NATIONAL HIV/AIDS STRATEGIC FRAMEWORK 2017 - 2021

LEAVING NO ONE BEHIND ON THE FAST TRACK TO CONTROLLING THE HIV EPIDEMIC BY 2020 AND ENDING THE THREAT OF HIV AND AIDS AS A PUBLIC HEALTH ISSUE BY 2030

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
CDC	Centres for Disease Control and Prevention
DEC	Drug Enforcement Commission
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
CWA	Community Welfare Assistance
DACA	District AIDS Coordination Advisor
DATF	District AIDS Task Force
DBS	Dry Blood Spot
DHS	Demographic and Health Survey
DFID	Department for International Development
DWA	District Welfare Assistance
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
FISP	Farmer Input Support Programme
FSW	Female Sex Worker
GBV	Gender Based Violence
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GIDD	Gender in Development Division
GRZ	Government of the Republic of Zambia

HCW	Health Care Worker
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IEC	Information, Education and Communication
JARP	Joint Annual Review Process
JMTR	Joint Mid-Term Review
KII	Key Informant Interview
LDTD	Long Distance Truck Drivers
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Populations
MCP	Multiple Concurrent Partnerships
MOH	Ministry of Health
MSM	Men who Have Sex with Men
MYSCD	Ministry of Youth, Sports and Child Development
NAC	National HIV/AIDS/STI/TB Council
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
NZP+	Network of Zambian People Living with HIV
OVC	Orphans and Vulnerable Children
PACA	Provincial AIDS Coordination Advisor
PATF	Provincial AIDS Task Force
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV

PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disabilities
PWID	People Who Inject Drugs
R-NASF	Revised National AIDS Strategic Framework
R-SNPD	Revised Sixth National Development Plan
SADC	Southern African Development Community
SBCC	Social and Behaviour Change Communication
SCT	Social Cash Transfer
SDG	Sustainable Development Goals
SMAGs	Safe Motherhood Action Groups
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
UTH	University Teaching Hospital
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
VSU	Victim Support Unit
WHO	World Health Organisation
WILSA	Women in Law in Southern Africa
WV	World Vision
YWCA	Young Women Christian Association

ZAMPHIA	Zambia Population Based HIV Impact Assessment
ZDHS	Zambia Demographic and Health Survey
ZNBTS	Zambia National Blood Transfusion Services

FOREWORD

Over the past three decades, the Government of the Republic of Zambia, together with its development partners, have provided unwavering support to the Acquired Immune Deficiency Syndrome (AIDS) response in the country. Since 2002, when the first National AIDS Strategic Plan was launched, Zambia has recorded remarkable accomplishments in halting and beginning to reverse the effects of the epidemic. Estimated annual new infections among adults aged over 15 years have dropped from 67, 000 to 46, 000 during this period, while those for children aged 0 - 14 years have dropped from 23, 000 to 8, 900. Annual AIDS-related deaths have seen similar decreases from 69, 000 to 20, 000. Out of the estimated 1, 060, 000 People Living with HIV (PLHIV) as at December 2016, currently over 800, 000 are on life-saving Anti-Retroviral Therapy (ART) while around three million are counselled and tested and know their HIV results annually. By the end of 2016, there were over 1, 800 health facilities countrywide providing HIV testing and counselling services and the number of ART sites had increased from 509 in 2011 to over 870 in 2016.

In spite of all these achievements, Zambia is still one of the top 10 countries in the world with the highest number of PLHIV. Nevertheless, the Government is committed to ending the AIDS epidemic by 2030 by adopting the Joint United Nations Programme on AIDS (UNAIDS) Fast-Track Goals of achieving the 90-90-90 treatment targets by 2020 and focusing on high-burden locations and populations affected by the epidemic. In order to achieve these targets, it is necessary to remove treatment thresholds and move to "test and start" with particular focus on adolescents, young people and populations left behind, as well as strengthening viral load testing. Continued commitment to achieving gender equity and equality is also required in the spirit of not leaving anyone behind with regards to HIV prevention, treatment, care and support. In this regard, Zambia reaffirms its commitment to apply 25 per cent of HIV resources to prevention and maintain a legal, political and social environment that enables an effective HIV and AIDS response.

In the existing economic climate, effective resource mobilisation is required as donor assistance has declined steadily over the past several years. Government continues to increase funding to the health sector in general and the HIV response specifically, evidenced by, among other measures, the provision of varying budgetary allocations to Government Ministries for public sector HIV and AIDS mainstreaming activities. Zambia will, however, still require support from cooperating partners with a focus on assistance that contributes to sustainable programmes and systems.

I, therefore, would like to thank all the stakeholders who have collaborated in the national AIDS response to date and call on their continued partnership as we approach a critical point in permanently changing the course of the AIDS response.

Dr. Chitalu Chilufya
Minister of Health

PREFACE

The National AIDS Strategic Framework (NASF) 2017 - 2021 is designed to provide adequate space and opportunities for communities, civil society, private sector, development partners (bilateral and multi-lateral agencies) and Government institutions to actively participate in the implementation of evidence-based HIV and AIDS programmes, depending on their mandates and comparative advantages.

This NASF was developed through a highly participatory and consultative process and reflects the aspirations of the people of Zambia in their efforts to fight the HIV and AIDS epidemic. The framework will support decentralised implementation with meaningful involvement of communities, PLHIV, Civil Society Organisations (CSOs) and marginalised populations so as not to leave anyone behind in the response.

I, therefore, urge all stakeholders to formulate and implement innovative interventions that are aligned to this NASF. The National HIV/AIDS/STI/TB Council (NAC) will provide policy and technical guidance throughout the process of implementation. It is my sincere hope that all stakeholders will continue supporting NAC and the Government as a whole in the HIV and AIDS response as we embark on the last mile of ending AIDS by 2030.

Dr. George Tembo
Chairperson
National HIV/AIDS/STI/TB Council

ACKNOWLEDGEMENTS

The National HIV/AIDS/STI/TB Council (NAC) secretariat wishes to acknowledge, with gratitude, the valuable contribution of several individuals and organisations that supported the development of the National HIV and AIDS Strategic Framework (NASF) 2017 - 2021.

NAC wishes to express special thanks and appreciation to members of all the Technical Working Groups (TWGs) and the NASF Technical and Steering Committee for their tireless efforts and invaluable contributions, which made it possible to put together the innovative strategies contained in this document.

Sincere appreciation is also extended to Cooperating Partners, Government ministries and departments, CSOs, PLHIV, Provincial and District AIDS Task Forces and community members for their meaningful participation which helped to improve the quality and comprehensiveness of this document. We acknowledge both the technical and financial assistance provided by the Joint United Nations Programme on HIV and AIDS in Zambia during the process of development and review of this document.

Finally, I want to express my gratitude to the staff of the National HIV/AIDS/STI/TB Council for their dedication and hard work during the entire process. Without their cooperation and support, the NASF 2017 - 2021 would not have been possible.

Dr. Reuben Kamoto Mbewe
Director General
National HIV/AIDS/STI/TB Council

CHAPTER 1: INTRODUCTION

1.1 Country Context

Zambia is resource-rich in mineral endowments and agricultural potential. Spanning a geographical area of 752, 612 km, it is a large but sparsely populated country of 15 million people (CSO 2010). The country has a young population with 45.4 per cent of the people aged below 15 years. The population is also characterised by continuing urban drift. Between 2000 and 2010, the percentage distribution of youths in rural areas aged 15 - 35 years reduced from 34.5 per cent to 33.3 per cent and increased from 41.4 per cent to 41.9 per cent in urban areas. The Overall Dependency Ratio was nine persons aged 0 - 14 and 65 years and above per 100 persons aged between 15 - 64 years (GRZ, CSO 2012).

Following a period of sustained growth over the past 10 to15 years, much of it between 2006 and 2010, Zambia achieved the Lower Middle Income Country (LMIC) status in 2011. In 2012, Zambia was among the 10 fastest growing economies in Sub-Saharan Africa. This record of growth, however, did not translate into corresponding improvements in incomes and living standards of the people. This is particularly notable for the rural population because, while the national poverty incidence in 2010 was 60 per cent compared to 62.8 per cent in 2006, rural poverty incidence in 2010 was 78 per cent compared to 80 per cent in 2006. Thus, poverty in Zambia has continued to be more of a rural than an urban phenomenon with the rural poverty rate being three times that in urban areas. In 2010, rural poverty was an estimated 77.9 per cent compared to 27.5 per cent for urban areas (GRZ, CSO 2011).

