Action Plan and the Gender based Violence Action Plan	129,678	136,162	142,970	**408,810**	**292**	**1,400**		*	*	PSMD,MIBS,NAC	
				15.2 Conduct community based interventions that address negative traditional practises that encourage the subordination of women and girls, and create vulnerability for both females and males	2,905	3,050	3,202	**9,157**	**30**	**305**		*	*	PSMD,MIBS,NAC	
				15.3Train sectors in skills for mainstreaming gender in sector programmes to address gender inequalities, sexual and gender based violence.	2,905	3,050	3,202	**9,157**	**30**	**305**		*	*	PSMD,MIBS,NAC	
				15.4 Establish partnership with different groups such as women with HIV, men's network against GBV, children living with HIV and AIDS, and GIDD	67,744	71,131	74,687	**213,562**	**150**	**1,424**	*	*	*	PSMD,MIBS,NAC	
														PSMD,MIBS,NAC	

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.1 - Social and Behaviour Change			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	1	2	3		
	[OP9] Communities addressing the root causes of vulnerability increased from xx to 50% by 2015 (social norms, practices, GBV)	50%	Strengthen community response to sexual abuse including rape	16.1 Scale- up and intensify community conversation programs to challenge social norms that perpetuate gender inequality and increase vulnerability of female and male to HIV infection.	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	PSMD, MIBS,NAC	
				16.2 Develop and implement activities that promote male involvement in HIV prevention initiatives (condom, male circumcision, PMTCT prevention of GBV)	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	PSMD, MIBS,NAC	
	[OP10] Females who have received post rape care services (counselling, treatment, and legal support) have increased from 20.2% in 2007 to 40% in 2013 and to 80% by 2015.	40%	Strengthen community response to sexual abuse including rape	16.3 Conduct community based awareness of sexual abuse including rape	202,830	212,972	223,620	**639,422**	**438**	**1,460**		*	*	PSMD, MIBS,NAC	
				16.4 Develop mass media campaigns on sexual abuse and HIV and in particular rape	252,525	265,151	278,409	**796,085**	**6**	**132,681**		*	*	PSMD, MIBS,NAC	
				16.5 Establish community care centres for survivors of rape, other forms of sexual abuse and domestic violence	229,950	241,448	253,520	**724,917**	**73**	**9,930**			*	PSMD, MIBS,NAC	
SDA HRH				HRH	3,129,271	3,129,271	3,129,271	**9,387,812**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure				Infrastructure	350,448	350,448	350,448	**1,051,344**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL Social and Behaviour Change SDA COST					**32,894,781**	**31,664,709**	**31,006,342**	**95,051,024**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.2 - HIV Counseling and Testing			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	3 year Target	Unit Cost	1	2	3		
[OC4]: Females and males aged 15-49 who know received an HIV test in the last 12 months and know their results has increased from 15.4% in 2008 to 30% in 2013 and 50% by 2015	[OP11] Females and males aged 15-49 who received an HIV test in the last 12 months and know their results has increased from 28% (1910253/6822332) in 2009 to 41% (3,023,728/7330249) in 2013 and 50% (3,816,765/7633530) by 2015	3,023,728	Strengthen the national capacity for HIV counselling and testing	2.1.1Review and update guidelines for HIV counselling and testing (every 2 years)	36,750	8,820	9,261	**54,831**	**6,000 copies**	**9**	*			NAC, MOH,	
				2.1.2 Procure and distribute HIV testing kits	2,625,000	2,756,250	2,894,063	**8,275,313**	**1,655,063 Kits**	**5**	*	*	*	NAC, MOH,	
				2.1.3 Standardise the training of HIV Counsellors and testers (for use by all stakeholders)	7,262	114,111	8,006	**129,379**	**73 trainings**	**1,772**			*	NAC, MOH,	
				2.1.4 Train and certify additional HIV counsellors and testers	832,070	1,310,511	1,834,715	**3,977,296**	**391 counsellors**	**10,160**	*	*	*	NAC, MOH,	
				2.1.5 Integrate HIV counselling and testing with other services including MC, PMTCT, STI, PEP, blood donors	778,732	817,669	858,552	**2,454,954**	**219 orientations**	**11,210**		*	*	NAC, MOH,	
				2.1.6 Strengthen the referral system to other services (by training service providers)	172,463	181,086	190,140	**543,688**	**219,000 refereal manuals copies**	**2**			*	NAC, MOH,	
			Intensify community mobilisation to increase demand for HCT.	2.2.1 Increase the number of HIV counselling and testing sites with certified and trained staff, adequate testing kits	647,430	679,801	713,791	**2,041,022**	**81**	**25,198**		*	*	NAC, MOH,	
				2.2.2 Scale up youth and adolescent friendly counselling and testing services	1,450,463	1,522,986	1,599,135	**4,572,584**	**438units**	**10,440**			*	NAC, MOH,	
				2.2.3 Refer people including infants who test HIV positive to other appropriate services i.e. PMTCT, ARV, nutrition services, etc	1,280,967	1,345,015	1,412,266	**4,038,248**	**438 trainings**	**9,220**		*	*	NAC, MOH,	
			Intensify education and awareness of HCT and especially among the key programmes such as MARPS, MC, PMTCT, and PEP. This will require development of appropriate social and behaviour change materials	2.3.1 Conduct community, school, and workplace educational and awareness campaigns on the importance of HCT	208,731	219,167	230,126	**658,024**	**139,770 booklets**	**5**		*	*	NAC, MOH,	

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.2 - HIV Counseling and Testing			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	3 year Target	Unit Cost	1	2	3		
			Scale up paediatric counselling and testing	2.4.1 Develop guidelines for paediatric counselling	2,800	2,940	13,506	19,246	2000 guidelines	10		*	*	NAC, MOH,	
				2.4.2 Train paediatric counsellors	47,043	49,395	51,864	148,302	180 counsellors	824			*	NAC, MOH,	
	[OP12] Females and males in stable relationships who know their HIV status is increased to 50% in 2013 and to 80% by 2015	50%	Promote couple counselling including discordant couples	2.5.1 Conduct orientation workshops for HIV counsellors on couple and discordant couple counselling	979,744	1,910,501	1,080,168	3,970,413	1168workshop s	3,399		*	*	NAC, MOH,	
				2.5.2 Develop mass media to promote couple counselling	425,809	447,100	469,455	1,342,364	300,000 IEC materials	4		*	*	NAC, MOH,	
	[OP13] Most at risk population who received an HIV test in the last 12 months and know their status has increased to 35% by 2013 and to70% by 2015 [disaggregated by MARP category	35%	Develop user friendly counselling and testing services for MARPS	2.6.1 Recruit and train MARP mobilisers on HIV counselling and testing	29,921	31,417	32,988	94,325	18 workshops	5,240		*	*	NAC, MOH,	
				2.6.2 Provide HCT for MARPs and other vulnerable groups	242,690	254,825	267,566	765,081	146 mobization meetings	5,240		*	*	NAC, MOH,	
	[OP14] Health and non-health facilities with adequate capacity to provide HCT increased from 1563 in 2008 to 1850 in 2013 and to 2000 by 2015	1850	Strengthen the capacity of health facilities to offer HIV counselling and testing	2.7.1 Train lay counsellors to offer HCT in communities, and the workplace	242,690	254,825	267,566	765,081	5840 lay counselors	131		*	*	NAC, MOH,	
				2.7.2 Procure and distribute testing kits to health facilities	-	154,284	-	154,284	30,857	5	*	*	*	NAC, MOH,	
				2.7.3 Mobilise communities to participate in the voluntary HIV counselling and testing	433,223	454,884	477,628	1,365,734	219 meetings	6,236	*	*	*	NAC, MOH,	
SDA HRH				HRH	7,014,760	7,014,760	7,014,760	21,044,281	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*	NAC, MOH,	
SDA Infrastructure				Infrastructure	584,080	584,080	584,080	1,752,240	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastr ucture	*	*	*		
TOTAL HCT SDA COST					18,042,628	20,114,426	20,009,636	58,166,689							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.3 - Condoms Marketing and Distribution			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC5] Females and males aged 15–49 with more than one partner in the past 12 months who used a condom during their last sexual intercourse has increased from 37% for female and 50% for male in 2007 to 45% for female and to 60% for male in 2013 and 55% for female and 70% for male by 2015	[OP15] Female and male condoms distributed for free per year increased for Male from 40 million in 2009 to 80million in 2013 and 100 million in 2015 and for Female from 450,000 in 2009 and 650,000 in 2013 and 1,000,000 in 2015	M= 80 Million W= 650,000	Increase availability and distribution of male and female condoms in the all workplace settings and community settings .	3.1.1 Procure and distribute male and female condoms	4,116,000	4,321,800	4,537,890	**12,975,690**	**81,200,000**	**0.16**		*	*	NAC, MOH,	
				3.1.2 Review and strengthen (train) the capacity of the procurement and supply chain at national and district levels	350,000	367,500	385,875	**1,103,375**	**540 officers trained**	**2,043**		*	*	NAC, MOH,	
				3.1.3 Develop new community based condom outlet points / dispensers including in such places as bus stops etc	525,000	551,250	578,813	**1,655,063**	**60000 dispecers**	**28**		*	*	NAC, MOH,	
				3.1.4 Develop a truckers "first Aid Kit" that would include both male and female conducts and recorded messages on HIV and AIDS in particular consistent and correct use of condoms	259,356	272,324	285,940	**817,620**	**219 workshops**	**3,733**	*	*	*	NAC, MOH,	
				3.1.5 Introduce a 'condom wallet" for MARPS and other vulnerable groups	350,000	367,500	385,875	**1,103,375**	**150,000 wallets**	**7**	*	*	*	NAC, MOH,	
				3.1.6 Conduct advocacy to review existing policies on condom distribution to ensure universal access	102,203			**102,203**	**73advocacy meetings**	**1,400**	*	*	*	NAC, MOH,	
				3.2.1 Brand condoms to make them more attractive and appealing to different target groups especially the youth and discipline forces.	350,000	367,500	385,875	**1,103,375**	**3 million codoms**	**0.37**	*	*	*	NAC, MOH,	
			Support social marketing of condoms	3.2.2 Intensify female condom social marketing	2,808,140	1,474,273	1,547,987	**5,830,401**	**7592 awareness meetings**	**768**	*	*	*	NAC, MOH,	
				3.2.3 Establish partnerships with small and medium businesses to serve as condom distribution points (as part of external mainstreaming)	468,023	491,424	515,996	**1,475,444**	**1898 workshops**	**777**			*	NAC, MOH,	
				3.2.4 Integrate condom marketing in family planning education programmes	389,034			**389,034**	**292**	**1,332**	*	*	*	NAC, MOH,	
	[OP16] Condom retail outlets and service centres that reported no condom stock out increased to 60% in 2013 and to 100% by 2015	60%	Intensified education and awareness on the correct and consistent use of condoms	3.2.5 Establish user friendly condom dispensers for most at risk populations and vulnerable groups	131,250	137,813	144,703	**413,766**	**15,000**	**28**	*	*	*	NAC, MOH,	
				3.3.1 Produce disseminate IEC materials on condoms	306,600	321,930	338,027	**966,557**	**219,000**	**4**	*	*	*	NAC, MOH,	
				3.3.2 Develop mass media campaigns to promote male and female condoms including linking messages to Male circumcisions, PMTCT and STI prevention	810,768	851,306	893,871	**2,555,945**	**35**	**72,665**	*	*	*		
				3.3.3 Conduct community outreach activities targeting stable relationships / unions , discordant partners on consistent and correct condom use	180,009	189,009	198,460	**567,478**	**146**	**3,887**	*	*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collabo rating partners
3.1.3 - Condoms Marketing and Distribution			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
				3.3.4 Conduct (district and community HIV and AIDS coordinating structures) weekly monitoring visits to check on community based condom dispensers and re-stock them	99,645	104,627	109,859	**314,131**	**11,388**	**28**	*	*	*	NAC, MOH,	
				3.3.5 Integrate condom education / supply with other HIV prevention services i.e. male circumcision, STI, PMTCT	97,259			**97,259**	**73**	**1,332**		*	*	NAC, MOH,	
			Ensure correct and consistent use of female and male condoms. This information will be useful if disaggregated by age and gender, and where possible by MARP and Vulnerable Groups	Conduct TOTs and Cascade training on condom use for MARPs and Vulnerable groups	310,846	310,846	310,846	**932,539**	**9**	**103,615**			*	NAC, MOH,	
		60%	Conduct research on correct and consistent use of female and male condoms. This information will be useful if disaggregated by age and gender, and where possible by most at risk populations (MARP)	3.4.1 Develop a research protocol based on best practices	-	37,209	-	**37,209**	**1**	**37,209**				NAC, MOH,	
			Conduct research on correct and consistent use of female and male condoms. This information will be useful if disaggregated by age and gender, and where possible by most at risk populations (MARP)	3.4.2 Identify and train research assistants	-	110,250	-	**110,250**	**450**	**245**				NAC, MOH,	
			Conduct research on correct and consistent use of female and male condoms. This information will be useful if disaggregated by age and gender, and where possible by most at risk populations (MARP)	3.4.3 Conduct the research - collect, analyse and disseminate and information		1,567,316		**1,567,316**	**1**	**1,567,316**				NAC, MOH,	
SDA HRH				HRH	2,780,555	2,780,555	2,780,555	**8,341,665**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*	NAC, MOH,	
SDA Infrastructure				Infrastructure	116,816	116,816	116,816	**350,448**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastruct ure**	*	*	*	NAC, MOH,	
TOTAL CONDOM AND MARKETING SDA COST					**14,551,504**	**14,741,250**	**13,517,387**	**42,810,142**							

3.1.4 - Male Circumcision (MC)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Implementation period Y 1	Y2	Y3	Lead agency	Collaborating partners
[OC6] Men aged 15 years who are circumcised and had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse.	**[OP17]** Male aged 15-49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015.	30% [150,000]	Increase availability and accessibility of male circumcision services with priority focus with low MC and high HIV prevalence	4.1.1 Identify and refurbish potential MC sites	9,450	2,860,161		2,869,611	519	5,529	*	*	*	MOH,	
				4.1.2 Launch Mobile MC service delivery units	1,509,047	1,509,047	-	3,018,094	37	81,570			*	MOH	
				4.1.3 Develop and train on a minimum package for Male circumcision (see narrative section)	660,727		-	660,727	2,500	264	*	*	*	MOH, PEPFAR, CDC	UNFPA, WHO
				4.1.4 Procure male circumcision kits	-	18,218,357	-	18,218,357	1,235,143	15	*	*	*	MOH, CHAZ,	PEPFAR, UNFPA
				4.1.5 Provide drugs for pain management for circumcised men	525,000	551,250	578,813	1,655,063	331,013	5	*	*	*	MOH,	
				4.1.6 Mobilise neonatal parents on MC and encourage them to have infants circumcised	19,663	20,646	21,678	61,987	438 trained nurses	142	*	*	*	MOH, CHAZ,	ZNAN, NZP+,
				4.1.7 Provide post circumcision counselling on post operative care including HIV prevention information	378,000	396,900	416,745	1,191,645	90000 jobaids	13	*	*	*	MOH,	Civil society organisations
			Develop a Male Circumcision communication strategy	4.2.1 Develop, produce and disseminate accurate and comprehensive information on MC	18,900	19,845	20,837	59,582	3000 copies	20	*	*	*	MOH, CDC	PEPFAR, GFATM
				4.2.2 Conduct community mobilisation to generate demand for MC country wide	540,027	567,028	595,380	1,702,435	292	5,830	*	*	*	NAC, MOH,	
			Strengthen the skills and Knowledge (quality) of MC services providers	4.3.1 Train(1200) MC service providers (doctors, medical licentiate, clinical officers etc)	1,105,854	1,157,839	1,215,731	3,479,423	1,200	2,900	*	*		NAC, MOH,	
				4.3.2 Incorporate male circumcision training in pre-service training of health professionals (doctors, nurses, clinical officers etc)	163,402			163,402	5000 printed curriculums	33	*	*	*	NAC, MOH,	
				4.3.3 Assess and certify MC service providers	292,268	306,881	322,226	921,375	540 sites	1,706	*	*	*	NAC, MOH,	
			Increase the number of HIV negative males including Neo neonates accessing safe male circumcision services	4.4.1 Provide voluntary counselling and testing for HIV and STIs for males seeking circumcision	-	-	-	Costed under HCT	-	-	*	*	*		
				4.4.2 Distribute male condoms to all men seeking male circumcision	-	-	-	Costed under Condoms	-	-	*	*	*		
			Strengthen Collaboration with Traditional male circumcisers	4.5.1 Train traditional male circumcisers on safe surgical techniques	139,963	146,962	154,310	441,235	3,650	121	*	*		Ministry of health and Traditional Circumcisers Association (?)	