The major constraints and challenges facing the country include: the high poverty levels particularly in rural areas; high unemployment levels particularly among the youth; weak social-safety nets; high burden of disease; infrastructure challenges; and, geographical and social barriers. It should be noted that all these constraints and challenges have significant implications on health service delivery (GRZ, MoH 2012, 5).

Poverty reduction is an important development challenge in Zambia. The need for economic restructuring has forced the Government to initiate the withdrawal of fuel and maize subsidies. In parallel with these measures, the Government is scaling up social protection by increasing allocations to the Social Cash Transfer (SCT) and Food Security Pack (FSP) programmes and other poverty mitigation measures. The national roll-out of the SCT, which is the flagship national anti-poverty social transfer programme, has scaled up, reaching 500, 000 households by 2016. Plans are underway to further increase the number of beneficiaries of this intervention. Scaling up of these programmes, however, will need to be carefully targeted to ensure that the neediest households are prioritised with the available resource envelope.

1.2 Background to the NASF 2017 - 2021

The National HIV/AIDS Strategic Framework (NASF 2017 - 2021) is the fifth in a series of National HIV/AIDS Strategic Frameworks and is a five-year strategy aligned to the Vision 2030; Seventh National Development Plan; National AIDS Policy; and, international and regional commitments. The priority focus for the NASF 2017 - 2021 is to intensify combination HIV prevention in the national multi-sectoral HIV

response, with a view of reducing new HIV infections. This NASF 2017 - 2021 recognises the HIV/AIDS epidemic as a socio developmental challenge and, therefore, incorporates emerging issues in the epidemic and the application of the Fast Track strategies to achieve the 90-90-90 targets by 2020 and the ultimate elimination of new HIV infections by 2030. The NASF 2017 - 2021 builds on the experiences of the R-NASF 2014-2016 and the progress made so far.

1.3 Purpose of the NASF 2017 - 2021

The purpose of the framework is to:

i. Provide an overall strategy for the planning, coordination and implementation of the multi-sectoral national response based on available evidence;
ii. Articulate national priorities, expected outcomes and targets that all stakeholders should work towards, based on their respective mandates, resources and comparative advantage;
iii. Articulate an agreed framework for the implementation of the multi-sectoral response developed in partnership with civil society, private sector, public sector and development partner inputs that is in line with the three-ones principle (one strategy, one coordinating body and one M&E system); and,
iv. Provide a transparent framework to form the basis for reaching agreement with development partners on their technical and financial support and the management and coordination of the response.

The principal goal of the NASF 2017 - 2021 is to reposition prevention of new HIV infections as the main focus of the national multi-sectoral HIV and AIDS response. Thus, greater emphasis will be placed on scaling-up HIV combination prevention services that enable individuals to maintain their HIV negative status as well as improve access to quality treatment and care services. HIV combination prevention will also target PLHIV with Positive Health, Dignity and Prevention (PHDP) interventions that reduce their transmitting HIV to others. The NASF 2017 - 2021 is developed in the light and context of the Constitution of Zambia (Amendment) Act 2 of 2016 which declares to "UPHOLD the human rights and fundamental freedoms of every person" and thus guaranteeing freedom from discrimination.

1.4 Development Process

The NASF 2017 – 2021 is a five-year strategy aligned with international commitments, strategies and targets. The priority focus for the NASF 2017 - 2021 is to achieve the 90-90-90 treatment targets while intensifying combination HIV prevention in the national multi-sectoral HIV response with a view of reducing new HIV infections.

The development of this NASF was informed by, among other things, the programme review of the just ended R-NASF 2014 - 2016. The programme review and the development of NASF 2017 - 2021 were undertaken consecutively over a period of three months from October 2016 to January 2017, starting with the programme review for the R-NASF followed by the development of the NASF 2017 - 2021.

The programme review was conducted in seven of the 10 provinces of Zambia, covering a total of 21 districts. One of the objectives of the review was to collect information that would inform the development of the new Fast-Track NASF 2017- 2021. A series of consultative processes and tools were used to conduct the programme review and the NASF 2017 - 2021 development, including provincial and district stakeholder consultations with implementing partners, PLHIV, adolescents, key population groups and stakeholders and community members. After field consultations and stakeholder engagements, the programme review report was drafted. Limitations and gaps were identified, and recommendations for systematic interventions designed to address identified gaps to service delivery and coordination, implementation and monitoring were made.

A steering committee chaired by the NAC Chairperson comprising Permanent Secretaries from line Government ministries and cooperating partners reflecting a multi-sectoral approach provided overall oversight, facilitated high level engagements and mobilised resources for the two tasks. In addition, a technical committee comprising different stakeholder groups, including cooperating partners, government ministries, civil society organisations, private sector, network of PLHIV, implementing partners, was formed to support the process, provide direction and facilitate stakeholder consultations. The technical committee, in collaboration with the NAC secretariat ensured that existing coordination structures were fully utilised for the programme review as well as the new NASF development process. The technical committee reviewed and validated the findings of the R-NASF 2014-2016 Review Report and approved the new NASF framework.

Technically, the programme review and development of the NASF 2017 - 2021 were guided by a mix of local and international standards recently set or used in several countries to review national HIV/AIDS strategic plans, frameworks and operational plans. These standards included the WHO/Global Fund gap analysis approach and framework, the UNAIDS/World Bank AIDS Strategy and Action Plan process and existing Joint Annual Review Process (JARP) tools and guidelines.

CHAPTER 2: EPIDEMIOLOGY AND RESPONSE ANALYSIS

2.1 The Epidemiology of HIV and AIDS in Zambia

Zambia has one of the highest HIV burdens in Sub-Saharan Africa. In 2016, around 46, 000 people became newly infected with HIV in Zambia (ZAMPHIA 2016. The current estimates for overall HIV annual incidence among adult men and women aged 15-49 years is 0.70 per cent (PEPFAR 2016b; UNAIDS 2016b). The annual incidence of HIV among adults aged 15 - 49 is higher in women (1.08 per cent) compared to men (0.33 per cent) (PEPFAR 2016b). The adult HIV prevalence in Zambia has also declined, falling by 19 per cent from 2003 to the current levels of 11.2 per cent (CSO 2014). However, despite the declines, the HIV prevalence rate is the seventh highest rate globally (UNAIDS 2016). Approximately there are 1.2 million people in Zambia living with HIV (UNAIDS 2016b). Zambia has a generalised HIV epidemic among adults aged 15-49 years with more women (13.6 per cent) than men (8.5 per cent) living with the virus (CSO 2014). Women are disproportionately affected due to several factors including gender imbalances in all spheres of life and Gender Based Violence (GBV).

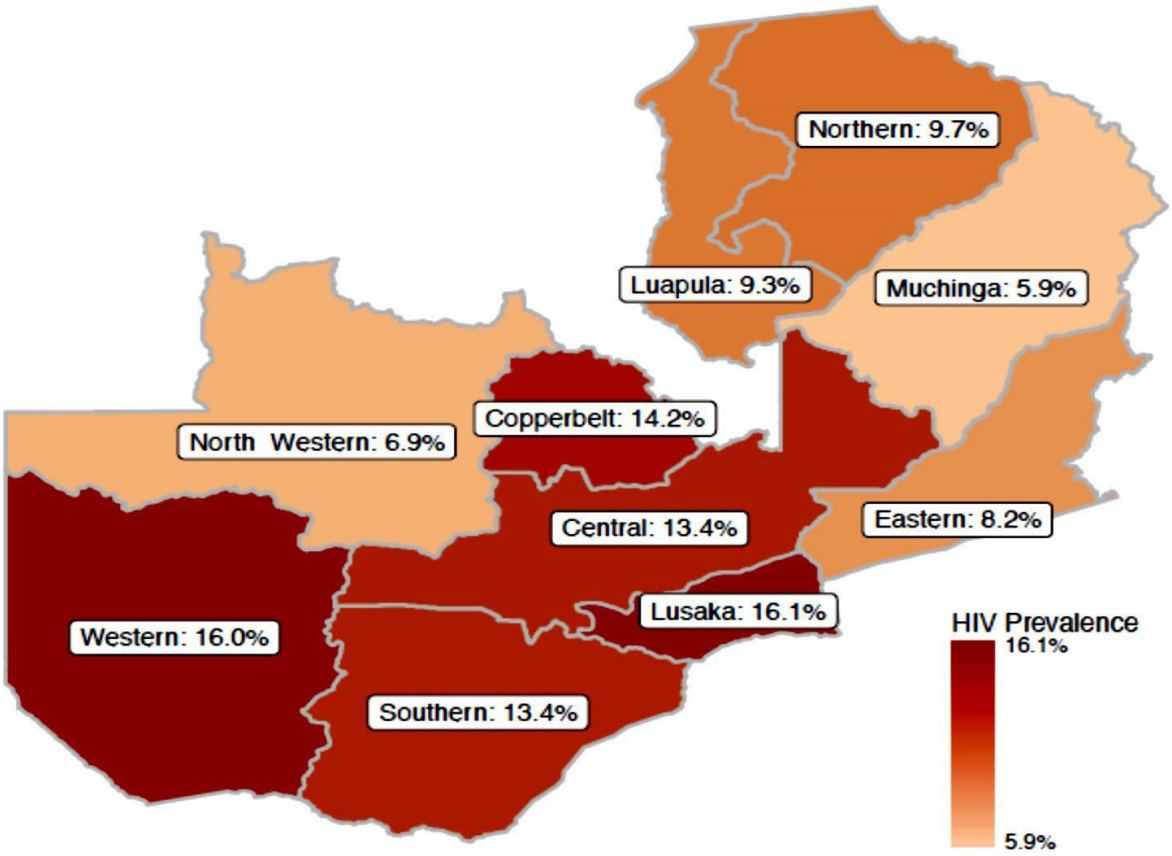
2.2 HIV Prevalence among adolescent boys and girls

Adolescents aged 10-19 comprise 23 percent of the total Zambian population. Based on the re-analysis of the 2013-2014 Zambia Demographic and Health Survey (ZDHS) HIV testing data the estimated HIV prevalence rates among adolescent girls and boys aged 15-19 is at 3.5 per cent for girls and 1.8 per cent for boys. Adolescents girls, aged 15-19, continue to be disproportionately affected by HIV due to behavioural, cultural and biological vulnerabilities to HIV infection. In 2013-14, 7.2 per cent of sexually active adolescent girls reported having had sexual intercourse with a man who was 10 or more years older than them. This was a 60 per cent increase in this behaviour from the rate of 4.5 per cent reported in the 2007 ZDHS. Although prevalence rates declined among adolescents aged 15-19 from 2007 to 2014, from 5.7 per cent to 3.5 per cent for girls and from 3.6 per cent to 1.8 per cent for boys, this prevalence data translates to around 28,000 girls and 16,000 boys living with HIV. Hence there is a need to continue to prioritise HIV combination prevention with adolescents in Zambia.

2.3 Geographical Heterogeneity of the Epidemic

Data from the ZDHS indicates that the Zambian HIV epidemic is geographically heterogeneous with provincial prevalence rates ranging from 4.8 per cent to 15.1 per cent. HIV prevalence rates among men and women aged 15-49 years are higher in urban (15.6 per cent) compared to rural (7.4 per cent) areas (CSO 2014). There are also variations among provinces (Zambia Population Based HIV Impact Assessment (ZAMPHIA), 2016)) with the highest prevalence rates, that is, Lusaka (16.1 per cent), Western (16 per cent) Copperbelt (14.2 per cent), followed by Southern and Central (13.4 per cent). The other provinces with the prevalence rate above six percent are Northern (9.7 per cent), Luapula (9.3 per cent) and Eastern (8.2 per cent). Provinces with the lowest prevalence are Muchinga (5.9 per cent) and North-Western (6.9 per cent). All the districts in Zambia have an adult prevalence greater than five per cent. See Figure 1 below.

Figure 1: HIV prevalence by Province



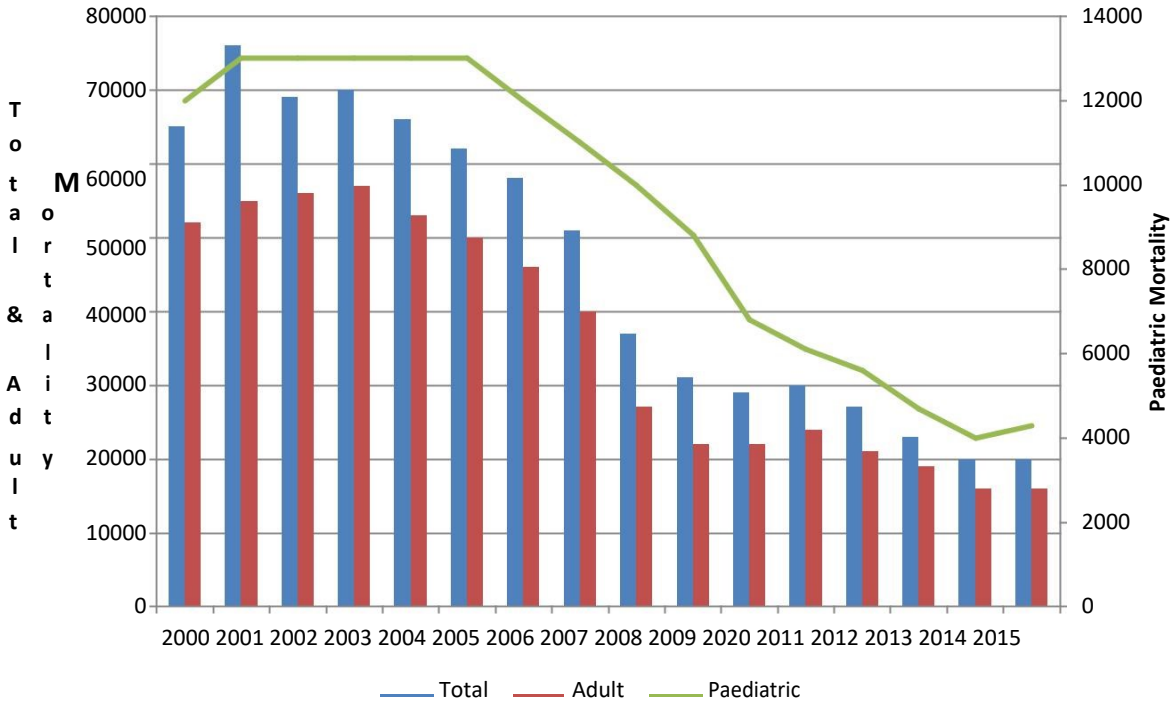
Source: ZAMPHIA, 2016

2.4 Morbidity and Mortality Trends

Zambia has recorded significant improvements in health with corresponding reductions in the burden of disease. The reductions, however, are not adequate as the burden of disease remains high. The high disease burden in Zambia is compounded by high levels of poverty as discussed above and high HIV prevalence.

SPECTRUM estimates that mortality rate from AIDS in adults aged 15 years and older has decreased from a peak of 8 per cent in 2002 to 2.1 per cent in 2013. These declines have been attributable to the success of the ART programme in the country. The survival and retention of people on ART at 12 months has increased from 65 per cent in 2010 to 85 per cent in 2016 (PEPFAR 2016b). See figure below.