Zambia National Operational Plan (NOP) for NASF 2011-2013

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.4 - Male Circumcision (MC)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
				4.5.2 Develop a memorandum of understanding on how the collaboration between health facilities and traditional male circumcisers will be managed	9,450	-	-	9,450	1	9,450	*	*		NAC, MOH,	
				4.5.3 Mobilise and engage traditional leaders to support safe surgical male circumcision	401,701	421,786	442,876	1,266,363	876	1,446	*	*	*	NAC, MOH,	
			Conduct operational research on male circumcision in Zambia	4.6.1 Conduct Research on risk compensation and behavioural research, healing and keratinisation	50,420			50,420				*	*	NAC, MOH,	
	[OP18] Between 2011 and 2015 at least 50% of all infants born in a health facility are circumcised in the first week of life	25%	Strengthen capacity for neonatal circumcisions	4.7.1 Provide appropriate equipment to health facilities with maternity services with neonatal circumcisions	1,858,500	1,951,425	2,048,996	5,858,921	9	650,991	*	*	*	NAC, MOH,	
				4.7.2 Implement task shifting for MC to enable qualified nurses to conduct neonatal circumcisions	1,111,876	1,167,470	-	2,279,347	146	15,612	*	*	*	NAC, MOH,	
				4.7.3 Sensitise parents on neonatal circumcisions	840,000	882,000	926,100	1,324,050	300,000	4	*	*	*	NAC, MOH,	
SDA HRH				HRH	3,342,427	3,342,427	3,342,427	10,027,280	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
SDA Infrastructure				Infrastructure	1,168,160	1,168,160	1,168,160	3,504,480	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructure	*	*	*		
TOTAL MALE CIRCUMCISION SDA COST					**14,144,835**	**34,688,184**	**11,254,277**	**58,763,246**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.5 - Prevention of Mother To Child Transmission (PMTCT)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC8] Infants born to HIV-infected mothers who are infected reduced from 7% in 2009 to 5% in 2013 and to less than 2% by 2015	[OP21] Women who were counselled during the ANC for their most recent pregnancy, and who were offered and accepted an HIV test and received their test results in the last twelve months increased from 67% in 2009 to 80% in 2013 and 95% by 2015	80%	Mobilise communities to participate in the PMTC programme	5.1.1 Roll out PMTCT services in more health facilities including maternal, newborn, and child health care settings	958,125	1,006,031	1,056,333	**3,020,489**	**37**	**81,635**	*	*	*	MOH, PEPFAR, NAC	
				5.1.2 Produce and disseminate information and educational awareness materials on PMTCT	799,572	1,434,900	1,506,645	**3,741,118**	**380,000**	**10**	*	*	*	MOH, NAC	JFA, ZPCT, CIDRZ, HCP
				5.1.3 Strengthen health facilities to provide "provider initiated counselling and testing for PMTCT	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	MOH, CDC, PEPFAR	GFATM
	[OP22] Women aged 15-49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015	41%	Integrate family planning education and strategies with PMTCT services	5.2.1 Provide sexual and reproductive health information in all PMTCT clinics	1,773,272	1,861,935	-	**3,635,207**	**2,600**	**1,398**	*	*	*	MOH, CDC	CDC, SHARe,JHPIEGO,CIDRZ, JFA,
				5.2.2 Conduct advocacy with opinion leaders at community level to increase the number of health facility based deliveries	360,018	378,019	396,920	**1,134,957**	**292**	**3,887**	*	*	*	NAC (DATF, PATF), MOH	CDC, SHARe,JHPIEGO,CIDRZ, JFA,
	[OP23] HIV-infected pregnant women who received Antiretrovirals to reduce the risk of mother-to-child transmission has increased from 61% (47175/79498) in 2009 to 85% (72828/85708)in 2013 and 95% (85655/90163) by 2015	85% (72,828)	Strengthen the national capacity for virtual elimination of MTCT of Hive	5.3.1 Review and update national guidelines, training materials and Job aids to ensure harmonised and accelerated implementation of PMTCT for virtual elimination	14,175	-	-	**14,175**	**45**	**315**	*	*		MOH, CDC, PEPFAR	CHAZ, WHO
				5.3.2 Conduct annual networking meetings between MOH, NAC, and cooperating partners to ensure harmonisation of strategies for virtual elimination of MTCT.	-	22,221	23,332	**45,553**	**2**	**22,777**				MOH, NAC, UNAIDS	All partners
				5.3.3 Improve quality assurance through supervision (quarterly facility visits) and on going training of service providers	418,077	438,981	460,930	**1,317,988**	**73**	**18,055**	*	*	*	MOH, PEPFAR	NAC, WHO
				5.3.4 Strengthen the tracking system of mother baby pairs in all districts	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	MOH, CDC	PEFPAR, GFATM
				5.3.5 Provide ART to HIV infected pregnant women and infants once diagnosed	-	-	-	**Costed under ART**	**-**	**-**	*	*	*	MOH,CHAZ,	CDC, PEPFAR
				5.3.6 Procure drugs and related commodities for PMTCT	-	-	-	**Costed under ART**		**-**	*		*	MOH	CDC, SHARe,JHPIEGO,CIDRZ,

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.5 - Prevention of Mother To Child Transmission (PMTCT)			**Strategies**	**Activities**	**Cost for year One**	**Cost for year Two**	**Cost for year Three**	**Total Cost**	**Target**	**Unit Cost**					
				5.3.7 Strengthen the supply management system for the provision of commodities and equipment for comprehensive services (e.g. PMTC, SRH, FP, Nutrition, and paediatric HIV)	-	-	-	**Costed under ART**		**-**	*	*		MOH, NAC	CDC, PEPFAR, GFATM
				5.3.8 Train health workers on PMTCT	141,987	149,086	156,541	**447,614**	**584**	**766**	*	*	*	MOH, PEPFAR, CDC	WHO
				5.3.9 Implement the "task shifting" to allow nurses provide some services to increase coverage	851,921	894,517	939,243	**2,685,682**	**3,504**	**766**	*	*	*	NAC, MOH	
				5.3.10 Provide community based nutrition counselling to parents	253,900	266,595	279,925	**800,419**	**20,000**	**40**	*	*	*	MOH	DAFT, PATF, District Health Teams
	[OP24] HIV positive mothers, who have received care at home /community increased to 75% in 2013 and to 100% by 2015	75%	Strengthen and Expand home and community based care and support for PLHIV	5.4.1 Train home based care volunteers on PMTCT	141,500	148,576	156,004	**446,080**	**36,000**	**12**	*	*	*	MOH,	ZNAN,
				5.4.2 Train health serrvice providers (including Traditional Birth Attendants) on PMTCT	61,300	64,365	67,584	**193,249**	**365**	**529**			*	MOH	CDC, SHARe,JHPIE GO,CIDRZ, JFA,
				5.4.3 Implement stigma reduction interventions (develop stigma reduction IEC materials - posters and pamphlets / organise workplace talks)	600,009	1,197,038	1,256,890	**3,053,936**	**300,000**	**10**	*	*	*	NAC, MOH	ALL Stakeholders
				5.4.4 Strengthen infant feeding and nutrition counselling and support for women, their children and families	576,029	831,641	873,224	**2,280,894**	**30,000**	**76**	*	*	*	MOH, CHAZ,	
				5.4.5 Strengthen the referral system and train services providers on its application	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	NAC, MOH	
	[OP25] Male participation in PMTCT programming increased to 50% (equivalent of 50% of women on PMTCT) by 2013 and 80% by 2015.	50%	Strengthen male involvement in PMTCT interventions	5.5.2 Provide couple counselling and testing services for PMTCT	420,000	441,000	463,050	**1,324,050**	**300,000**	**4**	*	*	*	MOH	CARE Int'l. JFA. CIDRZ, CDC, SHARe, JFA
				5.5.3 Develop and implement male involvement interventions (at community and health facility levels) including developing and producing male targeted IEC materials	194,517	204,243	214,455	**613,215**	**438**	**1,400**	*	*	*	MOH, CHAZ,	PEPFAR, ZNAN, NZP+
				5.5.4 Strengthen referral system to ART services for both women and men who test HIV positive	100,026	105,027	110,278	**315,331**	**219**	**1,440**	*	*	*	MOH, NAC	UNFPA, ZNAN, Zambia Police, UN, USG, Zambia Defence Force

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.5 - Prevention of Mother To Child Transmission (PMTCT)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
	[OP26] Infants born to HIV-infected Female (HIV-exposed infants) receiving ARV prophylaxis to reduce the risk for MTCT has increased from 62% (21050/36215) in 2009 to 50% (31110,39469) in 2013 and 95% 36140/38042)by 2015	50%	Strengthen early infant / child diagnosis and treatment of HIV	5.6.1 Strengthen and scale up the capacity for health facilities to collect DBS specimens for HIV PCR DNA	245,201	652,398	665,271	**1,562,870**	**292**	**5,352**	*	*	*		
		50% (31,110)	Strengthen early infant / child diagnosis and treatment of HIV	5.7.1 Train health facility staff in DBS specimen collection	-	41,968	44,066	**86,034**	**400**	**215**				MOH,	
	[OP27] Infants born to HIV-infected Female started on Cotrimoxazole prophylaxis within the last two months of birth has increased from 34% in 2009 to 50% by 2013 and to 100% by 2015	50%	Strengthen early infant / child diagnosis and treatment of HIV	5.8.1 Procure and distribute cotrimoxazole to health facilities	-	-	-	**Cost under ART**	**-**	**-**		*		MOH, PEPFAR, CDC	WHO,
				5.8.2 Provide supportive counselling for parents	126,000	132,300	138,915	**397,215**	**90,000**	**4**		*	*	MOH	CDC, SHARe,JHPIE GO,CIDRZ, JFA,ZPCT,CHA Z, Care Int'l.
				5.8.3 Strengthen health systems to support expansion of PMTCT services to community level	-	2,414,475	2,535,199	**4,949,674**	**876**	**5,650**		*	*	MOH,	Community Based Organisations , CHBC volunteers
SDA HRH				HRH	12,290,487	12,290,487	12,290,487	**36,871,460**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**		*	*	MOH,	Community Based Organisations , CHBC volunteers
SDA Infrastructure				Infrastructure	1,168,160	1,168,160	1,168,160	**3,504,480**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL PMTCT SDA COST					**22,077,827**	**26,756,692**	**25,446,816**	**74,281,335**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
3.1.6 PLHIV – Promoting Positive Health Dignity and HIV Prevention			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
[OC09] PLHIV aged15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased t o X% by 2015	**[OP29]** People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards		Strengthen the involvement of PLHIV in accelerating universal access to HIV and AIDS services	6.1.1 Train PLHIV groups and other community based organisations on outreach activities targeting PLHIV	540,027	567,028	595,380	1,702,435	438	3,887	*	*	*	NZP+, ZNAN, NAC	MOH, UNAIDS
				6.1.2 Develop and implement health facility based innovative strategies for engaging PLHIV	389,034	408,486	428,910	1,226,431	438	2,800	*	*	*	MOH, NAC	NZP+, ZNAN, NAC
				6.1.3 Develop a minimum package for HIV prevention involving PLHIV	389,034	408,486	428,910	1,226,431	438	2,800	*	*	*	NAC, NZP+, ZNAN, MOH	WHO, UNAIDS,
				6.1.4 Develop and development social and behaviour change materials on "prevention with the positives"	-	-	-	Costed under social behaviour	Costed under social behaviour	Costed under social behavio ur		*	*	UNAIDS, NAC	MOH, CARE Int'l. JFA. CIDRZ, CDC, SHARe, JFA, NZP+, ZNAN,MOH
				6.1.5 Build the capacity of support groups to coordinate community based PLHIV targeted interventions	-	-	-	Costed under OVC	Costed under OVC	Costed under OVC	*	*	*	NAC, UNAIDS	MOH, PEPFAR, CDC, GFATM
[OC10] PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015	**[OP30]** Females and males who received counseling and testing services for HIV and received their test results		See activities: 3.1.2.2 ; 3.1.2.5; 3.1.2.6 under HCT	See activities: 3.1.2.2.1 -3; 3.1.2.5.1 & 2; 3.1.2.6.1 &2 under HCT	-	-	-	Costed under relevant Activities	Costed under relevant Activities	Costed under relevant Activitie s	*	*	*		
TOTAL PLHIV SDA COST															

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.7 - Post Exposure Prophylaxis			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC11] People who report that they have accidentally or forcibly been exposed and therefore in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)	[OP33] Reported needle prick injuries in health facilities has reduced from 6.7% in 2008 in 4% by 2013 and to less than 2 % by 2015	4 %	Scale up provision of PEP to all health facilities and in providing those offering ART and PMTCT	7.1.1 Procure and distribute PEP kits	9,450,000	9,922,500	10,418,625	**29,791,125**	**1,500,000**	**20**	*	*	*	MOHA	JHPIEGO
				7.1.2 Train health workers on universal precautions and safe injection practices	693,456	728,129	764,536	**2,186,121**	**760**	**2,876**		*		MOHA	JHPIEGO
				7.1.3 Review, reprint and distribute PEP guidelines to services providers	24,150	25,358	26,625	**76,133**	**5,000**	**15**	*	*		MOH, PEPFAR	
				7.1.4 Train peer educators / Counsellors at the workplace on PEP procedures	223,281	234,445	246,167	**703,892**	**8,760**	**80**		*	*	MOH	
			Increased uptake of PEP services by survivors of sexual and gender-based violence through education and awareness.	7.2.1 Conduct community outreach to create awareness of PEP	540,027	567,028	595,380	**1,702,435**	**438**	**3,887**	*	*	*	JHPIEGO	
				7.2.2 Provide PEP for health care workers and victims of sexual abuse.	189,000	198,450	208,373	**595,823**	**36,000**	**17**	*	*	*	MOH, CDC	
			Strengthened capacity of service providers, including Health professionals, Law enforcement agencies, and the judiciary) in the management of SGBV survivors, and for effective response to cases of GBV respectively	7.3.1 Train health workers, police and communities on how to deal with survivors of sexual abuse include rape and procedures for accessing PEP	1,260,103	1,368,610	1,389,263	**4,017,976**	**758**	**5,301**	*	*	*	MOHA	
				7.3.2 Integrate training on the management of victims o f GBV training into pre-ervice training	1,305,013	1,370,263	1,438,777	**4,114,053**	**758**	**5,428**	*	*	*	MOH,GIDD	
				7.4.1 Train health workers on universal precautions and safe injection practices	1,067,987	1,121,386	1,177,455	**3,366,828**	**219**	**15,374**	*	*	*	MOH,GIDD	
				7.4.2 Develop and disseminate educational materials on universal precautions in health setting	78,750	82,688	86,822	**248,259**	**5,000**	**50**		*	*	MOH	WHO,PEPFAR, GF,CDC,
SDA HRH				HRH	4,021,570	4,021,570	4,021,570	**12,064,710**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure				Infrastructure	350,448	350,448	350,448	**1,051,344**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL PEP SDA COST					**20,521,880**	**21,374,874**	**22,177,240**	**64,073,994**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.1.7 - Sexually Transmitted Infections (STI)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC12]: Females and males who reported receiving treatment for an STI in the past 12 months has reduced for females from X in 2010 to X in 2013 and to X in 2015 and for males from X% 2010 to X in 2013 and X in 2015	**[OP35]** Health facilities offering comprehensive STI treatment and integrate HTC and referral for treatment increased to 100% and remains at the same level by 2015		Strengthen health systems to provide comprehensive STI services.	8.1.1 Train health workers on syndromic management of STIs	1,267,184	1,330,543	1,397,070	3,994,797	36,390	110		*	*	MOH;WHO	SFH;HCP; UN;JHPIEGO,UTH,CIDRZ
				8.1.2 Procure STI commodities: drugs and test kits	4,037,759	4,325,871	4,060,294	12,423,924	20	613,500		*	*	MOH	NAC;WHO,GF,COH
				8.1.3 Integrate STI services with HIV Interventions in particular, HCT, Male circumcisions, and PMTCT	389,034	408,486	428,910	1,226,431	876	1,400	*	*	*	MOH	CDC,WHO
				8.1.4 Refer uncircumcised men seeking STI treatment for male circumcision	-	-	-	Costed under MC	Costed under MC	Costed under MC	*	*	*	Health facilities and Traditional healers	WHO,
				8.1.5 Provide condoms and condom education at all STI clinics	-	-	-	Costed under Codoms	Costed under Codoms	Costed under Codoms	*	*	*	NAC, MOH	COH;GF.
				8.1.6 Offer STI counselling, diagnosis and treatment to STI patients	-	-	-	Costed under HCT	Costed under HCT	Costed under HCT	*	*	*	MOH	
			Conduct microbiological surveillance for STI	8.2.1 Conduct a microbiloigical surveillanceof STI in Zambia every two years	225,209	1,972,061	248,293	2,445,562	2	1,222,781				NAC, MOH	WHO,
				8.2.2 Review current surveillance protocol and update it	35,315	37,080	38,934	111,329	1	111,329	*			NAC, MOH	WHO,
			Develop and implement a National STI Social and Behaviour Change and Communication Strategy	8.3.1 Develop, produce and distribute IEC materials on STIs	1,048,950	1,101,398	1,156,467	3,306,815	720,000	5	*	*		MOH	SFH;HCP; UN;JHPIEGO,UTH,CIDRZ
				8.3.2 Conduct school based educational outreach on STIs	1,088,173	1,147,542	1,199,710	3,435,425	2,580	1,332	*	*	*	MOH	SFH;HCP; UN;JHPIEGO,UTH,CIDRZ
				8.3.3 Organise community outreach involving civil society organisations on STI prevention and early treatment	202,830	212,972	223,620	639,422	438	1,460	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				8.3.4 Organise workshops on STI targeted to most at risk populations	505,705	530,990	557,539	1,594,233	540	2,952	*	*	*	NAC, MOH	NAC,MOH,GF, COH
SDA Infrastructure				HRH	3,479,734	3,479,734	3,479,734	10,439,202	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
				Infrastructure	467,264	467,264	467,264	1,401,792	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructure	*	*	*		
TOTAL STI SDA COST					12,747,156	15,013,940	13,257,837	41,018,932							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
3.1.8 -Blood screening			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
[OC13] Equity of access to safe, adequate and cost effective blood and blood products attained.	[OP36] National annual targets for blood collections met, and 100% of donated blood tested for HIV and other Transfusion Transmissible Infections (TTIs), in accordance with the national guidelines.	130,000 units in 2013 (from baseline of 104,000 in 2009)	1. Scale up blood collections towards meeting national blood needs.	1.1. Scale up mobilisation of communities, and recruitment of voluntary non-remunerated blood donors.	202,650	157,658	165,540	525,848	450,000	1.2				ZNBTS/MOH	MOH,WHO
				1.2. Strengthen blood donor management and retention.	491,505	516,080	541,884	1,549,470	126,000	12	*	*	*	ZNBTS/USG	MOH,WHO
				1.3. Scale up mobile outreach blood collection activities.	1,113,420	557,865	585,758	2,257,043	46	49,165	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
		100%	2. Mandatory laboratory screening (100%) of blood for HIV and other TTIs.	2.1. Strengthen and expand laboratory capacities at provincial blood transfusion centres, to cope with projected increases in blood collections.	915,810	961,601	171,907	2,049,318	11	179,700	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
				2.2. Ensure adherence to GMP and GLP standards at all laboratories at the provincial transfusion centres.	770,000	808,500	848,925	2,427,425	8	314,285	*	*	*	ZNBTS/USG	GRZ;JFA,PEPFAR
			3. Promotion of appropriate and rational clinical use of blood and blood products.	3.1. Review and update the National Guidelines on Appropriate and Rational Clinical use of blood and blood products.	72,450	55,125	57,881	185,456	1,000	185	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
				3.2. Establish hospital blood transfusion committees throughout the country.	28,560	29,988	31,487	90,035	51	1,765	*		*	ZNBTS	GRZ;JFA; PEPFAR
			4. Strengthen blood safety commodity security	4.1. Ensure availability of adequate blood safety commodities.	2,370,092	2,488,596	2,613,026	7,471,713	860,000	9	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WH
			5. Strengthen quality assurance.	5.1. Periodically review the capacity of blood transfusion centres/ laboratories to ensure quality.	43,138	45,294	47,559	135,991	26 field trips	5,230	*	*	*	ZNBTS	MOH/MOE
			6. Strengthen training in blood safety and capacity building.	6.1. Training of blood donor services staff.	6,195	6,505	6,830	19,530	60 training	325	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
				6.2. Training of laboratory services staff.	6,195	6,505	6,830	19,530	61 training	325	*	*	*	ZNBTS	MOH/MOE
				6.3. Training of clinicians	10,369	10,887	11,432	32,687	75 tarining	436	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,
			7. Strengthen national coordination of the blood transfusion system, in accordance with WHO guidelines.	7.1. Strengthen policy and legislation for blood safety.	37,170	39,029	40,980	117,178	3	39,059	*	*	*	ZNBTS	MOH/MOE
				7.2. Strengthen Administrative, financial, operational and M&E systems.	2,379,332	2,321,898	2,437,993	7,139,223	50	142,784	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
			8. Strengthening critical linkages with other HIV prevention, treatment, care and support programmes.	8.1. Establish formal referal systems with HIV Testing/ART Centres, and MC programmes fo synergistic and mutual benefits.	26,009	8,820	9,261	44,090	4	11,022				ZNBTS	MOH/MOE
SDA HRH				HRH	3,018,522	3,018,522	3,018,522	9,055,567	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
SDA Infrastructure				Infrastructure	876,120	876,120	876,120	2,628,360	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructure	*	*	*	ZNBTS/MOH	GRZ,JFA,PEPFAR,CDC,WHO
TOTAL BLOOD SCREENING SDA COST					12,367,535	11,908,992	11,471,937	35,748,464							