Figure 2: Trends in AIDS Mortality: Zambia 2000-2015

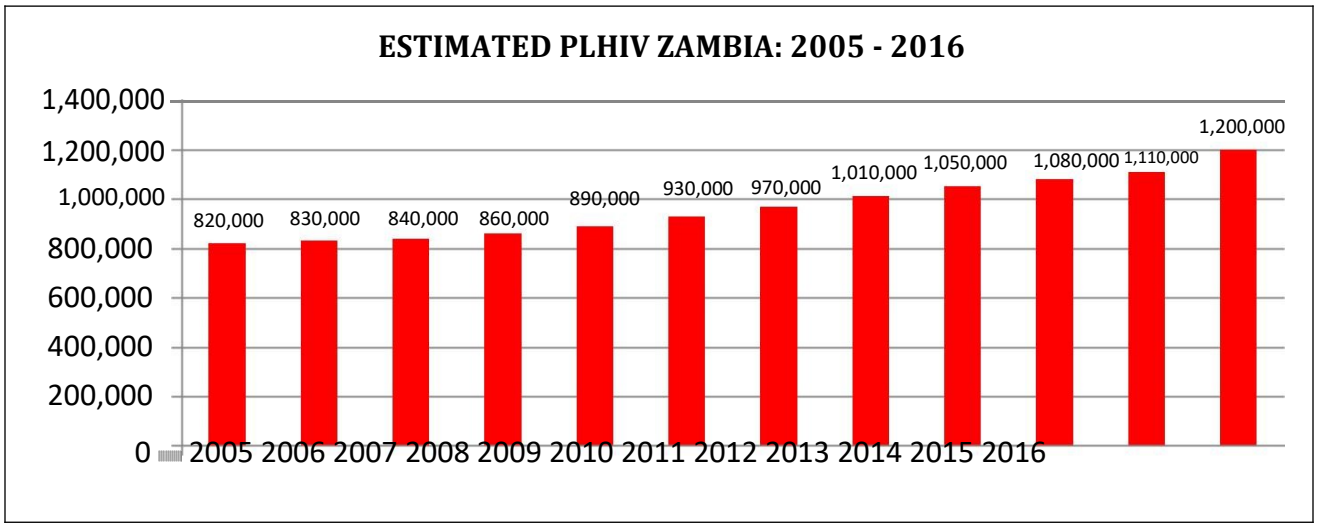


Source: SPECTRUM, 2015

2.5 People Living With HIV in Zambia

The number of PLHIV continues to grow from about 820,000 in 2005 to 1.2 million in 2016, in part due to successful scale up of the ART programme, improving the survival of PLHIV. See graph below.

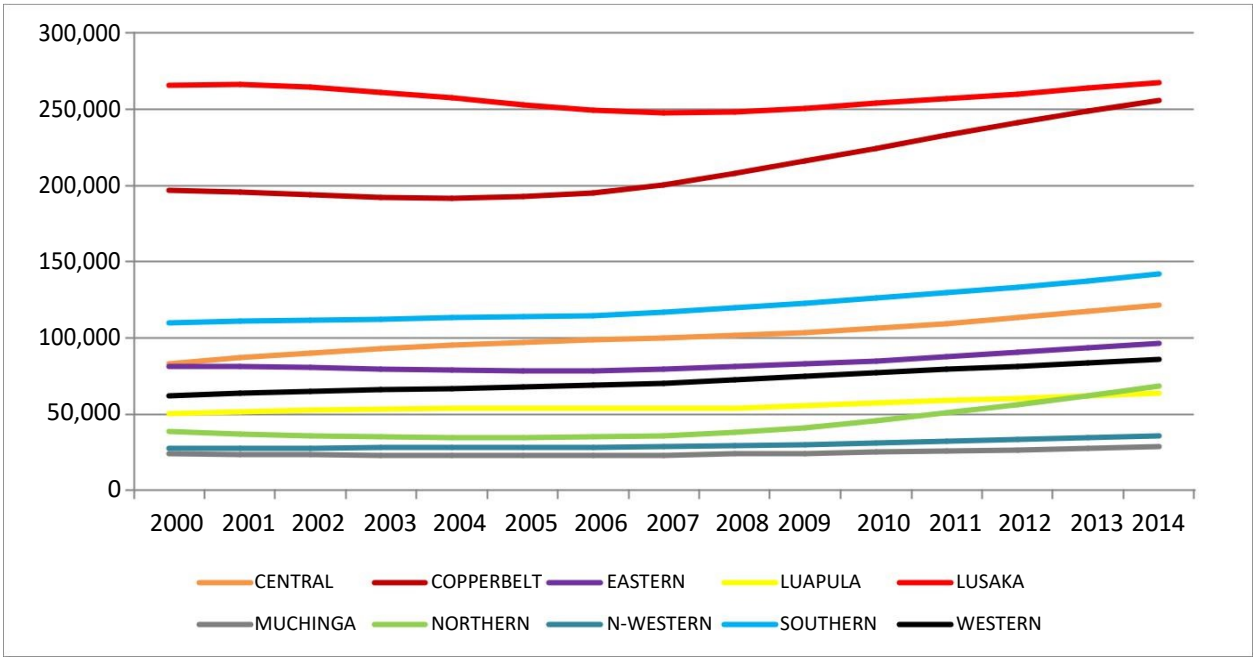
Figure 3: Estimated PLHIV Zambia, 2005 – 2016



Source: SPECTRUM, 2016

Just like HIV prevalence there is greater heterogeneity of numbers of estimated PLHIV across provinces as shown in the graph below.

Figure 3: Estimated PLHIV across provinces: 2000-2014



Source: SPECTRUM, 2015

2.6 The National HIV and AIDS Response Analysis

The phrase "National HIV Multi-Sectoral Response" has been preferred to "The National AIDS Response" as it is more inclusive in that not everyone living with HIV has progressed to AIDS.

2.6.1 Factors fuelling HIV infections

The Zambian HIV epidemic is driven mainly by unprotected heterosexual sex, with 90 per cent of new infections recorded as a result of not using a condom. Several reports have provided insights into the drivers of the HIV new infections which include: multiple and concurrent partnerships (MCP); low and inconsistent condom use; low medical male circumcision; migration and mobility; mother to child transmission; and, marginalised and underserved populations (NAC 2014). Furthermore, these key drivers are compounded by social factors that continue to increase risk, decrease resilience and drive HIV new infections through high risk sexual behaviours such as:

i. Intergenerational sex;
ii. Transactional sex;
iii. Denial and marginalisation of key population and vulnerable groups;
iv. Stigma and discrimination;

v. Marriage patterns and polygamy;
vi. Religious beliefs against ARVs and condom use;
vii. Gender inequalities including Gender-Based Violence (GBV);
viii. Deepening poverty and food insecurity;
ix. Widespread abuse of alcohol and other substances;
x. Poor enforcement of anti-discrimination laws; and,
xi. Weak social and legal protection of vulnerable populations (NAC 2017, NAC 2014, NAC 2013).

It is now a matter of settled consensus that the HIV and AIDS epidemic in Zambia has far reaching socio-economic causes and consequences and that it calls for no less than a multi-layer, multi-sectoral, engendered and rights-based response to effectively address it. The causal factors that have driven, and continue to drive, the epidemic includes the entrenched cultural and religious beliefs, norms and practices; gender inequalities; stigma and discrimination against key population groups.

2.7 Marginalised and Underserved Populations

Delivering HIV and AIDS related prevention and treatment services in the national response, requires opinion leaders, other gatekeepers and service providers, to urgently recognise the implications of key populations on the general population. Addressing the HIV service needs of key populations—efficiently, effectively and respectfully—is not just the right thing to do, in a human rights sense, it is also the smart thing to do from a self-interest perspective as illustrated in Figure 5. It is vital, therefore, to develop a clear understanding of the dynamics of the epidemic within these populations and to develop effective responses, and implement them, on that basis. This is subject to identifying these populations clearly and without implied threat to them, and then addressing the cultural, legal, and structural barriers to meeting their HIV prevention and treatment needs.

The UNAIDS GAP Report 2014 identified 12 populations that have been left behind by the AIDS response. The report further describes the struggles they face, why they have been left behind and how to close the gap in order to end the epidemic by 2030 with the principle of 'leaving no one behind'. These groups are People Living with HIV, adolescent girls and young women, prisoners, migrants, people who inject drugs, sex workers, gay men and other men who have sex with men, transgender people, children, and pregnant women living with HIV, displaced persons, persons with disabilities, migrants and people aged 50 years and older.

The NASF 2017 - 2021 definition of key populations coincides with these groups and in addition includes young men to ensure inclusiveness, population and location-focused programming and HIV service delivery. Therefore, the NASF 2017 - 2021 defines key populations as:

i. People living with HIV
ii. Adolescent girls and young women
iii. Young Men
iv. Inmates

v. Migrants
vi. People who inject drugs
vii. Sex workers
viii. Gay men and other men who have sex with men
ix. Transgender people
x. Children and pregnant women living with HIV
xi. Displaced persons
xii. Persons with disabilities
xiii. People aged 50 years and older

2.7.1 Legal, Policy and other Barriers to HIV Services for Key Populations

The preamble to the Constitution of Zambia (Amendment) Act 2 of 2016 includes the vow to "UPHOLD the human rights and fundamental freedoms of every person" and affirms "…the equal worth of women and men and their right to freely participate in, determine and build a sustainable political, legal, economic and social order." The HIV response in Zambia is, therefore, catered for by the Constitution and laws of Zambia and corresponding international conventions to which Zambia is a signatory and is, generally, driven by a rights-based approach to HIV programming. The current laws, however, have gaps in terms of being unspecific to HIV status with regard to prohibiting discrimination (Kalibala and Mulenga 2011).

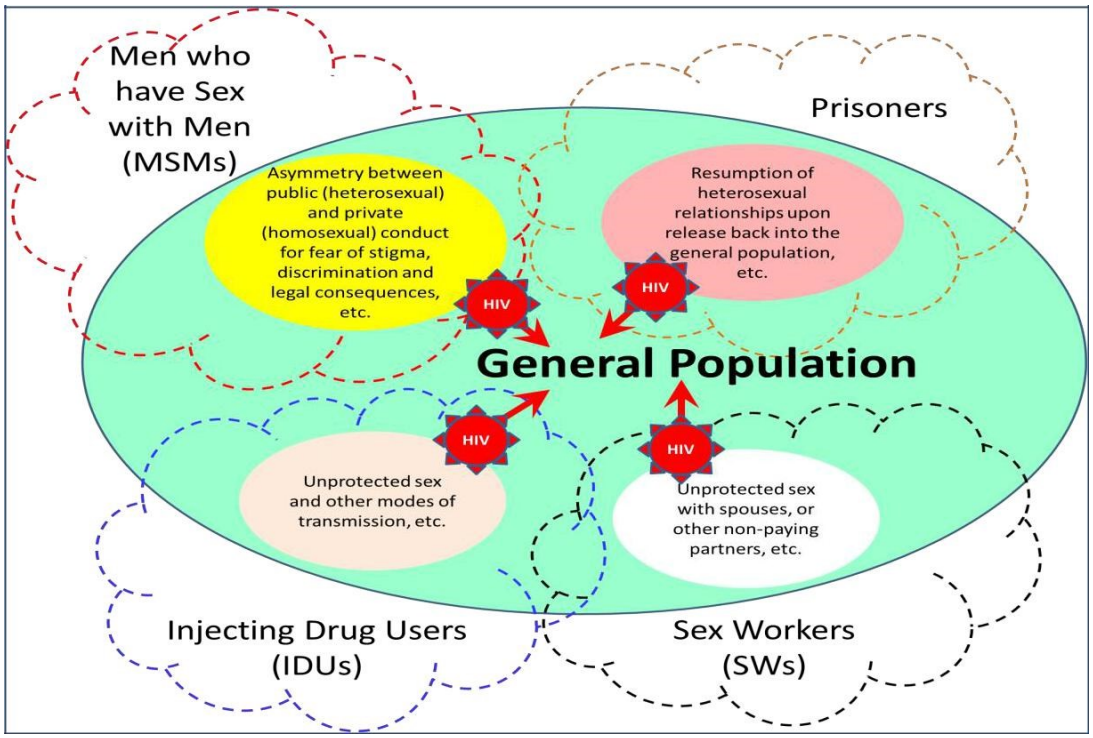
In terms of HIV transmission, the actual risk of infection is linked to the sexual behaviour. It is unprotected vaginal and anal sexual intercourse which puts Zambia's population at risk of HIV infection.

A public health approach needs to focus on raising awareness of, and reducing the risks of, the behaviours through the widespread distribution of condoms and water based lubricants rather than focusing on individuals and their private sexual behaviours.

This also applies to the issue of injecting drug use. According to the Drug Enforcement Commission (DEC), injecting drug use has seen an upsurge in Zambia over the past four years as Zambia has long been a transit point for the international trade in heroin and other psychotropic substances. These drugs have now begun to filter into the local Zambian population, hence the upswing in injecting drug use in the country. The actual risk of HIV infection from injection drug use is from the sharing of needles and syringes and the evidence based response to this is to focus BSCC efforts on reducing this behaviour among individuals who inject drugs and ensure that needles and syringes are easily available to individuals with this behaviour. In addition, drug addiction treatment services also need to be provided in settings where these behaviours take place[1].

[1] Implementing comprehensive HIV and HCV programmes with people who inject drugs - Practical Guidance for collaborative interventions. WHO, 2017.

Figure 4: Modes of cross-transmission from a selection of key populations



2.7.2 Discrimination Against Female Sex Workers (FSWs)

The UNAIDS Advisory Group on HIV and Sex Work noted that: "There is very little evidence to suggest that any criminal laws related to sex work reduce demand for sex or the number of sex workers. Rather, all of them create an environment of fear and marginalisation for sex workers, who often have to work in remote and unsafe locations to avoid arrest of themselves or their clients. These laws can undermine sex workers' ability to work together to identify potentially violent clients and their capacity to demand condom use from clients. Where sex work is criminalised, sex workers are very vulnerable to abuse and extortion by police in detention facilities and elsewhere."

2.7.3 Legal and Policy Framework for Adolescents and Young People

As noted above, there are laws that are repressive toward Most-At-Risk Populations (MARPs), such as sex workers, thus making it difficult for them to be reached with public health programmes and services. Adolescents, aged 10-19 years and young adults, aged 20-24 years comprise large proportions of such populations. In addition, due to their young age, sexually active adolescents are often denied services. The current Ministry of Health (MOH) policy is to allow adolescents, from the age of 16 years, to access HIV services without parental consent. In addition, under the Family Planning policy, mature minors can also access Sexual and Reproductive Health (SRH) services. The provision of this service is, however, dependent on the service provider's own judgment and, hence, a quality service is not always assured. In some neighbouring countries (i.e. Malawi, South Africa, etc.) the age of consent for HIV services has been reduced to 12 years to formalise easy access to HIV and SRH services for sexually mature early

adolescents. With approximately one in 20 girls aged 15 years and one in four 17-year-old girls having already started child bearing in Zambia (ZDHS 2014), there is a need to review the age of consent for HIV and SRH services. The other relevant policy in Zambia is the Youth Policy, which clearly highlights the importance of HIV prevention among adolescents and young adults. However, the policy does not highlight the specific needs of adolescents and young adults living with HIV nor the special needs of the early adolescents aged 10–14.

2.7.4 Persons with Disabilities and the HIV Response

Zambia has a population of more than 1.5 million persons with disabilities, comprising a significant percentage of the national population[2]. This population constitutes a significant group of people, across the nation, in the development dynamics such as social and economic spectrum, including the national HIV response. On the other hand, HIV and AIDS interventions hardly take into account the numerous existing challenges and barriers that such persons face. These challenges manifest themselves in the context of the physical environment to, and at, the service points as well as attitudinal barriers from both community and service provider levels in the HIV and AIDS response's spheres. Each disability category comes with its own unique problems in so far as mainstreaming into the HIV and AIDS response is concerned. It is also important to take into account the fact that persons with disabilities are not homogenous, and some groups, like adolescents with disabilities have special challenges. Overall, people with disabilities have challenges accessing health services and other products or supplies such as condoms for the prevention of HIV. Accessing ART for the treatment of HIV and AIDS is the biggest challenge among the blind and deaf persons.

Despite the National HIV/AIDS/STI/TB Policy of June 2005 being in place and therein explicitly indicating the need for HIV and AIDS interventions for persons with disabilities, there have been barely tangible actions for persons with disabilities in relation to HIV and AIDS interventions. However, more recently, the R-NASF 2014–2016 acknowledged and described persons with disabilities as among the key populations who have not been reached or adequately serviced in HIV and AIDS interventions. The R-NASF 2014-2016 highlighted some of the challenges, gaps and barriers that impede such persons from being part of, and accessing, interventions in the HIV and AIDS response as per disability category and with special/or specific needs. Since 2004, such policy and strategic positions have only been partially responded to by the national HIV response coordinating body – NAC – providing various spaces/platforms on the national HIV response structures for persons with disabilities under the principle of self-representation through respective Disabled People's Organisations (DPOs) such as Zambia Disability HIV/AIDS Human Rights Programme (ZAMDHARP). The context and extent of actual HIV and AIDS benefits among persons with disabilities barely exists as there are hardly any HIV and AIDS interventions that have mainstreamed issues and needs of persons with disabilities. The HIV and AIDS interventions accessed by persons with disabilities in Zambia are more on a chance, by-the-way or charity basis and not human rights based.