3.2. TREATMENT

Zambia National Operational Plan (NOP) for NASF 2011-2013

3.2.1 - Antiretroviral Therapy (ART)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Implementation period Y 1	Y2	Y3	Lead agency	Collaborating partners
[OC14] Adults PLHIV (15 and older, and children (0-14) with HIV who still alive at 12 months after the initiation of ART is increased for adults from X% in 2010 to X% in 2013 and to X% in 2015; and from X% in 2010 to X% in 2013 and to X% by 2015 for children	**[OP37]** PLHIV who know their HIV status is increased to 50% by 2013 and to 75% by 2015	50%	Scale up the provision of HCT service	1.1.1 Mobilise communities to take HCT	2,620,434	2,751,456	2,889,028	**8,260,918**	**3,780**	**2,185**	*	*	*		
				1.1.2 Strengthen the capacity for "provider initiated counselling and testing	246,881	1,499,538	272,187	**2,018,606**	**15**	**134,574**	*	*	*	MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				1.1.3 Strengthen referral system	168,322	5,462,408	5,684,294	**11,315,024**	**800**	**14,144**	*	*	*	MOH	NAC;WHO,GF,COH
	[OP38] Adults enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to 2015	100%	Provide CTX for adults and children who meet the national ART guidelines criteria	1.2.1 Provide CTX for adults and children in accordance with national guidelines	1,757,700	1,845,585	1,937,864	**5,541,149**	**1,050,000**	**5**	*	*	*	MOH	CDC,WHO
				1.2.2 Train health worker and ART service providers on CTX treatment literacy	1,202,686	1,262,820	1,325,961	**3,791,467**	**6,570**	**577**	*	*	*	Health facilities and Traditional healers	WHO,
				1.2.3 Recruit and train PLHIV as peer educators to support community based CTX treatment literacy	332,893	349,538	367,015	**1,049,446**	**2,700**	**389**	*	*	*	NAC, MOH	COH;GF.
				1.2.4 Develop Mass media (radio) programme for CTX literacy using community conversations	2,020,200	2,121,210	2,227,271	**6,368,681**	**7,696**	**828**	*	*	*	MOH	
				1.2.5 Conduct a study to establish the impact of CTX adherence interventions	1,645,682	-	-	**1,645,682**	**1**	**1,645,682**				NAC, MOH	WHO,
	[OP39] Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to 2015			1.2.6 Provide nutrition for malnourished PLHIV, children and infants	-	-	-	**Costed Under OVC**		**-**	*	*	*	NAC, MOH	WHO,
				1.2.7 Increase parent/guardian awareness on importance of CTX	540,027	567,028	595,380	**1,702,435**	**45,000**	**38**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
	[OP40] Female and Male with advanced HIV infection receiving ART has increased from 68% in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015	87% (420,415)	Provide ART for adults and children who meet the national ART guidelines criteria	1.3.1 Identify and certify additional ART service centres	225,945	269,942	283,439	**779,326**	**450**	**1,732**				MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ, JICA
				1.3.2 Assess all PLHIV in need of ART	28,350	-	-	**28,350**	**1**	**28,350**	*	*	*	NAC, MOH	NAC,MOH,GF, COH, JICA

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.2.1 - Antiretroviral Therapy (ART)			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
				1.3.3 Procure ARV diagnostics for eligible adults and children	6,298,461	6,613,384	6,944,053	19,855,898	1,000,000	20	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				1.3.4 Accelerate the use of SMART card technology for PLHIV enrolled on ART	17,772	18,660	19,593	56,025	6	9,338	*	*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				1.3.5 Train health personnel on the use of SMART card technology	648,664	681,098	715,153	2,044,915	8,760	233	*	*	*	MOH	NAC;WHO,GF,COH
	[OP41] Children (aged 0-14) eligible for ART receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015	87% (420,415)	Provide ART for adults and children who meet the national ART guidelines criteria	1.3.6 Offer polymerase chain reaction (PCR) testing for children as per national guidelines	29,715	31,201	32,761	93,676	30,000	3	*	*	*	MOH	CDC,WHO, JICA
				1.3.7 Train more health staff in paediatric ART management	621,016	652,067	684,671	1,957,754	1,200	1,631	*	*	*	Health facilities and Traditional healers	WHO, JICA
				1.3.8 Scale up access to paediatric ART	37,742	39,630	41,611	118,983	60	1,983	*	*	*	NAC, MOH	COH;GF, JICA
				1.3.9 Mobilise parents to enrol their children for paediatric ART	540,027	567,028	595,380	1,702,435	45,000	38	*	*		MOH	JICA
	[OP42] Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015	400 Health facilities	Create an enabling legal and policy environment for rapid ART scale up countrywide	1.4.1 Review and update the National HIV/AIDS/STI/TB policy	37,064	-	-	37,064	1	37,064	*	*		NAC, MOH	WHO,

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
3.2.1 - Antiretroviral Therapy (ART)	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
		1.4.2 Update the ART protocol and guidelines	-	-	40,863	**40,863**	**1**	**40,863**	*	*	*	NAC, MOH	WHO,
		1.4.3 Strengthen and consolidate the public private partnership to accelerate and expand the provision of ART by different stakeholders	128,836	135,278	142,042	**406,157**	**36**	**11,282**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO, UTH,CIDRZ
	Strengthen the health system - Monitoring and Evaluation systems including surveillance and operations research for HIV care and ART Services	1.4.4 Develop an efficient monitoring and reporting system in line with the national M&E system.	264,957	286,582	281,697	**833,236**	**767**	**1,086**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO, UTH,CIDRZ, JICA
	Strengthen the health system to support effective delivery of ART services	1.5.1 Increase the number of health facilities dispensing ART to 400 sites	8,714	-	-	**8,714**	**1**	**8,714**	*	*	*	NAC, MOH	NAC,MOH, GF, COH
		1.5.2 Renovate and equip health facilities (Infrastructure, laboratories, pharmacies etc) to provide comprehensive, integrated and quality HIV services	1,014,650	2,014,415	2,115,135	**5,144,200**	**73**	**70,468**	*	*	*	NAC, MOH	NAC,MOH, GF, COH, JICA
		1.5.3 Integrated patient tracking system for HIV, TB and Hepatitis B.	159,053	167,005	175,356	**501,414**	**219**	**2,290**	*	*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO, UTH,CIDRZ
		1.5.4 Integrated patient tracking system for TB and AIDS patients.	34,857	36,599	38,429	**109,885**	**36**	**3,052**	*	*	*	MOH	NAC;WHO, GF,COH, JICA

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
3.2.1 - Antiretroviral Therapy (ART)	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
		1.10.1 Train officers in drug/commodity logistics	96,627	101,459	106,532	304,618	27	11,282	*	*	*	NAC, MOH	NAC,MOH, GF, COH
	Strengthen the Drug procurement and supply chain management systems	1.10.2 Improve the storage capacity for hospitals and health facilities for ART and other commodities	1,575,000	1,653,750	1,736,438	4,965,188	300	16,551	*	*	*		
		1.10.3 Procure ARV for eligible adults and children	86,689,770	97,701,698	91,181,578	275,573,046	1,354,885	203	*	*	*		
	Strengthen the health system - Procurement, storage, distribution, and logistics for HIV care and ART Services	1.10.4 Procure and supply drugs for opportunistic infections	1,575,000	1,653,750	1,736,438	4,965,188	1,500,000	3	*	*	*		
		1.10.5 Procure and distribute food for ART patients in need for the first 6 months when they start ART	-	-	-	Costed Under OVC	-	-	*	*	*		
SDA HRH		HRH	14,649,431	14,649,431	14,649,431	43,948,293	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
SDA Infrastructure		Infrastructure	2,336,320	2,336,320	2,336,320	7,008,960	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructur e	*	*	*		
TOTAL ART SDA COST			**133,559,854**	**152,943,587**	**144,288,124**	**430,791,564**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.2.2 - Tuberculosis / HIV Co-infection			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC15] PLHIV with new smear-positive TB who have been success fully treated or cured increase d from 47% in 2010 and to 60% in 2013 and to 80% by 2015	**[OP43]** The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 47 % in 2009 to 60% 2013 and to 80% by 2015.	60%	Pursue quality DOTS and Strengthen the capacity of TB/HIV service delivery	Review and disseminate guidelines and tools for TB/HIV collaborative activities	20,504			**20,504**	**1**	**20,504**	*	*		MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				Advocate for Political commitment with increased and sustained financing	56,524	59,350	62,317	**178,191**	**10,000**	**18**			*	MOH	NAC;WHO,GF,COH
				Improve case detection through quality-assured bacteriology	1,428,000	-	-	**1,428,000**	**100**	**14,280**				MOH	CDC,WHO
				Standardize treatment, with Dinnervision and patient support	9,157			**9,157**	**3**	**3,052**	*	*	*	Health facilities and Traditional healers	WHO,
				Provide and sustain counselling and testing for patients presenting for HIV testing or TB diagnosis	1,108,228	1,163,639	1,221,821	**3,493,688**	**7,665**	**456**	*	*	*	NAC, MOH	COH;GF.
				Integrate TB diagnosis and HIV counselling testing services (one stop shop)	82,653	86,786	91,125	**260,564**	**27**	**9,651**	*	*	*	MOH	
			Scale up TB/HIV collaborative initiatives	Hold joint TB and HIV/AIDS management meetings at Health facilities	819	860	903	**2,582**	**52**	**50**	*	*	*	NAC, MOH	WHO,
				Exchange visits to share good practices	5,927	6,223	6,534	**18,683**	**365**	**51**	*	*	*	NAC, MOH	WHO,
		60%	Address emerging risks of Drug resistant TB	Prevent and control of multi-drug resistant TB	28,056	29,458	30,931	**88,445**	**1,000**	**88**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				Expedite the publication and dissemination of National Guidelines for Programmatic Management of Drug Resistant TB	99,050	104,002	109,202	**312,254**	**27**	**11,565**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				Address TB/HIV in prisons and high risk groups such as refugees	519,750	545,738	573,024	**1,638,512**	**30,000**	**55**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				laboratory staff at all levels on biosafety and infection control as well as packaging and transport of biological specimens.	778,732	817,669	858,552	**2,454,954**	**4,380**	**560**			*	NAC, MOH	NAC,MOH,GF, COH

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.2.2 - Tuberculosis / HIV Co-infection			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
			To provide comprehensive TB/HIV co-infection services	Capacity building of Staff in TB/HIV co-infection management	2,290,732	817,669	2,525,532	**5,633,934**	**13,140**	**429**	*	*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				Scale up IPT and the Three Is strategies to minimise the incidence of TB among HIV	-	-	4,631	**4,631**	**1**	**4,631**				MOH	NAC;WHO,GF,COH
				Strengthen TB case (passive and active) detection	2,529,759	2,656,247	2,789,059	**7,975,065**	**438**	**18,208**	*	*	*	MOH	CDC,WHO
	[OP44] HIV-positive TB patients who are started on ART has increased from 6595 in 2007to 15,000 in 2013 and to 20,000 in 2015.	15,000	Strengthen the capacity to increase the cure rate for TB significantly.	Provide CTX to PLHIV	250,387	276,052	304,347	**830,786**	**166,157**	**5**	*	*	*	Health facilities and Traditional healers	WHO,
			Strengthen the capacity to increase the cure rate for TB significantly.	Procure and distribute TB drugs to health facilities providing TB services	12,987,188	14,317,341	15,783,783	**43,088,311**	**450,000**	**96**	*	*	*	NAC, MOH	COH;GF.
			Strengthen the capacity to increase the cure rate for TB significantly.	Conduct program-based operational research	105,000			**105,000**	**1**	**105,000**	*	*	*	MOH	
			Enable and promote research	Strengthen TB/HIV support groups	10,408			**10,408**	**9**	**1,156**	*	*	*	NAC, MOH	WHO,
			Empower people with TB and communities	Community preparedness/participation in TB care	34,650	36,383	38,202	**109,234**	**146**	**748**	*	*	*	NAC, MOH	WHO,
			Empower people with TB and communities	Advocacy & Communication through social mobilization	9,604	10,084	10,588	**30,276**	**9**	**3,364**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
			Empower people with TB and communities	Strengthen community systems to support HIV and TB related care and support	33,805	35,495	37,270	**106,570**	**73**	**1,460**	*	*	*	MOH	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ

Zambia National Operational Plan (NOP) for NASF 2011-2013										Implementation period			Lead agency	Collaborating partners
										Y 1	Y2	Y3		
3.2.2 - Tuberculosis / HIV Co-infection			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost				
			Empower people with TB and communities	Implement Task Shifting and allow community health workers take on more role in the management of TB/HIV co-infection services	4,741	4,978	5,227	**14,947**	**3**	**4,982**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
SDA HRH				HRH	5,121,927	5,121,927	5,121,927	**15,365,781**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
SDA Infrastructure				Infrastructure	1,168,160	1,168,160	1,168,160	**3,504,480**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL TB/HIV SDA COST					**28,683,761**	**27,258,060**	**30,743,137**	**86,684,958**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
.2.3 - Community and Home Based Care (CHBC			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC16] Females and Males 18-59 yrs, who have been either very sick or who died within the past 12 months after being very ill, whose households received at least one type of free basic external support in the past 30 days increased from X % in 2010 to X% in 2013 and to X% by 2015	[OP45] People receiving palliative care increased from 157,712 in 2007 to 200,000 in 2013 and 250,000 in 2015	200,000	Develop a National Vulnerability Reduction strategy – that harmonises all the existing initiating including Coordination aspects	3.1.1 Undertake a comprehensive review of existing strategies and approaches for vulnerability reduction	9,450	-	-	9,450	1	9,450	*	*		MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				3.1.2 Compile and disseminate report to stakeholders to agree on the recommendations of the vulnerability survey	8,683	-	-	8,683	1	8,683		*	*	MOH	NAC;WHO,GF,COH
				3.1.3 Develop a National Vulnerability Reduction Strategy that harmonises all the existing initiating including Coordination aspects	-	3,410	-	3,410	1	3,410			*	MOH	CDC,WHO
				3.1.4 Conduct stakeholders orientation / and implement the National Vulnerability Reduction Strategy	-	9,117	-	9,117	1	9,117				Health facilities and Traditional healers	WHO,
				3.1.5 Review existing policy guidelines related to vulnerability and poverty reduction to mainstream strategies for household level movement towards self-reliance	9,450	-	10,419	19,869	1	19,869		*	*	NAC, MOH	COH;GF.
			Support the implementation of sustainable livelihoods.	3.2.1 Provide seed grants for vulnerable households to start and implement sustainable livelihood projects	4,411,642	4,632,225	4,863,836	13,907,703	30,000	464		*	*	MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
.2.3 - Community and Home Based Care (CHBC	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		3.2.2 Support vulnerable households in a community to set up a "revolving fund" that will help them reduce dependency on government and donor funding				Costed under OVC			*	*	*	NAC, MOH	WHO,
		3.2.3 Mainstream sustainable livelihood programmes with Ministries of Community Development, Agriculture, and Rural Development respectively	389,034	408,486	428,910	1,226,431	438	2,800	*	*	*	NAC, MOH	WHO,
	Train vulnerable households and communities in development and management skills relevant to sustainable livelihood	3.3.1 Train vulnerable households / communities in project management skills (planning and marketing etc)	-	-	-	Costed Under OVC	10,000	-	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.3.2 Train vulnerable households / communities in financial management skills	-	-	-	Costed Under OVC	20,000	-	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.3.3 Develop a mentorship programme drawing on resource persons in the community or with community based organisations	915,849	2,404,104	2,524,309	5,844,261	4,380	1,334	*	*	*	NAC, MOH	NAC,MOH,GF , COH
	Provide social protection for people made vulnerable from the effects of HIV and AIDS	3.4.1 Conduct a Quality of Impact Mitigation Survey (QUIMS)	105,000	-	105,000	105,000	1	105,000		*	*	NAC, MOH	NAC,MOH,GF , COH
		3.4.2 Provide cash transfers to senior citizens affected by Hive and AIDS	-	-	-	Costed Under OVC		-	*	*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
.2.3 - Community and Home Based Care (CHBC	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		3.4.3 Develop mechanisms to ensure equitable access to productive assets (land, equipment, credit and skills) by females and males	270,013	283,514	297,690	851,217	292	2,915	*	*	*		
		3.4.4 Support the amendment of Zambia labour laws to include access to social, health and welfare benefits by informal sector workers	30,613	-	-	30,613	3	10,204		*	*		
	Promote small scale sustainable community or households agricultural projects that will improve household food security.	3.5.1 Provide production inputs (seed packs, fertilisers, start up stock,				Costed Under OVC	10,000	-					
		3.5.2 Train households on backyard or community gardening skills	315,000	330,750	347,288	Costed Under OVC	14,600	#VALUE!	*	*	*		
SDA HRH		HRH	3,608,122	3,608,122	3,608,122	10,824,365	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
SDA Infrastructure		Infrastructure	233,632	233,632	233,632	700,896	Total Cost of SDA Infrastructu re	Total Cost of SDA Infrastruct ure	*	*	*		
TOTAL SDA COST			10,306,489	11,913,35 9	12,419,20 5	33,541,014							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
[3.3.2] Vulnerable Households and Individuals			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
[OC17] Females and males aged 15-59 who either have been very sick or who died within the last 12 months after being very sick, whose households received certain free basic external support to care for them within the last year increased from 41% in 2009 to 50% in 2013 and 60% by 2015	**[OP47]** Households with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015	10%	Develop a National Vulnerability Reduction Framework– that harmonises all the existing initiating including Coordination aspects	2.1.1 Undertake a comprehensive review of existing strategies and approaches for vulnerability reduction	9,930			**9,930**	**2**	**4,965**	*	*		MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				2.1.2 Compile and disseminate report to stakeholders to agree on the recommendations of the vulnerability survey	43,496			**43,496**	**1**	**43,496**			*	MOH	NAC;WHO,GF,COH
				2.1.3 Develop a National Vulnerability Reduction Strategy– that harmonises all the existing initiating including Coordination aspects	29,791			**29,791**	**2**	**14,896**			*	MOH	CDC,WHO
				2.1.4 Conduct stakeholders orientation / and implement the National Vulnerability Reduction Strategy	45,786			**45,786**	**2**	**22,893**			*	Health facilities and Traditional healers	WHO,
				2.1.5 Review existing policy guidelines related to vulnerability and poverty reduction to mainstream strategies for household level movement towards self-reliance	88,483	92,907	97,553	**278,943**	**27**	**10,331**				NAC, MOH	COH;GF.
			Support the implementation of sustainable livelihoods	2.2.1 Provide seed grants for vulnerable households to start and implement sustainable livelihood projects	315,000	330,750	347,288	**993,038**	**10,000**	**99**			*	MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
[3.3.2] Vulnerable Households and Individuals	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		2.2.2 Support vulnerable households in a community to set up a "revolving fund" that will help them reduce dependency on government and donor funding	255,500	268,275	281,689	**805,464**	**73**	**11,034**			*	NAC, MOH	WHO,
		2.2.3 Mainstream sustainable livelihood programmes with Ministries of Community Development, Agriculture, and Rural Development respectively	107,652	113,035	118,687	**339,374**	**24**	**14,141**				NAC, MOH	WHO,
	Train vulnerable households and communities in development and management skills relevant to sustainable livelihood	2.3.1 Train vulnerable households / communities in project management skills (planning and marketing etc)	2,269,867	953,344	2,502,529	**5,725,740**	**20,000**	**286**			*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		2.3.2 Train vulnerable households / communities in financial management skills TOT	129,500	135,975	142,774	**408,249**	**27**	**15,120**			*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		2.3.3 Develop a mentorship programme drawing on resource persons in the community or with community based organisations	540,027	567,028	595,380	**1,702,435**	**146**	**11,661**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
	Provide social protection for people made vulnerable from the effects of HIV and AIDS	2.4.1 Conduct a Quality of Impact Mitigation Survey (QUIMS)	1,645,682			**1,645,682**	**1**	**1,645,68 2**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
		2.4.2 Provide cash transfers to senior citizens affected by Hive and AIDS	18,900,000	19,845,00 0	20,837,25 0	**59,582,250**	**50,000**	**1,192**	*	*	*	MOH;WHO	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ

Zambia National Operational Plan (NOP) for NASF 2011-2013												Implementation period			Lead agency	Collaborating partners
												Y 1	Y2	Y3		
[3.3.2] Vulnerable Households and Individuals			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost						
				2.4.3 Develop mechanisms to ensure equitable access to productive assets (land, equipment, credit and skills) by females and males	202,830	212,972	223,620	639,422	292	2,190	*	*	*	MOH	NAC;WHO,GF,COH
				2.4.4 Support the amendment of Zambia labour laws to include access to social, health and welfare benefits by informal sector workers	389,034	408,486	428,910	1,226,431	54	22,712	*	*	*	MOH	CDC,WHO
			Promote small scale sustainable community or households agricultural projects that will improve household food security.	2.5.1 Provide production inputs (seed packs, fertilisers, start up stock,	6,300,000	6,615,000	6,945,750	19,860,750	100,000	199	*	*	*	Health facilities and Traditional healers	WHO,
		no baseline information (TBA)	Strengthen strategies to improve household food security	2.6.1 Conduct national assessment on households that are food insecure	1,666,845		1,837,697	3,504,542	2	1,752,271	*	*	*	NAC, MOH	COH;GF.
	[OP48] Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from X% in 2010 to X% in 2013 and to X% in 2015.	no baseline information (TBA)		2.6.2 Train communities and households on nutrition requirements for malnourished people	1,679,262	1,763,225	1,851,386	5,293,873	50,000	106	*	*	*	MOH	
		no baseline information (TBA)		2.6.3 Prioritise food assistance to food insecure households with chronically ill adults and children	63,000	66,150	69,458	198,608	4,000	50	*	*	*	NAC, MOH	WHO,

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
[3.3.2] Vulnerable Households and Individuals			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		no baseline information (TBA)		2.6.4 Provide nutrition supplement for PLHIV and OVC	223,281	234,445	246,167	703,892	10,000	70	*	*	*	NAC, MOH	WHO,
	[OP47] Households with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015	10%		2.6.5 Develop and disseminate nutritional education and awareness materials (preferably in local languages)	261,450	274,523	288,249	824,221	200,000	4	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
	[OP48] Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from X% in 2010 to X% in 2013 and to X% in 2015.	no baseline information (TBA)		2.6.6 Train households on backyard or community gardening skills	260,768	273,806	287,497	822,071	5,000	164	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
SDA HRH				HRH	4,907,208	4,907,208	4,907,208	14,721,624	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*	NAC, MOH	NAC,MOH,GF , COH
SDA Infrastructure				Infrastructure	584,080	584,080	584,080	1,752,240	Total Cost of SDA Infrastru cture	Total Cost of SDA Infrastru cture	*	*	*	NAC, MOH	NAC,MOH,GF , COH
TOTAL SDA COST					40,918,473	37,646,209	42,593,169	121,157,851							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
.3.3 - Orphans and Vulnerable Children (OVC)-			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC18] Male and female OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16% in 2009 to 25% in 2013 and to 40% by 2015	[OP49] A national framework for the protection, care and support of OVC developed		Develop a national plan of action for OVC that will guide and direct care and support interventions	3.1.1 Conduct a national survey on the situation of orphans and vulnerable children in Zambia	78,330	82,246	86,359	246,935	9	27,437	*	*		MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				3.1.2 Hold a stakeholders dissemination workshop of the situation analysis report - to consider the results	315	331	347	993	1	993			*	MOH	NAC;WHO,GF,COH
				3.1.3 Develop a National OVC Policy taking cognisance of the provisions in the National Child Policy	9,450	-	-	9,450	1	9,450			*	MOH	CDC,WHO
				3.1.4 Develop a National OVC Plan of Action and a Monitoring and Evaluation Plan	47,250	-	-	47,250	1	47,250			*	Health facilities and Traditional healers	WHO,
				3.1.5 Conduct OVC service providers orientation on the provisions of the National Operational Plan and the M&E plan	480,665	504,698	529,933	1,515,297	600	2,525	*	*	*	NAC, MOH	COH;GF.
			Develop a national database of OVC	3.2.1 Train OVC service providers in monitoring and evaluation of OVC, and the services being provided	87,007	91,357	95,925	274,290	18	15,238			*	MOH	
				3.2.2 Develop, print and distribute standardised tools for data capturing and reporting forms	16,284	17,098	17,953	51,334	2,000	26			*	NAC, MOH	WHO,
				3.2.3 Conduct a national conference on care and support of OVCs every two years - to share experiences and best practices	352,834	370,475	388,999	1,112,308	1	1,112,308				NAC, MOH	WHO,

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
.3.3 - Orphans and Vulnerable Children (OVC)-			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
	[OP50] Children under the age 18 years whose primary caregivers have made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28% in 2009 to 40% in 2013 and 60% by 2015	40%	Strengthen the capacity of primary caregivers to develop succession plans	3.3.1 Train and assist caregivers in writing and managing their "wills".	363,911	382,107	401,212	**1,147,231**	**50,000**	**23**			*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				3.3.2 Train caregivers in developing family or households records (inventory) on property and family trees etc.	1,581,562	1,207	1,268	**1,584,037**	**50,000**	**32**			*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				3.3.3 Support CBO to facilitate on-going family dialogue between the primary caregiver, immediate potential caregivers and the children in line with succession planning	202,830	212,972	223,620	**639,422**	**438**	**1,460**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				3.3.4 Ensure that all OVC have a birth certificate	1,260,446	529,669	556,152	**2,346,267**	**200,000**	**12**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
	[OP51] Orphans and vulnerable children under age 18 years whose household had not received any basic external support to care for the child in the last 12 months has decreased from 84% in 2007, to 50% in 2013 and 25% by 2015	50%	Improve access to health / medical care by OVC	3.4.1 Create awareness among OVC and caregivers on available health and medical care services from health facilities and community home based care	33,289	34,954	36,701	**104,945**	**2,190**	**48**	*	*	*	MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				3.4.2 Ensure regular medical check up including nutritional related of OVC by a health worker	15,005	15,756	16,543	**47,304**	**27**	**1,752**	*	*	*	MOH	NAC;WHO,GF,COH
				.3.5.1 Provide emotional and psychosocial support for OVC in and out of school.	602,918	633,064	664,717	**1,900,699**	**25,000**	**76**	*	*	*	MOH	CDC,WHO

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
.3.3 - Orphans and Vulnerable Children (OVC)-	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		3.5.2 Train teachers and caregivers in child counselling / other psychosocial services	16,538	17,364	18,233	52,134	3,600	14	*	*	*	Health facilities and Traditional healers	WHO,
		3.5.3 Monitor the conditions of OVC requiring or who have received psychosocial support and refer them to other services and support if need	121,275	127,339	8,682	257,296	2,500	103	*	*	*	NAC, MOH	COH;GF.
		3.5.4 Promote and support community-based care of OVCs and families looking after orphans	53,550	56,228	59,039	168,816	500	338	*	*	*	MOH	
		3.5.5 Create awareness of child abuse and exploitation among the OVC and the community in general and provide strategies to combat abuse and exploitation	768,289	806,704	847,039	2,422,032	219	11,060	*	*	*	NAC, MOH	WHO,
	Strengthen the capacity to provide emotional / psychosocial support for OVC and their caregivers	3.6.1Train caregivers in OVC support	648,664	681,098	715,153	2,044,915	50,000	41	*	*	*	NAC, MOH	WHO,
		3.6.2 Ensure all OVC have a shelter and a responsible caregiver	945,000	99,225	104,186	1,148,411	20,000	57	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.6.3 Provide nutritional support to OVC and child headed households	11,037,600	11,589,48 0	12,168,95 4	34,796,034	50,000	696	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.6.4 Train caregivers in legal aid	40,705	12,972	13,621	67,298	500	135			*	NAC, MOH	NAC,MOH,GF , COH

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
.3.3 - Orphans and Vulnerable Children (OVC)-	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		3.6.5 Provide recreation facilities for children including OVC in the community settings	132,681	139,315	146,281	**418,277**	**500**	**837**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
		3.6.6 Develop and disseminate a minimum package for social protection of OVC that would include among others protection from sexual abuse, exploitation, stigmatisation and discrimination	15,750	16,538	17,364	**49,652**	**4,000**	**12**	*	*	*	MOH;WH O	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.6.7 Strength Integration OVC and home-based care services	369,881	388,376	407,794	**1,166,051**	**438**	**2,662**	*	*	*	MOH	NAC;WHO,G F,COH
	Provide school related support for OVC	3.7.1 Provide educational grants for infrastructure and other educational supplies	12,600,000	13,230,00 0	13,891,50 0	**39,721,500**	**30,000**	**1,324**	*	*	*	MOH	CDC,WHO
		3.7.2 Provide awareness of the availability of bursaries to qualifying OVC (those who meet the criteria for bursaries)	202,830	212,972	223,620	**639,422**	**2,000**	**320**	*	*	*	Health facilities and Traditional healers	WHO,
		3.7.3 Provide lifeskills based HIV Education to OVC in and out of school	480,048	504,050	529,253	**1,513,350**	**219**	**6,910**	*	*	*	NAC, MOH	COH;GF.
		3.7.4 Provide hostels for OVC / other children in schools where the environment is not conducive for children to travel long distances - making them vulnerable to abuse	81,344	85,411	89,682	**256,437**	**20,000**	**13**	*	*	*	MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013										Implementation period			Lead agency	Collaborating partners
										Y 1	Y2	Y3		
.3.3 - Orphans and Vulnerable Children (OVC)-		Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
			3.7.5 Support school feeding programmes	1,050,000	1,102,500	1,157,625	**3,310,125**	**3,000**	**1,103**	*	*	*	NAC, MOH	WHO,
	[OP52] OVC aged 5-17 possessing three minimum basic material needs increased from 49% in 2007 to 60% in 2013 and to 85% in 2015	Conduct assessment of OVC in need of basic minimum materials (shoes, clothes and blanket)	3.8.1 Register all children in need of basic minimum materials	15,750	-	-	**15,750**	**1**	**15,750**	*	*	*	NAC, MOH	WHO,
			3.8.2 Provide shoes, clothing and blankets to OVC in need.	-	-	-	**-**		**-**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
	[OP53] Ration of orphans to non orphans attending school is improved 1:1 by 2013 and maintained at that level by 2015	Conduct a national survey of all school going age in the country	3.9.1 Enrol all OVC of school going age in schools	-	-	-	**-**		**-**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
			3.9.2 Provide school related support (see above)	-	-	-	**-**		**-**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
			3.9.3 Provide school bursaries	383,250	402,413	422,533	**1,208,196**	**30,000**	**40**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
			3.9.4 Monitor OVC performance in school to ensure retention and completion of learning	37,800	39,690	41,675	**119,165**	**876**	**136**	*	*	*		
SDA HRH			HRH	2,571,921	2,571,921	2,571,921	**7,715,762**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure			Infrastructure	350,448	350,448	350,448	**1,051,344**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL OVC SDA COST				37,055,421	35,309,976	36,804,332	**109,169,729**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
3.4.1 - Enabling Policy and Legal Environment			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
[OC19] Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened	[OP54] Social and legal protection of vulnerable people and most at risk populations is strengthened: % of national policies and legal instruments reviewed and incorporated human and legal rights.	45%	Advocate for a comprehensive review of national policies and legislation to mainstream HIV/AIDS, gender and human rights	1.1.1 Conduct research on stigma and discrimination prevalence in various social settings including workplace, communities, health facilities, home and schools etc	117,600	13,230	13,892	144,722	1	144,722	*	*		MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				1.1.2 Organise a stakeholders workshop to disseminate the results	18,409	-	-	18,409	1	18,409		*		MOH	NAC;WHO,GF,COH
				1.1.3 Conduct training on HIV/AIDS, gender and human rights mainstreaming	582,750	611,888	642,482	1,837,119	110	16,777		*	*	MOH	CDC,WHO
				1.1.4 Provide on-going technical assistance to sectors to incorporate HIV and AIDS, gender and human rights in their sectoral policies and legislation	319,683	335,667	352,450	1,007,800	2,220	454	*	*	*	Health facilities and Traditional healers	WHO,
			Address gender inequality, gender based violence and exploitation of women and the girl child.	1.2.1 Create public and community awareness of gender issues in HIV and AIDS response	677,726	711,613	747,193	2,136,532	500,000	4	*	*	*	NAC, MOH	COH;GF.
				1.2.2 Support the implementation of the Gender Based Violence Action plan	594,152	623,860	655,053	1,873,065	20	93,653	*	*	*	MOH	
			Advocate for accelerated implementation of the CRC and CEDAW.	1.3.1 Create awareness of provisions of CEDAW and CRC	15,505	16,280	17,094	48,879	100	489	*	*	*	NAC, MOH	WHO,
				1.3.2 Support community activities on the implementation of CEDAW and CRC	79,725	83,711	87,897	251,333	18	13,963	*	*	*	NAC, MOH	WHO,