[2] The statistics are calculated using WHO standard which differs from the Zambia CSO official statistics

2.7.5 Stigma and Discrimination

Stigma and discrimination continue to be a harsh reality for PLHIV and other at-risk groups. According to key findings from the PLHIV Stigma Index, stigma remains a challenge in Zambia. Individuals have reported experiencing stigma in a variety of settings and about 30 per cent of men and 36 per cent of women have reported exclusion from social activities. Some 16.5 per cent of the respondents had been refused employment due to their HIV status and 39.9 per cent reported losing a job or some source of income at least once on account of their HIV status (NZP+, GNP+ 2012).

Despite the existence of a raft of instruments to protect human rights and prevent discrimination, there is currently no legislation that explicitly bans discrimination based on actual or perceived HIV status.

Health workers present an important inflexion point in the perpetuation or mitigation of stigma and discrimination related to HIV and AIDS. Corresponding investments should, therefore, be made into sensitisation and awareness creation for healthcare workers around their legal and ethical obligations towards clients for HIV-related and other health services.

A key aspect of these obligations is the requirement to respect the dignity of clients seeking healthcare and to protect the confidentiality of any data or information obtained in the process of delivering services to them. In this regard, all health information should be handled by medical personnel in accordance with the law. Confidentiality is also premised on voluntary disclosure of HIV status by clients evidenced by written consent in line with the HTS guidelines. Employers and health care personnel should be provided with training and guidance to ensure that confidential medical information is handled in accordance with the law (GRZ, MCT 2010). Such measures against HIV-related discrimination should be supported by the availability of strong legal recourse with transparency and monitoring mechanisms.

2.7.6 Meaningful Engagement of Key and Vulnerable Populations and Networks

Under its core objective to "Promote and Protect Human Rights and Gender Equality," the Global Fund Strategy lists the operational objective of supporting the "…meaningful engagement of key and vulnerable populations and networks in Global Fund-related processes." As noted above, key populations include PLHIV, among others.

The Greater Involvement of People Living with HIV and AIDS (GIPA) Declaration was signed in 1994[3]. In its policy brief, UNAIDS notes that PLHIV, "are entitled to the same human rights as everyone else, including the right to access appropriate services, gender equality, self-determination and participation in decisions affecting their quality of life and freedom from discrimination" (UNAIDS 2007) and further notes that the, "engagement of people living with HIV is all the more urgent as countries scale up their national AIDS responses to achieve the goal of universal access to prevention, treatment, care and support services."

[3] UNAIDS prefers the umbrella term "people living with HIV". The acronym GIPA is used for historical reasons.

To date NAC has enjoyed a strong partnership and collaboration with the Network of Zambian People Living with HIV (NZP+), the national representative organisation for People Living with HIV, including adolescents. Given the broader definition of key populations in this and previous iterations, of the NASF, a wider platform for engagement of, and collaboration with, other key and vulnerable populations and networks will need to be proactively pursued by NAC and other actors and partners in the national response.

2.8 Opportunities and Emerging Issues

2.8.1 Opportunities

The NASF 2017 - 2021 will embrace existing opportunities for the multi-sectoral HIV national response including:

i. Shifting the implementation of the national response from business-as-usual to the Fast Track national response;

ii. Strengthening the integration of gender and human rights with HIV and AIDS programmes. In line with the need to achieve the Fast-Track targets, the capacity of service providers to adequately integrate gender and human rights in HIV and AIDS programme planning and service delivery will be enhanced;

iii. Expanding service coverage to reach geographical areas with highest burden of HIV and groups that have historically been marginalised and neglected to ensure that "no one is left behind";

iv. Institutionalising government decentralisation policy and strategies to ensure that decentralised planning processes are cascaded to districts and community levels. Over the course of the NASF period, communities should be empowered and supported to develop their own action plans;

v. Taking advantage of the willingness of stakeholders to adopt and mainstream the national M&E framework, improve on reporting mechanisms and expand the scope of stakeholders' use of M&E data to enhance the quality of services; and,

vi. Enhancing community involvement and systems is increasingly being recognised as a cornerstone of HIV programmes. This has the potential to improve the uptake of HIV services and promote local-level ownership, accountability and resource mobilisation. Community systems strengthening will be key in reaching the Fast-Track targets.

2.8.2 Emerging issues and themes

Some of these emerging issues and themes are as follows:

i. Adolescents face numerous challenges in accessing adolescent responsive HIV services. Four out of 10 adolescents in Zambia reported having sexual intercourse in 2014. Of these, six out of 10 did not use a condom at last sex. Although sexually active adolescents and young people have been articulated as a priority population in national plans and guidelines, such as the National Adolescent Health Strategic Plan for 2011 – 2015. The allocation of human and financial resources to these plans has often been sub-optimal. To be able to have a significant impact on new HIV infections, sexually active adolescents need to be a priority focus under a number of high impact interventions – specifically condoms, HIV testing and male circumcision interventions. In addition, adolescents and young adults are a significant proportion of the individuals who constitute key population groups and, therefore, the provision of the high impact interventions to adolescents and young adults need to be made in both a differentiated and responsive way to meet their diverse needs; and,

ii. Key populations are an emerging dynamic in Zambia in the face of HIV and AIDS. These populations include female sex workers, men who have sex with men (MSM), transgender; and people who inject drugs (PWID). The NASF 2017 - 2021 articulates guidance and suggests a comprehensive package of services targeting key populations so that the Fast Track targets can be reached.

CHAPTER 3: THE NATIONAL HIV AND AIDS STRATEGIC FRAMEWORK

3.1 Vision

As the anchor of the multi-sectoral national HIV response, the NASF 2017 - 2021 embraces the long-term vision of, *"A nation free from the threat of HIV by 2030."*

3.2 Mission Statement, Overall Goal and Objectives of the NASF 2017 - 2021

i. Mission Statement

Zambia is committed to rapidly and inclusively control the HIV epidemic by fast-tracking the multi-sectoral response and scaling up prioritised actions that are responsive to the public health needs of the country.

ii. Overall Goal

The NASF 2017 - 2021 strives to achieve the 90 90 90 fast-track towards ending the AIDS epidemic by 2030 and improving the wellbeing of the infected and affected by HIV and AIDS by ensuring that nobody is left behind .

iii. NASF 2017 - 2021 Objectives

a) To achieve 90 per cent of PLHIV knowing their status;
b) To achieve 81 per cent of PLHIV on ART;
c) To achieve 72.9 per cent of PLHIV having viral load suppression;
d) To reduce new HIV Infections to 18, 000 or fewer by 2020;
e) Achieve zero stigma and discrimination by 2020; and,
f) To increase domestic financing of the response by 50 per cent.

3.3 Guiding Principles

The following principles will guide the NASF 2017 - 2021:

i. Adoption of a human rights approach;
ii. Political leadership, commitment and engagement;
iii. Greater Involvement of PLHIV (GIPA);
iv. Evidence and Results-Based Planning;
v. Gender and Age Sensitivity;
vi. Governance and accountability;
vii. Strategic Partnerships and Alliances;
viii. "Three-Ones Principle";
ix. Health and Community Systems Strengthening;
x. Decentralised implementation;
xi. Investing for impact and maximising efficiencies; and,
xii. Alignment with National and International Policy Frameworks.

The NASF 2017 - 2021 will be aligned to the following national and international policy frameworks:

i . The Vision 2030;
ii . The Seventh National Development Plan;
iii . The National Prevention Strategy for HIV;
iv . The Decentralisation Policy;
v . The 2030 Agenda for Sustainable Development;
vi . Fast-Track Strategy;
vii . High Level Meeting (HLM) Political Declaration;
viii . PEPFAR Strategies;
ix . Global Fund Strategy on Ending Epidemics 2017 - 2022;
x . East and Southern Africa (ESA) Commitment; and,
xi . International Labour Organisation (ILO) World of Work Strategy.