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.1 - Enabling Policy and Legal Environment	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		1.3.3 Develop simple and user friendly awareness materials for learners on the provisions of CRC for distribution through schools and community based youth centres	33,600	35,280	37,044	**105,924**	**25,000**	**4**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
	Strengthen the capacity of political and community leaders in promoting and advocating for an enabling policy and legal environment	1.4.1 Train political and community leaders on HIV and AIDS issues with specific references to gender and human rights	132,717	139,353	146,320	**418,389**	**438**	**955**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
		1.4.2 Develop and distribute IEC materials on the linkages between gender, human rights and HIV/AIDS	35,000	36,750	38,588	**110,338**	**25,000**	**4**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
[OP55] Reduction stigma and discrimination: Female and Male aged 15-49 expressing accepting attitudes towards people living with HIV and AIDS increased from 34% in 2009 to 45% by 2013 and by 60% by 2015	Develop national guidelines on stigma and discrimination reduction / elimination	1.5.1 Conduct research on stigma and discrimination prevalence in various social settings including workplace, communities, health facilities, home and schools etc	1,658,282	-	-	**1,658,282**	**1**	**1,658,282**			*	NAC, MOH	NAC,MOH,GF, COH
		1.5.2 Create public awareness of on issues related to stigma and discrimination, and legal barriers that prevent most at risk populations accessing and utilising services adequately	57,750	16,538	17,364	**91,652**	**73**	**1,256**	*	*	*		
		30 - 1.5.3 Train leaders and policy makers on the management stigma and discrimination reduction strategies in society and workplace	778,732	817,669	858,552	**2,454,954**	**292**	**8,407**	*	*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.1 - Enabling Policy and Legal Environment	**Strategies**	**Activities**	**Cost for year One**	**Cost for year Two**	**Cost for year Three**	**Total Cost**	**Target**	**Unit Cost**					
		31 - 1.5.4 Support political and community leaders to organise and facilitate community meetings to discuss stigma and discrimination of PLHIV, OVC, MARPS and people affected by HIV/AIDS	221,929	233,025	244,677	**699,631**	**146**	**4,792**	*	*	*	NAC	
		32 - 1.5.5 Develop the capacity of civil society to monitor the environment	194,949	204,697	214,932	**614,578**	**438**	**1,403**	*	*	*	NAC	
		1.5.6 Facilitate provision of psychosocial safe space for youth living with HIV (Young Ambassadors of positive living)	689,850	724,343	760,560	**2,174,752**	**438**	**4,965**	*	*	*	NAC	
		1.5.7Increasing male involvement in HIV programmes and in stigma reduction programmes	31,858	33,451	35,123	**100,432**	**73**	**1,376**	*	*	*	NAC	
		1.5.8 Formation of support groups in the workplace	1,185	1,245	1,307	**3,737**	**1,000**	**4**	*	*	*	NAC	
		1.5.9 Support the Young Ambassadors of Positive Living to spear head stigma reduction in schools, and community settings among young people	4,335	4,552	4,780	**13,667**	**219**	**62**	*	*	*	NAC	
		1.5.10 Support the formation of Support Groups in the workplace to support stigma reduction and workplace programmes	12,600	13,230	13,892	**39,722**	**146**	**272**	*	*	*		
SDA HRH		HRH	690,590	690,590	690,590	**2,071,769**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure		Infrastructure	116,816	116,816	116,816	**350,448**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL SDA COST			7,065,744	5,463,785	5,696,603	**18,226,132**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period Y 1	Implementation period Y2	Implementation period Y3	Lead agency	Collaborating partners
3.4.2 - Coordination and Management			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC20] Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework	**[OP56]** National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated (human resources, funds, and skills, office space, equipments) to effectively and efficiently coordinate and manage the national response.		Strengthen national coordination framework in line with three-ones principles	2.2.1 Develop a National Coordination Framework that outlines the roles and responsibilities of the various coordinating structures in government, development partners, private sector and civil society organisations	137,253	157,346	166,950	**461,549**	**292**	**1,581**			*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				2.2.2 Develop an effective feed back and policy information dissemination mechanisms to development partners, CSO and private sector	1,584,719	1,651,662	1,739,454	**4,975,835**	**486**	**10,238**			*	MOH	NAC;WHO,GF,COH
			Strengthen the capacity of NAC to provide effective leadership of the national response	2.3.1 Review and re-structure NAC in line with emerging roles and responsibilities for coordinating the national decentralised multi-sectoral response.	27,562	28,940	10,592	**67,094**	**2**	**33,547**	*	*		MOH	CDC,WHO
				2.3.2 Train NAC Board on Governance, Gender and human rights issues in the context of HIV and AIDS response	36,048	37,850	39,743	**113,640**	**4**	**28,410**		*		Health facilities and Traditional healers	WHO,
				2.3.3 Schedule and hold quarterly meetings of the NAC Board	5,809	6,100	6,405	**18,314**	**12**	**1,526**	*	*	*	NAC, MOH	COH;GF.
				2.3.4 Organise at least two meetings with Provincial and District AIDS Coordinators	511,045	536,598	563,427	**1,611,070**	**164**	**9,824**	*		*	MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
3.4.2 - Coordination and Management	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
		2.3.5 Organise monthly meetings of NAC technical staff to review progress in the coordination of the multi-sectoral HIV and AIDS response.	26,142	27,450	28,822	**82,414**	**12**	**6,868**	*	*	*	NAC, MOH	WHO,
		2.3.6 Hold a retreat of the Cabinet Committee on HIV and AIDS annually	16,632	17,464	18,337	**52,432**	**3**	**17,477**				NAC, MOH	WHO,
	Strengthen system wide coordination with other stakeholders	2.3.7 NAC Business Plan	2,356,620	2,474,451	2,601,299	**7,432,370**	**366**	**20,307**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
		2.4.1 Convene and facilitate the meetings of the GFATM Country Coordinating Committee	105,000	110,250	115,763	**331,013**	**3**	**110,338**				MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
		2.4.2 Coordinate Joint Review of NASF	29,047	30,499	32,024	**91,571**	**3**	**30,524**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
		2.4.3 Facilitate coordination of the PEPFAR Partnership Framework with the Government of Zambia	52,285	54,899	57,644	**164,828**	**12**	**13,736**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
		2.4.4 Facilitate coordination between NAC and other Stakeholders i.e. Ministry of Health, GIDD, OVC programme etc	8,714	9,150	9,607	**27,471**	**9**	**3,052**	*	*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.2 - Coordination and Management	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
	Strengthen coordination with and among civil society organisations, private sector and development partners	2.5.1 Strengthen umbrella coordinating structures capacity in governance, networking and resource mobilisation	43,890	46,085	-	**89,975**	**9**	**9,997**	*	*	*	NAC	
		2.5.2 Provide operational funding for civil society networks (including networks of PLHIV)	17,428	18,300	19,215	**89,975**	**18**	**4,999**	*	*	*	NAC	
	Facilitate harmonisation and alignment of development partners including UN agencies on coordination and management structures with national systems	2.6.1 Advocate the alignment and harmonisation of coordination and management structures with development partners	17,428	18,300	19,215	**54,943**	**12**	**4,579**	*	*	*	NAC	
		2.6.2 Schedule and hold qarterly Partnership Forum meetings	10,893	11,437	12,009	**54,943**	**12**	**4,579**	*	*	*		
SDA HRH		HRH	237,616	237,616	237,616	**712,849**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure		Infrastructure	467,264	467,264	467,264	**1,401,792**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL SDA COST			5,691,397	5,941,660	6,145,386	**17,834,078**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.4.3 - HIV and AIDS, Gender and Human Rights Mainstreaming			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
[OC21] HIV and AIDS, Gender and Human Rights Mainstreaming [OC21] Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015	**[OP57]** Sectors and private sector institutions that have reviewed their policies and programmes and mainstreamed HIV and AIDS, gender and human rights in their internal (HIV workplace) and external (development) programmes increased to 75% by 2013 and 100% by 2015	75%	Advocate for the review of the sector and institutional policies to mainstream HIV/AIDS, gender and human rights in the work place and in development programmes	3.1.1 Commission sector policy reviews and compile the report	18,900	-	-	**18,900**	**1**	**18,900**		*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				3.1.2 Organise stakeholders meetings to review the results of the policy review exercise	13,071	-	-	**13,071**	**1**	**13,071**			*	MOH	NAC;WHO,GF,COH
				3.1.3 Revise the policies incorporating HIV/AIDS, Gender and human rights	31,971	-	-	**31,971**	**1**	**31,971**			*	MOH	CDC,WHO
			Conduct a comprehensive assessment of HIV and AIDS in the respective sector / organisation or company to inform the nature and scope of both the internal and external response	3.2.1 Conduct baseline surveys and compile and disseminate reports	-	140,512	-	**140,512**	**2**	**70,256**	*	*	*	Health facilities and Traditional healers	WHO,
				3.2.2 Develop reporting and accountability systems to integrate gender- and HIV-related obligations.	1,290,964	1,352,205	1,419,815	**4,062,984**	**219**	**18,552**	*	*	*	NAC, MOH	COH;GF.
			Collaborate with GIDD to support inter-governmental and inter-ministerial partnerships on GBV prevention, management and care	3.3.1 Develop an assessment protocol in line with human rights procedures	353,974	371,672	390,256	**1,115,902**	**73**	**15,286**		*	*	MOH	
				3.3.2 Sensitise employees on the prevention and management of various forms of GBV and provide psychosocial support to survivors	188,361	197,779	207,668	**593,807**	**146**	**4,067**	*	*	*	NAC, MOH	WHO,
			Integrate HIV with gender into impact assessment studies to examine the differential impact of development initiatives on HIV and gender relations with a particular focus on the status of women and girls	**3.4.1 A**dvocate with the Environmental Council to integrate HIV and AIDS and gender dimensions in environmental impact assessments of development / capital projects	450,085	472,589	496,219	**1,418,893**	**438**	**3,239**	*	*	*	NAC, MOH	WHO,
				3.4.2 Review existing impact assessment tools to mainstream HIV and AIDS, and gender	9,450	382,556	5,209	**397,216**	**2**	**198,608**	*	*		MOH	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.4.3 - HIV and AIDS, Gender and Human Rights Mainstreaming			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
				3.4.3 Review the existing legal framework to ensure mandatory inclusion of HIV and AIDS, and gender assessment in development projects	-	-	35,248	35,248	1	35,248	*	*		MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
			Support strategies that increase access to education and vocational training for vulnerable groups especially for women and girls	3.5.1 Support integrated literacy programmes (e.g. literacy, numeracy, and practical skills) for women and out of school youth that enhance their ability to initiate and manage sustainable livelihoods (income generating activities).	432,252	438,981	460,930	1,332,163	146	9,124	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				3.5.2 Conduct campaigns for zero tolerance to GBV, rape, and sexual harassment in institutions of learning, in the community and the workplace	546,705	574,040	602,742	1,723,488	219	7,870	*	*	*	NAC, MOH	NAC,MOH,GF, COH
			Develop a national framework to address HIV and AIDS in the informal sector	3.6.1 Conduct a situational analysis of HIV and AIDS in the informal sector	186,784	196,123	205,929	588,836	3	196,279	*	*	*	MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				.3.6.2 Strengthen the capacity of civil society organisations and business coalitions on HIV and AIDS to reach out to informal sector with HIV and AIDS interventions	211,602	222,182	233,292	667,076	100	6,671	*	*	*	MOH	NAC;WHO,GF,COH
				3.6.3 Develop a framework for delivering HIV and AIDS interventions in the informal sector.- the frameworks should determine a minimum package	426,825	448,166	470,575	1,345,566	219	6,144	*	*	*	MOH	CDC,WHO
				3.6.4 Expand access to micro-finance and credit opportunities for women to promote economic empowerment	216,221	227,033	238,384	681,638	438	1,556	*	*	*	Health facilities and Traditional healers	WHO,
	[OP58] Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015		Strengthening the capacity of stakeholders on gender mainstreaming and planning	3.7.1 Train stakeholders on gender analysis, planning and budgeting skills	87,742	82,053	86,156	255,951	2,500	102	*	*	*	NAC, MOH	COH;GF.

3.4.3 - HIV and AIDS, Gender and Human Rights Mainstreaming	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Implementation period Y 1	Y2	Y3	Lead agency	Collaborating partners
Zambia National Operational Plan (NOP) for NASF 2011-2013													
		3.7.2 Conduct HIV-related socioeconomic assessments to examine the differential impact of HIV on females and males to inform the planning process	56,700	37,758	15,628	110,086	1	110,086	*	*	*	MOH	
		3.7.3 Develop and incorporate gender indicators in operational plans	99,196	104,156	109,364	312,715	219	1,428	*	*	*	NAC, MOH	WHO,
	Promote greater involvement of PLHIV, including women, young people and marginalised groups in planning, programming, budgeting and in service delivery.	3.8.1 Train civil society organisations and faith based organisations om facilitation and analytical skills to enable them represent their cconstituencies in decision making and planning	277,357	291,225	305,786	874,367	1,000	874	*	*	*	NAC, MOH	WHO,
		3.8.2 Develop the structures that promote a participatory process in planning and decision making involving vulnerable and marginalised groups	8,225	-	-	8,225	1	8,225			*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
		3.8.3 Train community leaders in facilitation skills that promote gender sensitive development, attitudes and behaviour change to improve universal access to HIV and AIDS Services	418,077	438,981	460,930	1,317,988	2,000	659	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
[OP59] Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 12015.	Develop annual operational plans that have mainstreamed HIV/AIDS, gender and human rights using evidence and results based planning approaches	3.9.1 Train stakeholders on evidence and results based management skills	418,077	438,981	460,930	1,317,988	3,000	439	*	*	*	NAC, MOH	NAC,MOH,GF , COH
		3.9.2 Develop operational plans with clear described results / targets	20,432	-	-	20,432	1	20,432			*	NAC, MOH	NAC,MOH,GF , COH
		3.9.3 Allocate at least 2% of the annual budget for HIV and AID response	915,703	961,489	1,009,563	2,886,755	73	39,545			*		
		3.9.4 Develop a robust HIV monitoring and surveillance system to effectively track HIV infection by sex, age and patterns of sera-discordance in couples	1,780,343	1,869,360	1,962,828	5,612,531	219	25,628			*		

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.3 - HIV and AIDS, Gender and Human Rights Mainstreaming	**Strategies**	**Activities**	**Cost for year One**	**Cost for year Two**	**Cost for year Three**	**Total Cost**	**Target**	**Unit Cost**					
[OP60] Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015	Promote a gender-sensitive minimum wellness and HIV/AIDS workplace package	3.10.1 Develop engendered HIV and AIDS and wellness workplace programme	86,746	66,663	69,996	**223,406**	**9**	**24,823**		*	*	NAC	
		3.10.2 Appoint a HIV/AIDS Coordinators or Focal point persons	-	-	-	**Costed under HRH**	**-**	**-**		*	*	NAC	
		3.10.3 Provide resources (funds, space and equipment for the implementation of the workplace programme	-	-	-	**Costed under infrastructure**	**-**	**-**		*	*	NAC	
SDA HRH		HRH	924,627	924,627	924,627	**2,773,880**	**Total Cost of SDA HRH**	**Total Cost of SDA HRH**	*	*	*		
SDA Infrastructure		Infrastructure	350,448	350,448	350,448	**1,051,344**	**Total Cost of SDA Infrastructure**	**Total Cost of SDA Infrastructure**	*	*	*		
TOTAL SDA COST			9,820,838	10,589,579	10,522,522	**30,932,939**							

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.4.4 - Capacity Development and Systems Strengthening			**Strategies**	**Activities**	**Cost for year One**	**Cost for year Two**	**Cost for year Three**	**Total Cost**	**Target**	**Unit Cost**					
[OC22] Stakeholders capacity to implement NASF strengthened by 2013 and remains the same by 2015	**[OP61]** HIV and AIDS implementing partners whose capacity has been developed / strengthened in the areas of programme planning, resource mobilisation, service delivery, community mobilisation, monitoring, evaluation and reporting increased to 75% by 2015		Conduct a comprehensive national capacity assessment necessary for the implementation of NASF	4.1.1 Develop the capacity assessment tool	9,930			**9,930**	**1**	**9,930**	*			MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				4.1.2 Conduct assessment involving all sectors, civil society, private sector, provincial and district and communities	11,172			**11,172**	**1**	**11,172**		*	*	MOH	NAC;WHO,GF,COH
				4.1.3 Develop and implement a capacity development framework	21,074			**21,074**	**1**	**21,074**			*	MOH	CDC,WHO
			All sectors, districts and other implementing have been trained in HIV planning, programme development, implementations skills and M&E based on evidence and results based management approaches by 2013 and have develop their operational plans	4.2.1 Conduct training on evidence and results based management approaches	651,699	684,284	718,499	**2,054,483**	**438**	**4,691**				Health facilities and Traditional healers	WHO,
				4.2.2 Provide follow up mentorship and technical assistance in evidence and RBM	311,341	326,908	343,254	**981,503**	**219**	**4,482**				NAC, MOH	COH;GF.
	[OP62] Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013		Health systems are strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013	4.3.1 Develop human resource capacity (adequacy, skills, composition and retention of skilled persons) sufficient to support the planning and implementation of the NASF	372,606	373,647	392,330	**1,138,583**	**146**	**7,799**		*	*	MOH	

Zambia National Operational Plan (NOP) for NASF 2011-2013										Implementation period			Lead agency	Collaborating partners
										Y 1	Y2	Y3		
3.4.4 - Capacity Development and Systems Strengthening		Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
			4.3.2 Improve services delivery systems to eliminate waiting time, drugs stock out, inadequate patient follow up etc)	274,456	288,179	302,588	**865,222**	**73**	**11,852**	*	*	*	NAC, MOH	WHO,
			4.3.3 Strengthen Health Information systems to complement the national HIV/AIDS multisectoral M&E framework	113,264	118,927	124,874	**357,065**	**219**	**1,630**	*	*	*	NAC, MOH	WHO,
			4.3.4 Advocate for increased funding for health care and HIV and AIDS	1,031,713	1,083,299	1,137,464	**3,252,475**	**438**	**7,426**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
			4.3.5 Strengthen governance and leadership of health care services in a HIV and AIDS multisectoral environment	651,699	684,284	718,499	**2,054,483**	**219**	**9,381**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UT H,CIDRZ
	[OP63] Communities systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013	Community capacity is strengthened in leadership, planning and implementation of community based interventions in 100% of the districts by 2013	4.4.1 Train community based organisations in governance and leadership	1,320,371	1,386,389	1,455,709	**4,162,469**	**876**	**4,752**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
			4.4.2 Strengthen coordination of community based organisations including support groups of PLHIV	1,255,043	1,317,795	1,383,685	**3,956,523**	**438**	**9,033**	*	*	*	NAC, MOH	NAC,MOH,GF , COH
			4.4.3 Advocate for sustained and increased funding and technical support for community based HIV and AIDS projects	4,783,244	5,022,406	5,273,527	**15,079,177**		**#DIV/0!**	*	*	*		

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.4 - Capacity Development and Systems Strengthening	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		4.4.4 Review operational systems and support efforts to strengthen them for service delivery	515,025	44,651	46,884	606,560		#DIV/0!	*	*			
SDA HRH		HRH	569,477	569,477	569,477	1,708,432	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
SDA Infrastructure		Infrastructure	525,672	525,672	525,672	1,577,016	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructure	*	*	*		
TOTAL SDA COST			12,417,786	12,425,920	12,992,459	37,836,165							

3.4.5 - Resource Mobilisation			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3	Lead agency	Collaborating partners
[OC23] By 2015, NASF financial resource needs that have been mobilised, and used efficiently increased to 100% by 2015	**[OP67]** Public, civil society and private sectors that have developed annual HIV and AIDS operational plans that are aligned and harmonised with the national operational plan has increased to 100% for public and 75% for private sectors.		Provide technical assistance to public and private sectors and civil society organisations to develop evidence and results based operational plans that are costed	5.1.1 Train stakeholders on evidence and results based management and planning skills	168,322	176,739	185,575	530,636	200	2,653	*	*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				5.1.2 Train stakeholders on gender and human rights planning and budgeting	-	9,923	-	9,923	1	9,923			*	MOH	NAC;WHO,GF,COH
			Advocate for increased domestic funding for Health and HIV/AIDS	5.2.1 Develop a concept paper for policy makers on the need for increased domestic funding	-	9,923	-	9,923	1	9,923	*			MOH	CDC,WHO
				5.2.2 Organise quarterly briefing sessions with the Cabinet Committee on HIV.AIDS, and Parliament	17,365	18,234	19,145	54,744	12	4,562	*	*	*	Health facilities and Traditional healers	WHO,
				5.2.3 Mainstream HIV/AIDS budgets in sector operational budgets (as part of HIV/AIDS mainstreaming)	17,365	18,234	19,145	54,744	12	4,562		*	*	NAC, MOH	COH;GF.
			Develop a sustainability strategy	5.3.1 Develop sustainable financing mechanism for HIV and AIDS such as a HIV/AIDS Trust Fund , HIV Tax or endowment fund	17,365	18,234	19,145	54,744	12	4,562	*	*	*	MOH	
				5.3.2 Advocacy for increased government and donor flexible funding the HIV and AIDS, and the health systems in general	17,365	18,234	19,145	54,744	3	18,248	*	*	*	NAC, MOH	WHO,
				5.3.3 Strengthen financial management systems to improve on efficiency in resource use	11,864	12,457	13,080	37,402	18	2,078	*	*	*	NAC, MOH	WHO,