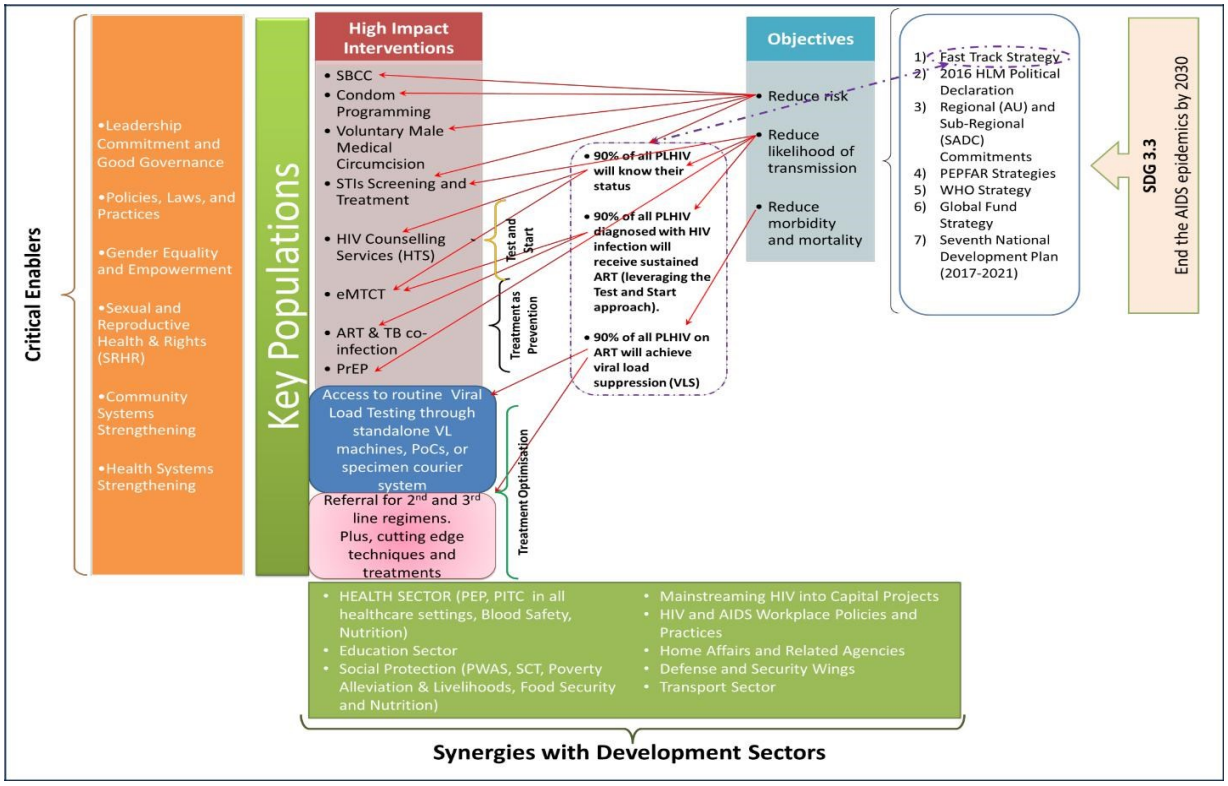
CHAPTER 4: NASF STRATEGIC INTERVENTIONS/OUTCOME RESULTS

4.1 The Investment Framework

The Investment Framework is a realistic and achievable road map to decisively accelerate progress in the national response. The framework is meant to maximise benefits in the response, support more rational allocation of resources and increase efficiencies in HIV Prevention, treatment, care and support.

Figure 5 below shows the modified UNAIDS Investment Framework overlain with (i) the SDG 3 objective for health and the HIV epidemic; (ii) the strategies and international commitments informing the Zambian response to the epidemic; and, (iii) the 90-90-90 treatment targets for the Fast-Track Strategy and the 90 per cent compensative prevention services target[4]. The arrows in the diagram indicate the mapping of the strategies, objectives and 90-90-90 targets into the high impact interventions envisaged for the national HIV multi-sectoral response going forward.

Figure 5: Modified Investment Framework



[4] See the 2016 High Level Political Declaration –para 62 (f) that encourages …"Member States with high HIV incidence to taking all appropriate steps to ensure that 90% of those at risk of HIV infection are reached by comprehensive prevention services."

4.2 NASF 2017 - 2021 Focus Areas

The NASF 2017 - 2021 strategic interventions were informed by the epidemiological and national response analysis of HIV and AIDS in Zambia. This provided the evidence used to identify and articulate the following national strategic interventions:

i. Social and Behaviour Change Communication (SBCC);
ii. Comprehensive Condom programming;
iii. Voluntary Medical Male Circumcision;
iv. Sexually Transmitted Infections;
v. HIV Testing Services;
vi. Elimination of Mother to Child Transmission;
vii. Treatment (ART);
viii. Critical enablers; and,
ix. Synergies with other development sectors.

4.2.1. Social and Behaviour Change Communications (SBCC)

Social and Behaviour Change Communication seeks to promote sustained positive behaviours using a variety of methods such as one-to-one talks; group discussions; community dialogues; individual and group counselling; advocacy; drama; and, mass media such as radio, television and print materials. In recent times, new technologies such as the use of Internet, texting and social media (Facebook, Twitter), U-Report and Tune Me have been successfully used for SBCC.

The NASF (2017 – 2021) seeks to promote the scale up of innovative approaches of delivering relevant and correct messages that are linked to determinants of the HIV epidemic, critical enablers and synergies for an effective HIV response. The main focus will be to develop and implement behavioural change communication strategies and messages that will facilitate and promote uptake of high impact interventions.

Programme Objective: To influence social and behaviour change among the general population with the emphasis on key and vulnerable populations to create demand for HIV prevention and care services.

Programme Strategies:

i. Mobilise members of the general, key and vulnerable populations that are underserved;

ii. Advocate for change of policies and discriminatory laws;

iii. Strengthen implementation of age appropriate Comprehensive Sexuality Education (CSE) and information for learners in school settings and out-of-school youth;

iv. Design and implement appropriate SBCC approaches and IEC materials that are gender sensitive;

v. Scale up age-appropriate messaging and services to ensure an adolescent and youth-friendly environment in HTS, condom promotion and distribution, VMMC and treatment adherence;

vi. Strengthen capacity of service providers and increase efficiency for delivery of HIV prevention and care services;

vii. Strengthen the capacity of peer educators, community health and outreach workers to effectively deliver stigma free prevention and provide effective referral to services;

viii. Strengthen engagement and influence leadership of FBOs and CBOs; PLHIV, traditional, civic and political leaders in implementation of SBCC interventions;

ix. Strengthen the Integration of SBCC in eMTCT, HTS, VMMC, GBV, condoms; PrEP, PEP, FP SRH and stigma/discrimination reduction programmes; and,

x. Scale up tailor-made HIV and harm reduction messaging to key populations through peer mobilisation.

Table 1: SBCC Targets

Indicator 1: % of adolescents 15-19 with comprehensive HIV knowledge[5]

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	F-887,398	900,881	915,124	932,473	954,923	983,185
	M-874,130	892,277	911,405	933,078	958,687	988,683
%Target	F-38.9 M-42.3	50% 50%	60% 60%	70% 70%	80% 80%	F-90 M-90

Source: ZDHS 2013 -2014

[5] 2016 High Level Political Declaration –para 62 (f) that encourages …"Member States with high HIV incidence to taking all appropriate steps to ensure that 90% of those at risk of HIV infection are reached by comprehensive prevention services – reaching 90% comprehensive knowledge is core prevention target.