Table title: Zambia National Operational Plan (NOP) for NASF 2011-2013; Implementation period: Y 1, Y2, Y3

Zambia National Operational Plan (NOP) for NASF 2011-2013												Implementation period			Lead agency	Collaborating partners
3.4.5 - Resource Mobilisation			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost		Y 1	Y2	Y3		
				5.3.4 Strengthen the resource tracking from both the demand and supplier sides to ensure equitable distribution of resource across priority areas.	196,135	205,942	216,239	618,316	73	8,470		*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				5.3.5 Expand the donor base and reduce dependency on a few donors	52,285	54,899	57,644	164,828	18	9,157		*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				5.3.6 Encourage and provide incentives to private sector to invest more in the HIV response.	26,142	27,450	28,822	82,414	18	4,579		*	*	*	NAC, MOH	NAC,MOH,GF, COH
	[OP68] Government funding spent on health has increased from to 15% in 2015	15%	Advocate for increased health sector funding	5.4.1 Develop a briefing paper - on why increased funding for health sector in necessary and strategic for HIV and AIDS response	9,450	-	-	9,450	1	9,450		*	*	*	NAC, MOH	NAC,MOH,GF, COH
				5.4.2 Conduct advocacy campaigns with cabinet and parliament	4,357	4,575	4,804	13,736	3	4,579		*	*	*		
SDA HRH				HRH	569,477	569,477	569,477	1,708,432	Total Cost of SDA HRH	Total Cost of SDA HRH		*	*	*		
SDA Infrastructure				Infrastructure	525,672	525,672	525,672	1,577,016	Total Cost of SDA Infrastructure	Total Cost of SDA Infrastructure		*	*	*		
TOTAL SDA COST					1,633,166	1,669,990	1,677,894	4,981,050								

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
3.4.6 - Monitoring Evaluation and HIV Research 3			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
[OC24] The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NSF results framework by 2013 and 100% by 2015.	**[OP69]** Key planned research studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015		Strengthen the capacity of stakeholders to generate data necessary for validating the NASF results	6.1.1 Train stakeholders on M&E skills at all levels	264,168	277,376	291,245	**832,789**	**2,160**	**386**	*	*	*	MOH;WHO	SFH;HCP;UN;JHPIEGO,UTH,CIDRZ
				6.1.2 Conduct orientation workshop on the NASF M&E framework with the aim of stakeholders understanding the results to be measured, how they will be measured (indicators used) and the reporting formats	103,940	57,136	59,993	**221,070**	**12**	**18,423**	*	*	*	MOH	NAC;WHO,GF,COH
				6.1.3 Produce and disseminate a Quarterly Services Coverage Report based on data submitted by implementing partners (as part of feedback)	404,565	27,838	29,230	**461,634**	**24**	**19,235**	*	*	*	MOH	CDC,WHO
	[OP70] A framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011.		Develop a National M&E Framework and Work plan	6.2.1 Develop a road map for the NASF M&E	4,511	4,737	4,974	**14,222**	**1**	**14,222**	*	*		Health facilities and Traditional healers	WHO,
				6.2.2 Develop and disseminate an indicator reference guide	1,575	1,654	1,736	**4,965**	**1**	**4,965**		*		NAC, MOH	COH;GF.
				6.2.3 Conduct an annual review of NASF indicators	62,475	65,599	68,879	**196,952**	**3**	**65,651**				MOH	
				6.2.4 Develop indicators to track gender and human rights related progress	420,000	441,000	463,050	**1,324,050**	**1**	**1,324,050**	*	*		NAC, MOH	WHO,
			Strengthen the National M&E System	6.3.1 Build the capacity of the national M&E system around the twelve components of the M&E	390,972	410,521	431,047	**1,232,540**	**12**	**102,712**	*	*	*	NAC, MOH	WHO,

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
											Y 1	Y2	Y3		
3.4.6 - Monitoring Evaluation and HIV Research 3			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
				6.3.2 Develop a national HIV/AIDS Database with linkages to HMIS in the Ministry of Health and with the OVC database	-	-	-	-	-	-	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				6.3.3 Conduct quarterly M&E supervision missions especially in the districts and provinces	378,108	397,014	416,865	1,191,987	876	1,361	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				6.3.4 Analyse, compile and disseminate an M&E quarterly services coverage report	82,653	86,786	91,125	260,564	73	3,569	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				6.3.5 Develop and expand the scope and capacity of NAC Resource Centre	259,577	272,556	286,184	818,318	3	272,773		*	*	NAC, MOH	NAC,MOH,GF, COH
				6.3.6 Train M&E officers in skills for engendering of the M&E system to ensure that data is disaggregated by gender, age, marital status, geographical locations and patterns of serodiscordance (among other parameters) to allow effective gender analysis	406,561	426,889		833,450	250	3,334		*	*	MOH;WHO	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
	[OP71] Key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015	80%	Develop standard tools for the National M&E system	6.4.1 Review and harmonise stakeholders M&E tools with national me tools	171,173	179,731	188,718	539,622	12	44,969	*	*		MOH	NAC;WHO,GF,COH
				6.4.2 Train M&E officers how to use the tools for data capturing and reporting	14,175	14,884	15,628	44,687	200	223		*	*	MOH	CDC,WHO

Zambia National Operational Plan (NOP) for NASF 2011-2013											Implementation period			Lead agency	Collaborating partners
3.4.6 - Monitoring Evaluation and HIV Research 3			Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost	Y 1	Y2	Y3		
				6.4.3 Harmonise HIV and AIDS reporting to avoid duplication and misreporting	45,249	47,511	49,887	**142,647**	**73**	**1,954**	*	*	*	Health facilities and Traditional healers	WHO,
[OC25] The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF	**[OP72]** Stakeholders capacity for applied research is assessed and strengthened	x	Review and approve research protocols for research studies in the country	6.5.1 Review research findings and disseminate results	431,251	452,813	475,454	**1,359,518**	**219**	**6,208**	*	*	*	NAC, MOH	COH;GF.
				6.5.2 Compile and continually update the research inventory (all research work done) in Zambia on HIV and AIDS	11,619	12,200	12,810	**36,628**	**3**	**12,209**	*	*	*	MOH	
	[OP73] 80% of the planned research studies and surveys have been conducted and results disseminated.		Strengthen the capacity to conduct applied HIV and AIDS research	6.6.1 Strengthen the capacity of the Ethics and Research Committee	11,970	12,569	13,197	**37,735**	**3**	**12,578**	*	*	*	NAC, MOH	WHO,
				6.6.2 Facilitate the implementation of the national research agenda	52,770	55,408	58,178	**166,356**	**12**	**13,863**	*	*	*	NAC, MOH	WHO,
				6.6.3 Develop research capacity among stakeholders through formal and in-service training, attachments etc	300,896	315,941	331,738	**948,576**	**36**	**26,349**	*	*	*	MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
				6.6.4 Review the HIV and AIDS research protocol / guidelines to ensure human rights and gender sensitivity	37,735			**37,735**	**1**	**37,735**	*	*		MOH	SFH;HCP;UN; JHPIEGO,UTH,CIDRZ
			Facilitate strategic research works related to HIV and AIDS in Zambia	6.7.1 Facilitate an AIDS Indicator Survey	166,356			**166,356**	**1**	**166,356**	*	*	*	NAC, MOH	NAC,MOH,GF, COH
				6.7.2 Facilitate a national study on HIV/AIDS epidemic drivers		323,242		**323,242**	**1**	**323,242**			*	NAC, MOH	NAC,MOH,GF, COH

Zambia National Operational Plan (NOP) for NASF 2011-2013									Implementation period			Lead agency	Collaborating partners
									Y 1	Y2	Y3		
3.4.6 - Monitoring Evaluation and HIV Research 3	Strategies	Activities	Cost for year One	Cost for year Two	Cost for year Three	Total Cost	Target	Unit Cost					
		6.7.3 Conduct the National Sentinel Surveillance			1,090,106	1,090,106	1	1,090,106					
		6.7.4 Facilitate a national study on MARPS	673,863			673,863	1	673,863			*		
		6.7.5 Facilitate the Zambian Demographic and Health Survey			673,863	673,863	1	673,863					
		6.7.6 HIV-related Education Study (EMIS)			230,750	230,750	1	230,750					
		6.7.7 PMTCT Reviews			948,576	948,576	1	948,576					
		6.7.8 ART Reviews			3,398,798	3,398,798	3	1,132,933					
		6.7.9 CT Reviews			582,292	582,292	1	582,292					
		6.7.10 TB/MDRTB reviews			948,576	948,576	1	948,576					
		6.7.11 BCC Reviews			948,576	948,576	1	948,576					
SDA HRH		HRH	1,736,443	1,736,443	1,736,443	5,209,328	Total Cost of SDA HRH	Total Cost of SDA HRH	*	*	*		
SDA Infrastructure		Infrastructure	584,080	584,080	584,080	1,752,240	Total Cost of SDA Infrastruc ture	Total Cost of SDA Infrastruct ure	*	*	*		
TOTAL SDA COST			7,016,686	6,203,928	14,431,997	27,652,612							
TOTAL NOP COST			441,517,761	483,629,119	466,456,301	1,388,721,920							

7.0 Item Costs

Category	Item	Measurement Unit	Unit Cost (USD)
CD4 Reagents	BD FACS Clean Solution 5 Liters	per item	$ 33.00
CD4 Reagents	BD FACS Count CD% Reagent kit 50 Test	per item	$ 320.00
CD4 Reagents	BD FACS Count Thermal Printing Paper 5 Rolls	per item	$ 15.00
CD4 Reagents	BD FACS Count-CD3/4 Reagent Kit	per item	$ 240.00
CD4 Reagents	BD FACS Count-Control Kit	per item	$ 180.00
CD4 Reagents	BD FACS Count-FacsClean	per item	$ 32.00
CD4 Reagents	BD FACS Count-FacsFlow	per item	$ 37.00
CD4 Reagents	BD FACS Count-FacsRinse	per item	$ 32.00
CD4 Reagents	BD FACS Count-Thermal Paper	per item	$ 8.00
CD4 Reagents	BD FACS Flow Sheath Fluid 20 Liters	per item	$ 37.50
CD4 Reagents	BD FACS Rinse Solution 5 Liters	per item	$ 32.50
CD4 Reagents	BD FACS Trucount Controls, 30 Tests	per item	$ 380.00
CD4 Reagents	BD FACSCount Control 25 Tests	per item	$ 250.00
CD4 Reagents	BD Tritest, CD3/CD4/CD45, w/Tubes, 50 Tests	per item	$ 300.00
CD4 Reagents	BD Vacutainer Needle with Pre-Attached Holder, 21 Gauge, 1.25"	per item	$ 7.19
CD4 Reagents	BD Vacutainer One-Use Holder	per item	$ 5.00
CD4 Reagents	BD Vacutainer Ribbed Pediatric Tube Adapter	per item	$ 9.75
CD4 Reagents	BD Vacutainer Stretch-Free Latex Tourniquet	per item	$ 1.00
CD4 Reagents	BD Vacutainer Tube, Grey Top	per item	$ 10.04
CD4 Reagents	BD Vacutainer Tube, Plastic, 4mL, Lavender, K2 EDTA 7.2mg	per item	$ 108.50
CD4 Reagents	BD Vacutainer Tube, Red Top, 4mL	per item	$ 10.04
Chemistry Reagents	Human TRIGLYCERIDES liquicolor Mono 9 x 15mL	per item	$ 29.36
Chemistry Reagents	Human UREA liquicolor, 2 x 100mL	per item	$ 21.97
Chemistry Reagents	Human, Glucose Liquicolor, 1L	per item	$ 29.74
Chemistry Reagents	Nofloxacin 10ug 250 Discs	per item	$ 7.26
Chemistry Reagents	Olympus AU400 Calibrator, 20 x 5mL	per item	$ 151.86
Chemistry Reagents	Olympus AU400 Cholesterol, 2000 Tests	per item	$ 143.00
Chemistry Reagents	Olympus AU400 Triglyceride, 4 x 50mL, 4 x 12.5mL	per item	$ 33.46
Chemistry Reagents	Olympus, AU400, ALT, 4 x 12mL and 4 x 6mL	per item	$ 77.00
Chemistry Reagents	Olympus, AU400, Bilirubin Total, 2000 Tests	per item	$ 99.00
Chemistry Reagents	Olympus, AU400, Creatinine, 1700 Tests	per item	$ 99.00
Chemistry Reagents	Olympus, AU400, Glucose, 2000 Tests	per item	$ 141.00
Chemistry Reagents	Olympus, AU400, Urea, 2000 Tests	per item	$ 143.66
Chemistry Reagents	Cobas Bilirubin Total 500 Tests	per item	$ 37.60
Chemistry Reagents	Cobas Integra 400 ISE Deproteinizer 23ml x 6 Vials	per item	$ 135.68
Chemistry Reagents	Cobas Integra AST/GOT 500 Tests	per item	$ 87.00
Chemistry Reagents	Cobas Integra Triglycerides 250 Tests	per item	$ 154.41
Chemistry Reagents	COBAS Reaction Cuvettes 20000 Pcs	per item	$ 886.97
Chemistry Reagents	Humalyzer 2000 Thermal Printing Paper 5 Rolls	per item	$ 40.16
Chemistry Reagents	Human TRIGLYCERIDES liquicolor Mono 9 x 15mL	per item	$ 29.36
Chemistry Reagents	Human, Glucose Liquicolor, 1L	per item	$ 29.74
Chemistry Reagents	Human, GOT (ASAT) IFCC mod LiquiUV Kit, 10 x 10mL	per item	$ 22.00
Chemistry Reagents	Olympus AU400 Calibrator, 20 x 5mL	per item	$ 151.86
Chemistry Reagents	Olympus AU400 Cholesterol, 2000 Tests	per item	$ 143.00
Chemistry Reagents	Olympus AU400 Triglyceride, 4 x 50mL, 4 x 12.5mL	per item	$ 33.46
Chemistry Reagents	Olympus Bilirubin Direct 4x25/4x25ml 100 ml	per item	$ 120.00
Chemistry Reagents	Olympus Control Serum 2, 20 x 5ml	per item	$ 242.31
Chemistry Reagents	Olympus, AU400, ALT, 4 x 12mL and 4 x 6mL	per item	$ 77.00
Chemistry Reagents	Olympus, AU400, Creatinine, 1700 Tests	per item	$ 99.00
Chemistry Reagents	Olympus, AU400, Urea, 2000 Tests	per item	$ 143.66
Chemistry Reagents	ABX Pentra Basolyse, Horiba ABX 1 Liter	per item	$ 93.00
Chemistry Reagents	ABX Pentra Cleaner 1 Liter	per item	$ 45.05
Chemistry Reagents	Sysmex PocH 65	per item	$ 62.50
Chemistry Reagents	Sysmex, Cell Cleaner, 50mL	per item	$ 111.24
Chemistry Reagents	ABX Pentra Eosinofix Horiba ABX 1 Liter	per item	$ 81.00
Chemistry Reagents	Sysmex KX21N Thermal Printer Paper 1 Roll	per item	$ 9.00
Chemistry Reagents	Acetone 2 Liters	per item	$ 25.37
Chemistry Reagents	Blood Culture media pediatrics, 50 bottles	per item	$ 162.50
Chemistry Reagents	BD Calibrite 3-color Beads 25 Tests	per item	$ 220.00
Chemistry Reagents	Campylobacter agar 200g 1 Each	per item	$ 129.00
Chemistry Reagents	Cary blair agar 500 Grams	per item	$ 37.95
Chemistry Reagents	Cefotaxim 30 ug 250 Discs	per item	$ 7.26
Chemistry Reagents	Chloraphenicol 30 ug 250 Discs	per item	$ 75.00
Chemistry Reagents	Chloroform Analytical Reagent grade 2.5 Liters	per item	$ 7.50
Chemistry Reagents	Ciprofloxacine 5ug 250 Discs	per item	$ 7.80
Chemistry Reagents	Columbia Blood Agar Base, 500g	per item	$ 39.31
Chemistry Reagents	Cotton Wool 1000 Grams	per item	$ 10.00
Chemistry Reagents	Cystine Lactose Electrolytes Deficient Agar, 500g	per item	$ 110.00
Chemistry Reagents	DPX Mountant For Microscopy 100mL	per item	$ 18.10
Chemistry Reagents	Ethyl Alcohol (Ethanol) 95% 1 Liter	per item	$ 20.27
Chemistry Reagents	Filter Paper, Round, Large, 100 Pcs	per item	$ 4.88
Chemistry Reagents	Filter Paper, Round, Medium, 100 Pcs	per item	$ 18.82
Chemistry Reagents	Formalin, 10% Formaldehyde, 500mL	per item	$ 20.22
Chemistry Reagents	Fuchsin Acid, Certified Biological Stain, 25g	per item	$ 55.30
Chemistry Reagents	Gentamycin 10 ug 250 Discs	per item	$ 7.00
Chemistry Reagents	Gloves, Latex, Powder-Free, Lg, 100 Pcs	per item	$ 5.59
Chemistry Reagents	Gloves, Latex, Powder-Free, Med, 100 Pcs	per item	$ 5.54
Chemistry Reagents	Gloves, Latex, Powder-Free, Sm, 100 Pcs	per item	$ 8.95
Chemistry Reagents	Harris Alum Haematoxylin 500 mL	per item	$ 46.48
Chemistry Reagents	Hepatitis B Surface Antigen (HBsAg) ELISA 96 Tests	per item	$ 85.00
Chemistry Reagents	Hydrochloric Acid 1 Liter	per item	$ 35.10
Chemistry Reagents	Kovacs Solution, 100mL	per item	$ 25.90
Chemistry Reagents	Latex Agglutination Cryptococcal Antigen 70 Tests	per item	$ 157.50
Chemistry Reagents	MacConkey Agar 500g	per item	$ 70.00
Chemistry Reagents	Media, Blood Culture, Septicheck, TSB, 10 x 70mL	per item	$ 162.50

Chemistry Reagents	Methanol 5 Liters	per item	$	20.26
Chemistry Reagents	Microbiology, Simmons Citrate Agar, 500g	per item	$	75.39
Chemistry Reagents	Microscope Slides, 25 x 75mm, Frosted, 1440 Pcs	per item	$	27.00
Chemistry Reagents	Mueller hinton agar 500 g	per item	$	70.00
Chemistry Reagents	Nalidixic acid 30mg 250 Discs	per item	$	6.50
Chemistry Reagents	Nofloxacin 10ug 250 Discs	per item	$	7.26
Chemistry Reagents	Orange G 6 solution 1000 mL	per item	$	45.69
Chemistry Reagents	Papanicolaou Stains EA-50 4L	per item	$	83.54
Chemistry Reagents	Plastic Serum Tube, 4mL, 13 x 75mm, 1000 Pcs	per item	$	8.60
Chemistry Reagents	Pregnancy Test Kit, Rapid, 100 Tests	per item	$	14.57
Chemistry Reagents	Reagent, Oxidase, 25g	per item	$	84.20
Chemistry Reagents	Salmonella Paratyphi A-O, 5ml	per item	$	15.37
Chemistry Reagents	Salmonella Paratyphi B-O, 5ml	per item	$	38.85
Chemistry Reagents	Salmonella Paratyphi C-H 5 mL	per item	$	22.00
Chemistry Reagents	Salmonella Paratyphi C-O, 5ml	per item	$	12.27
Chemistry Reagents	Salmonella polyvalent H phase 1& 2 antisera 5 ml	per item	$	100.71
Chemistry Reagents	Salmonella polyvalent O antisera 5 ml	per item	$	43.13
Chemistry Reagents	Shigella dysenteriae polyvalent 1-10 5 ml	per item	$	100.71
Chemistry Reagents	Sodium Hypochlorite Solution, 6-14%, 500 ml	per item	$	5.47
Chemistry Reagents	Spirit methylated 2.5 Liters	per item	$	5.50
Chemistry Reagents	Stain, Papanicolaou, EA 50, 500mL	per item	$	65.00
Chemistry Reagents	Test Strip, Uric Multistix, 100 Pcs	per item	$	39.44
Chemistry Reagents	Triple sugar iron agar (TSI) 500g	per item	$	22.72
Chemistry Reagents	Urea agar 500 g	per item	$	71.97
Chemistry Reagents	Vacutainer Tube, K2-EDTA, 4mL, Lavender, 100 Pcs	per item	$	112.35
Chemistry Reagents	Vacutainer, Lithium Heparin, 4mL, 100 Pcs	per item	$	100.00
Chemistry Reagents	Vacutainer, Tube holders, 1000 Pieces	per item	$	5.50
Communication	Banner	per item	$	25.00
Communication	Full page ad (newspaper)	per day	$	1,000.00
Communication	Handbills	per item	$	0.75
Communication	Maintenance of Website	per year	$	400.00
Communication	Multimedia projector + screen (rental)	per day	$	100.00
Communication	Posters	per item	$	1.50
Communication	Quarter page ad (newspaper)	per day	$	1,050.00
Communication	Radio antenna	per item	$	25.00
Communication	Radio transmitter	per item	$	90.00
Communication	Setting up of website	per item	$	1,785.71
Communication	Telephone (handset)	per item	$	40.00
Communication	Telephone (scratch card)	per item	$	10.00
Communication	Toll Free lines	per item	$	1,785.71
Equipment	Computer and Printer (rent)	per day	$	110.00
Equipment	Computer software - specialized areas (estimate)	per item	$	500.00
Equipment	Desktop computer	per item	$	1,250.00
Equipment	Laptop	per item	$	1,000.00
Equipment	Card Readers	per item	$	500.00
Equipment	Colour Printer	per item	$	800.00
Equipment	Digital Camera	per item	$	400.00
Equipment	Filing cabinets	per item	$	394.74
Equipment	Filing cabinets (large)	per item	$	1,491.00
Equipment	Fridge	per item	$	714.00
Equipment	Heavy duty photocopier	per item	$	2,500.00
Equipment	Maintenace of motor vehicles - Fixed amount	per item	$	2,000.00
Equipment	Maintenance and operation of motor vehicles (30 000km)	per item	$	9,350.00
Equipment	Motor Vehicle	per item	$	40,000.00
Equipment	Scanner	per item	$	100.00
Equipment	Touch Screen Computer	per item	$	1,500.00
Equipment	Air conditioner	per item	$	428.57
Equipment	Anglepoise lamp	per item	$	72.33
Equipment	Back-up Generator	per item	$	3,000.00
Equipment	Ceiling fan	per item	$	35.71
Equipment	Chair	per item	$	100.00
Equipment	Clinic Beds	per item	$	300.00
Equipment	Clinic Sets	per item	$	5,000.00
Equipment	Couches	per item	$	300.00
Equipment	Domestic Refrigerators	per item	$	2,000.00
Equipment	Gas Cylinder and burner	per item	$	71.43
Equipment	Generator	per item	$	500.00
Equipment	Incinerator	per item	$	285,000.00
Equipment	Laboratory Furniture (estimate)	per facility	$	30,000.00
Equipment	Office Furniture (estimate)	per facility	$	15,000.00
Equipment	Scanner	per item	$	142.86
Equipment	Table	per item	$	110.00
Equipment	Locked Cabinet	per item	$	180.00
Equipment	Shelves	per item	$	75.00
Equipment	Solar Panels (estimate)	per item	$	1,000.00
Equipment	Solar Power System (estimate)	per item	$	2,500.00
Facility	Administrative Building (construct)	per facility	$	30,000.00
Facility	ART Site (refurbish and expand)	per facility	$	50,000.00
Facility	Cold Storage/Second Consultation room (establish)	per facility	$	1,500.00
Facility	Counseling room (establish)	per facility	$	1,500.00
Facility	Hall rental for participants less that 25p	per day	$	150.00
Facility	Hall Rental(holding at least 25 persons)	per day	$	250.00
Facility	Health Club (establish)	per facility	$	1,500.00
Facility	Hotel room rental	per night	$	80.00
Facility	Laboratory (establish)	per facility	$	10,000.00
Facility	PMTCT Centre (establish)	per facility	$	1,500.00
Facility	Renovations of Facilities/Room construction	per facility	$	10,000.00
Facility	Renovations of Laboratory	per facility	$	3,500.00
Facility	Staff Housing (establish)	per facility	$	4,500.00
Facility	Training Venue (rental)	per day	$	150.00
Facility	VCT Centre (establish)	per facility	$	1,500.00
Facility	Youth Friendly Centre (establish)	per facility	$	1,500.00

Facility	Waiting Houses (establish)	per facility	$ 1,500.00
Medical Equipment	4° C Laboratory refridgerator, double door	per item	$ 2,475.00
Medical Equipment	4° C Laboratory refridgerator, single door	per item	$ 1,773.20
Medical Equipment	AFB Smear Microscopy microscopes	per item	$ 3,000.00
Medical Equipment	Auto clave (table-size)	per item	$ 6,000.00
Medical Equipment	Automated CD4 counting machine	per item	$ 30,000.00
Medical Equipment	Automated chemistry analyzer full system, 240 V - Low volume	per item	$ 12,000.00
Medical Equipment	Automated ELISA plate Reader & Washer & Parts	per item	$ 13,400.00
Medical Equipment	Automated ELISA plate washer (8 or 12 strip) with waste container	per item	$ 5,500.00
Medical Equipment	Automated haematology analyzer full system, Low volume	per item	$ 10,000.00
Medical Equipment	Binding machine	per item	$ 107.14
Medical Equipment	Biological safety hood	per item	$ 3,271.00
Medical Equipment	Blood Analyzing Machine	per item	$ 24,000.00
Medical Equipment	Blood Bag Separator	per item	$ 350.00
Medical Equipment	Blood Bank Freezers	per item	$ 3,300.00
Medical Equipment	Blood Bank Refrigerators (Large)	per item	$ 20,000.00
Medical Equipment	Blood Bank Refrigerators (Small)	per item	$ 11,500.00
Medical Equipment	Blood Pressure cuff	per item	$ 100.00
Medical Equipment	Blood Processing equipment	per item	$ 30,000.00
Medical Equipment	Bunsen Burners	per item	$ 30.00
Medical Equipment	Carbon Dioxide incubator	per item	$ 6,000.00
Medical Equipment	CD4 manual equipment set	per item	$ 2,690.99
Medical Equipment	Centrifuge, bench, non-refrigerated, with standard rotor to accept 13 x 100 mm blood tubes, 240 V, 50/60 Hz	per item	$ 1,800.00
Medical Equipment	Clamp	per item	$ 10.00
Medical Equipment	Delivery room equipment	per facility	$ 2,000.00
Medical Equipment	DNA PCR machine	per item	$ 200,000.00
Medical Equipment	ELISA Analysis System	per item	$ 20,440.00
Medical Equipment	Freezer, -20° C, 10 Cubic ft	per item	$ 3,200.00
Medical Equipment	Glucometer and strips	per item	$ 54.00
Medical Equipment	Heating blocks	per item	$ 550.00
Medical Equipment	Hematocrite Machine	per item	$ 36,000.00
Medical Equipment	Humidified CO2 incubator, with CO2 cylinder and regulator	per item	$ 4,000.00
Medical Equipment	Icebox for blood bags	per item	$ 40.00
Medical Equipment	Incinerator	per item	$ 15,000.00
Medical Equipment	Incubator (37 degree)	per item	$ 6,000.00
Medical Equipment	Incubator, 37?C	per item	$ 4,500.00
Medical Equipment	Insulated chest for blood transport	per item	$ 220.00
Medical Equipment	Laboratory scale and weights	per item	$ 100.00
Medical Equipment	Magnetic stirrer, with heater and stir bars	per item	$ 400.00
Medical Equipment	Manual Hemoglobinometer	per item	$ 250.00
Medical Equipment	Mechanical 3D bidirectional blood tube rocker/rotator 240V, 50/60 Hz	per item	$ 500.00
Medical Equipment	Microbiology incinerator	per item	$ 300.00
Medical Equipment	Microscope	per item	$ 959.00
Medical Equipment	Microtitre plate incubator	per item	$ 2,000.00
Medical Equipment	Mini Centrifuge	per item	$ 5,000.00
Medical Equipment	Mobile refrigerators	per item	$ 550.00
Medical Equipment	Needles and syringes	per item	$ 0.09
Medical Equipment	Olympus Blood Grouper	per item	$ 450,000.00
Medical Equipment	Pelvic model (male)	per item	$ 207.04
Medical Equipment	Pevlic model (female)	per item	$ 260.12
Medical Equipment	Platelet Mixer	per item	$ 2,750.00
Medical Equipment	Point of Care CD4 testing	per item	$ 15,000.00
Medical Equipment	Portable adjustable donor chairs	per item	$ 150.00
Medical Equipment	Portable donor table	per item	$ 1,600.00
Medical Equipment	Portable Eyewash station (gravity fed)	per item	$ 168.00
Medical Equipment	Scale for weighing blood	per item	$ 100.00
Medical Equipment	Sharps disposal containers	per item	$ 43.00
Medical Equipment	Sterilizer	per item	$ 2,258.85
Medical Equipment	Sterilizer (instant)	per item	$ 248.15
Medical Equipment	Stethoscope	per item	$ 90.00
Medical Equipment	Temperature control for platelet storage	per item	$ 5,500.00
Medical Equipment	Timer	per item	$ 34.32
Medical Equipment	Transverse Blood Bag Agitator	per item	$ 1,000.00
Medical Equipment	Uninterruptible power supply unit	per item	$ 1,000.00
Medical Equipment	Variable temperature water bath	per item	$ 1,000.00
Medical Equipment	Vortex-Genie mixer 230V 50/60 HZ	per item	$ 400.00
Medical Equipment	Water Bath	per item	$ 1,200.00
Medical Equipment	Water Distiller, complete with wall bracket and tubing	per item	$ 1,000.00
Medical Equipment	Analytical balance	per item	$ 3,500.00
Medical Equipment	Autoclave 110 ml	per item	$ 10,000.00
Medical Equipment	Chemistry Analyser	per item	$ 25,000.00
Medical Equipment	CD4 Count	per item	$ 4.25
Medical Equipment	CD4 Machine	per item	$ 30,000.00
Medical Equipment	Centrifuge	per item	$ 2,502.00
Medical Equipment	CentriVaprDNA Centrifugal Concentrator System and accessories	per item	$ 8,571.00
Medical Equipment	Distiller (water still) Dionizer	per item	$ 700.00
Medical Equipment	EID	per item	$ 14.00
Medical Equipment	Haematology	per item	$ 1.78
Medical Equipment	Haematology Analyser	per item	$ 30,000.00
Medical Equipment	Micro tube racks	per item	$ 12.00
Medical Equipment	Microscopes	per item	$ 1,500.00
Medical Equipment	Multichannel pipette/dispensers	per item	$ 952.00
Medical Equipment	Automated pipettes	per item	$ 540.00
Medical Equipment	PH Meter	per item	$ 1,500.00
Medical Equipment	Phenotypic resistance profiling	per item	$ 300.00
Medical Equipment	Pipettors P200	per item	$ 714.00
Medical Equipment	Powered pipette-aids	per item	$ 610.00
Medical Equipment	Test Tube Racks	per item	$ 12.00
Medical Equipment	Voltex mixer	per item	$ 2,000.00
Medical Equipment	Viral Load machine	per item	$ 160,000.00
Medical Supplies	8 channel manual serology pipettor, 50-250 ul	per item	$ 730.00
Medical Supplies	8 channel manual serology pipettor, 5-50 ul	per item	$ 730.00

Medical Supplies	ACT Diff II - 4 C Plus normal (control), 3 x 3.3 ml	per item	$	127.00
Medical Supplies	ACT Diff Rinse 1 litre	per item	$	47.00
Medical Supplies	ACT Diff. Pack reagent 15 l/0,3 l	per item	$	274.00
Medical Supplies	Adult Blood Bags	per item	$	2.43
Medical Supplies	Alcohol 70%	per item	$	30.00
Medical Supplies	Alcohol Swab	per item	$	2.14
Medical Supplies	Antibiotic (negative)	per item		
Medical Supplies	Antibiotic (positive)	per item		
Medical Supplies	Anaerobic satchets (package)	per item	$	23.55
Medical Supplies	Immersion oil	per item	$	1.48
Medical Supplies	Microaerophilic sachets	per item	$	34.65
Medical Supplies	Microcapillary tubes (A)	per item	$	2.50
Medical Supplies	Microcapillary tubes (B)	per item	$	3.66
Medical Supplies	Microscope cover slip	per item	$	5.16
Medical Supplies	Microscope slide	per item	$	1.70
Medical Supplies	Microscope slide cover slip	per item	$	8.00
Medical Supplies	Pipette tips (A)	per item	$	15.28
Medical Supplies	Pipette tips (B)	per item	$	6.54
Medical Supplies	Sterile swab	per item	$	39.20
Medical Supplies	Stool containers	per item	$	47.04
Medical Supplies	Universal container	per item	$	47.04
Medical Supplies	Vacutainer (A)	per item	$	17.50
Medical Supplies	Vacutainer (B)	per item	$	33.19
Medical Supplies	Vacutainer (C)	per item	$	17.37
Medical Supplies	Vacutainer holder	per item	$	9.00
Medical Supplies	Vacutainer needle	per item	$	9.05
Medical Supplies	Test tube	per item	$	2.41
Medical Supplies	CAP/CTM HIV - version 2.0	per item	$	1,116.00
Medical Supplies	COBAS TaqMan K Tubes	per item	$	922.50
Medical Supplies	CAP - G Wash Buffer	per item	$	78.00
Medical Supplies	CAP SPU Flapless	per item	$	697.50
Medical Supplies	CAP S Tubes (input)	per item	$	247.50
Medical Supplies	CAP K tips	per item	$	202.50
Medical Supplies	Roche AMPLICOR Ver 1.5 kit	per item	$	840.00
Medical Supplies	DBS Bundles	per item	$	141.00
Medical Supplies	DNA PCR Consumables Kits	per item	$	2,728.00
Medical Supplies	Plate Sealers	per item	$	4.00
Medical Supplies	Vacutainer Tube, K2-EDTA, 4mL, Lavender, 100 Pcs	per item	$	17.65
Medical Supplies	Vacutainer, Lithium Heparin, 4mL, 100 Pcs	per item	$	100.00
Medical Supplies	Vancomycin 30ug 250 Discs	per item	$	7.26
Medical Supplies	Blood Agar Base 500 Grams	per item	$	82.93
Medical Supplies	Cotton Wool 1000 Grams	per item	$	10.00
Medical Supplies	DPX Mountant For Microscopy 100mL	per item	$	18.10
Medical Supplies	Filter Paper, Round, Large, 100 Pcs	per item	$	4.86
Medical Supplies	Filter Paper, Round, Medium, 100 Pcs	per item	$	18.82
Medical Supplies	Fuchsin Acid, Certified Biological Stain, 25g	per item	$	55.30
Medical Supplies	Gloves, Latex, Powder-Free, Lg, 100 Pcs	per item	$	5.59
Medical Supplies	Gloves, Latex, Powder-Free, Sm, 100 Pcs	per item	$	8.95
Medical Supplies	Sysmex, Cell Cleaner, 50mL	per item	$	111.24
Medical Supplies	Orange G 6 solution 1000 mL	per item	$	45.69
Medical Supplies	Penicillin 10 units 250 Discs	per item	$	7.26
Medical Supplies	Plastic Serum Tube, 4mL, 13 x 75mm, 1000 Pcs	per item	$	8.60
Medical Supplies	Salmonella Paratyphi A-O, 5ml	per item	$	15.37
Medical Supplies	Salmonella Paratyphi B-O, 5ml	per item	$	38.85
Medical Supplies	Salmonella Paratyphi C-H, 5ml	per item	$	22.00
Medical Supplies	Salmonella Paratyphi C-O, 5ml	per item	$	12.27
Medical Supplies	Salmonella polyvalent O antisera 5 ml	per item	$	43.13
Medical Supplies	Selenite-F Broth, Salmonella Enrichment, 10 x 8mL	per item	$	30.12
Medical Supplies	Shigella boydii polyvalent 1-10 5 mL	per item	$	100.71
Medical Supplies	Sodium Hypochlorite Solution, 6-14%, 500 ml	per item	$	5.47
Medical Supplies	Spirit methylated 2.5 Liters	per item	$	5.50
Medical Supplies	Stain, Papanicolaou, EA 50, 500mL	per item	$	65.00
Medical Supplies	Biohazard Bags	per item	$	0.05
Medical Supplies	Bioline	per item	$	20.00
Medical Supplies	Biowaste plastic bags / large, autoclavable	per item	$	9.62
Medical Supplies	Biowaste plastic bags / medium, autoclavable	per item	$	9.62
Medical Supplies	Biowaste plastic bags / small size, autoclavable	per item	$	9.62
Medical Supplies	Bleach	per item	$	5.00
Medical Supplies	Blood Lancet	per item	$	0.01
Medical Supplies	Bottle plastic, 250 ml, wash bottle	per item	$	0.64
Medical Supplies	Calamine Lotion 100ml	per item	$	0.75
Medical Supplies	Capillus	per item	$	139.00
Medical Supplies	CHBC kit	per item	$	53.57
Medical Supplies	Chlorine Bleach (Jik)	per item	$	1.31
Medical Supplies	Clamedia kits lab reagent	per item		
Medical Supplies	Condom (female) + distribution + storage	per item	$	0.57
Medical Supplies	Condom (male) + distribution + storage	per item	$	0.04
Medical Supplies	Cotton Wool 500g	per item	$	2.95
Medical Supplies	Crepe Bandage 10.0 cm X 4 m	per item	$	0.17
Medical Supplies	Crepe Bandage 15.0 cm X 4 m	per item	$	0.25
Medical Supplies	Culture media 500g (basement agar)	per item		
Medical Supplies	Culture plate (carton of 400)	per item		
Medical Supplies	Determine Chase Buffer	per item	$	1.00
Medical Supplies	Determine test kit	per item	$	100.00
Medical Supplies	Diaphragm	per item	$	14.30
Medical Supplies	Disposable container (for sharps)	per item	$	11.00
Medical Supplies	Disposable, latex, powder-free gloves, Large	per item	$	5.74
Medical Supplies	Disposable, latex, powder-free gloves, Medium	per item	$	5.74
Medical Supplies	Disposable, latex, powder-free gloves, Small	per item	$	5.74
Medical Supplies	Disposables container (for Reagents & Consumables)	per item	$	11.00
Medical Supplies	Dynabeads Kit	per item	$	480.00
Medical Supplies	EQA Panels	per item	$	50.00

Medical Supplies	EQA test kit reagents (representative panel)	per item	$	2.00
Medical Supplies	Finnpipet 100-1000UL	per item	$	250.00
Medical Supplies	Finnpipet 20-200UL	per item	$	250.00
Medical Supplies	Gauze 2"	per item	$	0.02
Medical Supplies	Gauze 3"	per item	$	0.02
Medical Supplies	Gauze 4"	per item	$	0.02
Medical Supplies	Gentian Violet	per item	$	0.32
Medical Supplies	Gram stain (acetone) lab reagent	per item	$	53.57
Medical Supplies	Gram stain (neutral red) lab reagent	per item		
Medical Supplies	Gram stain 500mls (crystal violet) lab reagent	per item		
Medical Supplies	HBC commodities (kit)	per item	$	28.57
Medical Supplies	HBC kit	per item	$	4.40
Medical Supplies	Hepatitis B Test	per item	$	90.00
Medical Supplies	Hepatitis C Test	per item	$	90.00
Medical Supplies	Individually wrapped self-adhesive bandage	per item	$	5.00
Medical Supplies	IUCD	per item	$	0.80
Medical Supplies	IUCD insertion kit	per item	$	106.60
Medical Supplies	Lubricant (tube)	per item	$	0.89
Medical Supplies	Methylathed spirit liquid, 70% litres	per item	$	5.00
Medical Supplies	Mobile clinics	per item	$	1,000.00
Medical Supplies	Mobile vaccinations	per item	$	1,000.00
Medical Supplies	Nutritional Support for Adults (pk)	per month	$	14.29
Medical Supplies	Nutritional Support for children (pk)	per month	$	21.43
Medical Supplies	Oral contraceptive pills	per month	$	15.00
Medical Supplies	ORS Sachet	per item	$	0.25
Medical Supplies	Paper A4, 500 sheets, 80 g	per item	$	7.80
Medical Supplies	Partec Counter - CD4 easy count kit (100 Tests)	per item	$	287.79
Medical Supplies	Partec Counter - Thermal Paper, 5 Rolls	per item	$	15.39
Medical Supplies	Partec Counter- Celltrics 50 um Yellow, 250ml	per item	$	277.07
Medical Supplies	Partec Counter- Cleaning Solution, 250 ml	per item	$	13.69
Medical Supplies	Partec Counter- CountCheck Beads green, 50 Tests	per item	$	63.28
Medical Supplies	Partec Counter- Decontamination Liquid, 250 ml	per item	$	42.77
Medical Supplies	Partec Counter- Sample Tubes, 3.5 ml (500 pcs.)	per item	$	16.93
Medical Supplies	Partec Counter- Sheath Fluid (5L)	per item	$	80.40
Medical Supplies	Partec Cyflow - CD4 easy count kit (100 Tests)	per item	$	287.79
Medical Supplies	Partec Cyflow - Thermal Paper, 5 Rolls	per item	$	15.39
Medical Supplies	Partec Cyflow- Celltrics 50 um Yellow, 250ml	per item	$	277.07
Medical Supplies	Partec Cyflow- Cleaning Solution, 250 ml	per item	$	13.69
Medical Supplies	Partec Cyflow- CountCheck Beads green, 50 Tests	per item	$	63.28
Medical Supplies	Partec Cyflow- Decontamination Liquid, 250 ml	per item	$	42.77
Medical Supplies	Partec Cyflow- Sample Tubes, 3.5 ml (500 pcs.)	per item	$	16.93
Medical Supplies	Partec Cyflow- Sheath Fluid (5L)	per item	$	80.40
Medical Supplies	Pastuer Pipettes	per item	$	0.05
Medical Supplies	Pediatric Blood Bags	per item	$	4.32
Medical Supplies	PEP kit(PPEs)	per item	$	35.71
Medical Supplies	Petri dishes	per item	$	38.78
Medical Supplies	Petri dishes - 60mm X 15mm	per item	$	8.45
Medical Supplies	Pipette Tips, 200-1000µl (1000 pcs.)	per item	$	17.30
Medical Supplies	Pipette Tips, 20-200µl (1000 pcs.)	per item	$	17.30
Medical Supplies	Resuscitation Sets	per item	$	500.00
Medical Supplies	Ribbon Black OKI 3390 ou EPSON LX- 300 +	per item	$	29.71
Medical Supplies	Sharp bins	per item	$	1.34
Medical Supplies	Sharps container (1000 sharps capacity)	per item	$	9.75
Medical Supplies	Single channel pipette (1000 ul)	per item	$	250.00
Medical Supplies	Single channel pipette (20-200 ul)	per item	$	250.00
Medical Supplies	Single channel pipette (5-50 ul)	per item	$	250.00
Medical Supplies	Sodium Hypoclorite	per item	$	1.16
Medical Supplies	STI drugs (estimate)	per person	$	10.71
Medical Supplies	Swab gauze NS 8 ply 50 x 50	per item	$	30.00
Medical Supplies	RPR Syphilis Test Kit, 100 Tests	per item	$	7.00
Medical Supplies	Sysmex Kx 21 - Cell clean CL.50 50 ml	per item	$	67.81
Medical Supplies	Sysmex Kx 21 - CellPack PK 20 liters	per item	$	50.99
Medical Supplies	Sysmex Kx 21 - Control Eight-THECK Low, 1,5 ml	per item	$	22.10
Medical Supplies	Sysmex Kx 21 - Contrôle Eight-THECK Hight, 1,5 ml	per item	$	22.10
Medical Supplies	Sysmex Kx 21 - Contrôle Eight-THECK Normal, 1,5 ml	per item	$	22.10
Medical Supplies	Sysmex Kx 21 - printer paper roll 5m	per item	$	3.60
Medical Supplies	Sysmex Kx 21 - Stromatolyser-WH, 3x500 ml	per item	$	407.88
Medical Supplies	TB Treament appointment card	per item	$	0.40
Medical Supplies	Test kit (estimate)	per item	$	3.57
Medical Supplies	Test, blood group, anti A + B, 10 ml	per item	$	13.00
Medical Supplies	Test, blood group, anti A, 10 ml	per item	$	13.00
Medical Supplies	Test, blood group, anti B, 10 ml	per item	$	13.00
Medical Supplies	Test, blood group, anti D, 10 ml	per item	$	13.00
Medical Supplies	Transfusion Sets	per item	$	1.50
Medical Supplies	Unscented vaseline (blue seal)	per item	$	0.02
Medical Supplies	Vitros DT - 60 - ALP	per item	$	40.80
Medical Supplies	Vitros DT - 60 – Amylase	per item	$	40.80
Medical Supplies	Vitros DT - 60 - Bilirubin Direct	per item	$	40.80
Medical Supplies	Vitros DT - 60 - Bilirubin Total	per item	$	40.80
Medical Supplies	Vitros DT - 60 - BUN	per item	$	40.80
Medical Supplies	Vitros DT - 60 - Cholesterol	per item	$	40.80
Medical Supplies	Vitros DT - 60 - Creatinine	per item	$	40.80
Medical Supplies	Vitros DT - 60 - DT Printer Paper	per item	$	6.06
Medical Supplies	Vitros DT - 60 - DT Samples tips	per item	$	12.90
Medical Supplies	Vitros DT - 60 - DT-Plus Calibrator	per item	$	154.71
Medical Supplies	Vitros DT - 60 - Glucose	per item	$	40.80
Medical Supplies	Vitros DT - 60 - GOT	per item	$	40.80
Medical Supplies	Vitros DT - 60 - GPT	per item	$	40.80
Medical Supplies	Vitros DT - 60 – Triglycerides	per item	$	40.80
Medical Supplies	Vitros DT - 60 - Vitros DT Control 1	per item	$	64.49
Medical Supplies	Vitros DT - 60 - Vitros DT Control 2	per item	$	64.49
Misc	Annual Audit (estimate)	per year	$	28,571.43

Misc	Community Health Development Committees (CHDC) (establish)	per item	$	500.00
Misc	Cost for evening/overnight coverage (1 clinic)	per day		
Misc	Cost for weekend coverage (1 clinic)	per week		
Misc	Test Sample plus Courier fees (estimate)	per item	$	15.00
Misc	Daily Service Allowance - Facilitators	per day	$	150.00
Misc	Distribution cost of drugs to patients (estimate)	per person		
Misc	Drug sample analysis	per item	$	3,571.43
Misc	Estimated tuition (UNZA fee for 18mth)	per item	$	7,000.00
Misc	Transporting DBS sample	per item	$	2.00
Misc	UPS/DHL shipping (estimate)	per item	$	500.00
Misc	Overhead	per mth	$	500.00
Misc	Phenotypic resistance profiling	per item	$	300.00
Monitoring & Evaluation	SmartCard	per item	$	1.30
Monitoring & Evaluation	M&E Grant	per item	$	700.00
Monitoring & Evaluation	External quality assurance inspection	per inspection	$	4,762.00
Monitoring & Evaluation	HDR Surveillance - annual surveys	per survey	$	21,813.00
Monitoring & Evaluation	Monitoring visits to survey sites	per visit	$	1,663.00
Monitoring & Evaluation	Annual summary report on TB case finding	per item	$	2.40
Salary	Accountant	per year	$	30,000.00
Salary	Administrative Assistant	per year		
Salary	Anesthetist	per year		
Salary	Programme Auxiliary	per year	$	11,400.00
Salary	Project Manager	per year	$	30,000.00
Salary	M&E Officer	per year	$	24,000.00
Salary	Retention: Adherence supporter	per year	$	360.00
Salary	Retention: CHA	per month	$	50.00
Salary	Retention: Doctors	per year	$	1,800.00
Salary	Retention: Lab technicians	per year	$	1,200.00
Salary	Retention: Laboratory Supervisor	per year	$	1,800.00
Salary	Retention: M&E officers	per year	$	1,200.00
Salary	Retention: Nurses	per year	$	1,200.00
Salary	Retention: Paramedics	per year	$	1,200.00
Salary	Retention: Pharmacists	per year	$	1,200.00
Salary	Data Analyst (for software development)	per year	$	36,000.00
Salary	Driver	per year	$	6,000.00
Salary	Driver (on day contract)	per day	$	45.00
Salary	DSA - Accreditation surveyor	per day	$	35.00
Salary	DSA - Driver	per day	$	20.00
Salary	DSA - International Consultants	per day	$	750.00
Salary	DSA - Local Consultants	per day	$	500.00
Salary	DSA - Meeting participant (local)	per day	$	30.00
Salary	DSA - Meeting participant (non-local)	per day	$	35.00
Salary	International Consultants - fees	per day	$	300.00
Salary	International Consultants - international and domestic travel	per item	$	2,000.00
Salary	Lab Aide	per year	$	900.00
Salary	Lab Technician	per year	$	14,400.00
Salary	Local Consultants	per day	$	150.00
Salary	Local Consultants - travel(air travel)	per item	$	350.00
Salary	M&E Officer	per year	$	24,000.00
Salary	Security	per year	$	2,400.00
Salary	Software Developer	per year	$	36,000.00
Supplies	A4 Paper/Ream	per item	$	7.14
Supplies	Adhensive Tapes	per item	$	1.11
Supplies	Auto Disable syringes	per item	$	0.08
Supplies	Back drop	per item	$	142.86
Supplies	Bags	per item	$	2.14
Supplies	Bench Pad	per item	$	0.22
Supplies	Biro	per item	$	2.14
Supplies	Boxes of coverslips	per item	$	16.43
Supplies	Boxes of slide	per item	$	214.87
Supplies	Child Prophylaxis card	per item	$	0.40
Supplies	Child Prophylaxis register	per item	$	2.00
Supplies	Cohort reporting formats	per item	$	2.40
Supplies	Cohort reporting treatment outcome	per item	$	2.40
Supplies	Conference bag	per item	$	7.14
Supplies	Cotton wool	per item	$	2.83
Supplies	Defaulter tracing form	per item	$	2.40
Supplies	EDTA Bottles	per item	$	0.16
Supplies	ELISA Readers (Back up)	per item	$	4,400.00
Supplies	ELISA Washers (Back up)	per item	$	2,200.00
Supplies	Enumerators	per item	$	35.71
Supplies	Face cap	per item	$	2.86
Supplies	Files/Folder	per item	$	3.57
Supplies	Fine Tips Pen	per item	$	1.19
Supplies	Flip Chart Paper	per item	$	14.29
Supplies	Flip Chart Stand	per item	$	40.00
Supplies	Gloves (all sizes)	per item	$	0.05
Supplies	Hand Towels	per item	$	0.13
Supplies	Injectables	per item	$	2.50
Supplies	Laboratory Coats(All Sizes)	per item	$	13.57
Supplies	Laboratory register for culture	per item	$	2.00
Supplies	Laboratory slide collection and rechecking form	per item	$	2.40
Supplies	Laboratory sputum dispatch register	per item	$	2.40
Supplies	Laboratory sputum register	per item	$	2.00
Supplies	Latex Gloves	per item	$	0.05
Supplies	Marker (pack)	per item	$	4.00
Supplies	Order form for laboratory reagents and supplies	per item	$	2.40
Supplies	Pair of Scissors	per item	$	1.57
Supplies	Pencil	per item	$	0.35
Supplies	Pill box	per item	$	1.43
Supplies	Plaster	per item	$	5.00
Supplies	Postage	per item	$	0.71

Supplies	Printing of report	per item	$	4.00
Supplies	Quarterly anti-TB drug estimation form	per item	$	2.40
Supplies	Quarterly report on case finding in health facilities	per item	$	5.00
Supplies	Quarterly reporting formats of new smear positive cases	per item	$	2.40
Supplies	Quarterly reporting formats of sputum conversion of new smear positive cases	per item	$	2.40
Supplies	Quarterly stock report and order for anti-TB drugs	per item	$	2.40
Supplies	Registers	per item	$	7.14
Supplies	Reporting form	per item	$	1.25
Supplies	Request form for Sputum examination (AB Microscopy)	per item	$	0.36
Supplies	Request form for Sputum examination (Culture and DST)	per item	$	2.40
Supplies	Roll of cotton wool 100g	per item	$	2.83
Supplies	Rolls of plaster 4"	per item	$	5.00
Supplies	Ruler	per item	$	0.36
Supplies	Serviettes	per item	$	1.11
Supplies	Size estimation tags	per item	$	2.00
Supplies	SOP Guidelines	per item	$	10.00
Supplies	Beans 2Kg/ month	per quarter	$	6.00
Supplies	Cooking oil 1.5 litres	per quarter	$	9.00
Supplies	Heps 5 kg/month	per quarter	$	12.00
Supplies	Maize Meal 25kg per Month	per quarter	$	30.00
Supplies	RUTF supply for children	per quarter	$	33.70
Supplies	Salt/500g/month	per quarter	$	1.20
Supplies	Sugar 4 kg/month	per quarter	$	10.80
Supplies	Stationaries	per item	$	3.57
Supplies	Patient register	per item	$	2.00
Supplies	Patient treatment cards	per item	$	0.40
Supplies	Timers	per item	$	10.50
Supplies	Toilet Soap	per item	$	0.29
Supplies	Toner	per item	$	45.00
Supplies	Training manuals / guideline	per item	$	10.00
Supplies	T-Shirt	per item	$	4.29
Supplies	Tube Racks	per item	$	5.00
Supplies	Wash hand basin	per item	$	4.29
Supplies	Wash hand basin stand	per item	$	21.43
Supplies	Wash hand soap - liquid	per item	$	1.70
Supplies	Waste bin	per item	$	17.86
Supplies	Water	per item	$	0.50
Supplies	Water baths	per item	$	550.00
Supplies	Water distiller	per item	$	535.71
Supplies	Wristband	per item	$	2.14
Supplies	Writing pad	per item	$	2.14
Vehicle	Ambulance/ Delivery / Multi-purpose Vehicle (4x4)	per item	$	40,000.00
Vehicle	Bicycle	per item	$	100.00
Vehicle	Blood Collection delivery van	per item	$	35,000.00
Vehicle	Collection Vehicles	per item	$	30,000.00
Vehicle	Fuel (estimate)	per week	$	55.00
Vehicle	Fuelling, repairs and maintenace (annual)	per year	$	4,750.00
Vehicle	Insurance (estimate)	per year	$	2,500.00
Vehicle	Motorbike	per item	$	1,500.00
Vehicle	Motorbike fuelling, repairs and maintenance (annual)	per year	$	928.57
Vehicle	Truck rentals	per day	$	71.43