Indicator 2 : % of young adults 20-24 with comprehensive knowledge of HIV prevention

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	F-776,990	797,849	817,238	835,039	851,421	866,159
	M-750,271	774,663	795,680	814,881	833,604	851,902
%Target	F-45 M-53	F 55 M 60	F 65 M 70	F 75 M 75	F 85 M 85	F-90 M-90

Source: ZDHS 2013 -2014

4.2.2 Comprehensive Condom Programming

Condoms are critical in preventing new HIV and Sexually Transmitted infections as well as unintended pregnancies. Comprehensive Condom Programming addresses various components which include: leadership, coordination, demand, supply and support. The NASF 2017 - 2021 will adopt the 10 step approach for the Comprehensive Condom Programming as described below: developing a national condom support team; conduct a situation analysis; develop a comprehensive integrated national strategy; develop an operational plan and budget; linking operation plan to national commodities security plan; mobilise financial resources; strengthening human resources and institutional capacity; create and sustain demand; strengthening advocacy and engaging the media; monitoring programme implementation, conduct research and evaluate outcomes.

Programme Objective: To fully implement comprehensive condom programming that will contribute to the prevention of new HIV and sexually transmitted infections.

Programme Strategies:

i. Expand access, demand and use of condoms among sexually active populations;
ii. Improve supply chain management for condoms;
i. Improve generation of evidence on comprehensive condom programming; and,
ii. Adopt a total market approach to comprehensive condom programming.

Table 2: Condom Programming Targets

Indicator 2.1: Number of condoms procured (estimated on 30 male condoms per year per males 15-49 free and socially marketed combined)

	2016 Baseline	2017	2018	2019	2020	2021
Target (male condoms)	57,322,650	108 million	114 million	117 million	126 million	129 million
Target (female condoms)	2,084,543	3,325,342	4,853,932	5,908,543	6,867,251	7,894,983

Source: UNFPA (2016)

Indicator 2.2: % of never married adolescents 15-19 who used a condom at last sex

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	F184,000	189,000	192,000	196,000	200,000	205,000
	M 281,000	286,000	295,000	303,000	312,000	322,000
%Target	F 36.5 M 42.5	45 50	55 60	68 70	78 80	F-90 M-90

Source: ZDHS (2013 – 2014

Indicator 2.3:% non -married young adults 20-24 who used a condom at last sexual encounter

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	F 128,000	131,000	135,000	138,000	140,000	144,000
	M 339,000	348,000	358,000	366,000	374,000	387,000
%Target	F 44.7 M 55.5	50 65	60 70	70 75	80 85	F-90 M-90

Source: ZDHS (2013 – 2014)

Indicator 2.4: % men and women aged 15-49 reporting more than one sexual partner in the last 12 months, reporting condom use at last sex.

	2016 Baseline	2017	2018	2019	2020	2021
% Targeted	F: 30 M:29	F: 40 M:40	F:50 M:50	F: 60 M:60	F: 70 M:70	F: 80 M: 80

Source: ZDHS (2013 – 2014)

4.2.3 Voluntary Medical Male Circumcision (VMMC)

Medical male circumcision offers a 60% reduction to the risk of HIV infection to circumcised men. However, male circumcision should be combined with other interventions like condom use to ensure maximum protection from HIV during sexual intercourse. The country aims to, through the national Voluntary Medical Male Circumcision (VMMC) Strategy and Implementation Plan (2016-2020), increase the number of health facilities providing safe male circumcision services and increase the number of HIV negative males, including neonates, accessing safe male circumcision services by 2020. Accordingly, the NASF 2017 - 2021 seeks to increase availability and accessibility of VMMC in all hospitals and health centres as part of an integrated package of HIV and STI prevention.

Programme Objective: To contribute to the reduction of HIV incidence by scaling up VMMC to reach 90% of HIV-negative, sexually active men between the ages of 10-49, with a focus on individuals between the ages of 15-29 by 2020.

Programme Strategies:

i. Offer comprehensive VMMC package of services in an efficient, effective and integrated manner while ensuring highest quality of services;

ii. Provide improved systems to ensure successful campaigns and preparation for sustainability.

iii. Increase demand and meet targets for VMMC in the most effective age groups through targeted market/client-based approach;

iv. Develop and implement a robust plan for VMMC programme transition and integration in the sustainability and maintenance phase once scale up targets have been met.

v. Build sufficient technical and strategic capacity to coordinate and manage a growing VMMC programme at national and subnational levels;

vi. Increase and sustain programme visibility and priority at national and subnational levels;

vii. Mobilise sufficient financial resources to cover the programmatic funding gap while ensuring efficient and effective use of existing resources; and,

viii. Conduct operations research to fill VMMC information gaps and provide implementable recommendations for policy and practice.

Table 3: VMMC Targets

Indicator 3.1: Achieve 90 % VMMC coverage among HIV negative men aged 15-29 years by 2021

	2016 Baseline	2017	2018	2019	2020	2021
Estimated population in need	800,348	659,950	487,318	371,085	297,860	130,907
15-29 year old: % targeted	42%	47%	58%	69%	90%	90%

Source: MoH (2016)

Indicator 3.2: Achieve 40% VMMC coverage among HIV negative boys aged 10 - 14 years by 2021

	2016 Baseline	2017	2018	2019	2020	2021
Estimated population in need	149,017	193,066	168,404	159,648	206,588	151,388
10 - 14 year old: % Targeted	37	39	40	40	40	40

Source: MoH (2016)

Indicator 3.3: Achieve 20% VMMC coverage among HIV boys younger than 10 years and men older than 29 by 2021

	2016 Baseline	2017	2018	2019	2020	2021
Estimated population in need	308,328	404,842	310,075	248,458	245,557	192,610
All other ages: % Target	10%	11%	14%	17%	20%	20%

Source: MoH (2016)[6]

4.2.4 Sexually Transmitted Infections (STIs)

STIs increase susceptibility to HIV infection for several well documented reasons hence the need to have interventions that specifically address this aspect of the response. Zambia adopted a syndromic management approach for STIs in accordance with WHO recommendations. This approach allows frontline healthcare providers to manage STI patients without laboratory-based diagnostics which are not readily available particularly at subnational level health facilities. The NASF 2017 - 2021 seeks to support improved screening and management of STIs as an integral component of the HIV prevention strategy.

STIs Programme Objective

To integrate and expand coverage of STI screening and management in all clinical settings

Programme Strategies:

i. Implement awareness campaigns on STI management to promote early treatment seeking behaviour, partner notification and referral;
ii. Strengthen provision of comprehensive STI services and integration into primary health care;
iii. Target and reach key populations and other vulnerable populations;

[6] VMMC Operational Plan (2016 - 2019)

iv. Strengthen youth friendly services for integrated STI screening and management, HTS, condom promotion and distribution; and,
v. Integrated social behaviour change communication to improve awareness and create demand for STI screening and treatment.

Table 4: STI Targets

Indicator 4.1: % of males and females who reported an STI in the past 12 months

	2016 Baseline	2017	2018	2019	2020	2021
% Targeted	15%	12%	9%	7%	5%	2%

Source: MoH (2016)

4.2.5 HIV Testing Services (HTS)

HIV testing is the gateway to HIV prevention, treatment, care and other support services. HIV testing is the major strategy to achieve the first 90 of the Fast-Track strategy. People's knowledge of their HIV status through HIV Testing Services (HTS) is crucial to the success of the HIV response in Zambia. All forms of HIV testing should adhere to the WHO 5 Cs: Consent, Confidentiality, Counselling, Correct test results and Connection. In Zambia the prevalent approaches for HIV testing are Voluntary Counselling and Testing (VCT) and Provider Initiated Testing and Counselling (PITC), self-testing and home-based testing.

Zambia has adopted the Test and Start strategy which entails that every person who tests positive should be started on ART.

As the country gears up to achieve the Fast Track targets, the following testing options have been proposed in the National HTS Guidelines:

i. Community-based mobilisation and testing;
ii. Self- and home-based testing;
iii. Event- and location-based testing;
iv. Public-private partnerships;
v. Voluntary and provider-initiated testing and counselling; and,
vi. Targeted testing for the most affected populations.

Programme Objective

To increase the coverage and uptake of HTS and strengthen existing linkages to treatment, care and support services.

Programme Strategies:

i. Fast-Track unique identifiers to address multiple HIV testing at facility, community and self-testing settings;
ii. Strengthen the enabling HTS policy framework and capacity for programme leadership and management to facilitate sustainable scale-up of HTS service delivery;
iii. Target HTS utilisation among at-risk sub-populations at high risk of HIV infection;
iv. Mobilise people for HIV testing and counselling services through social and behaviour change communication;
v. Promote integration of effective condom demonstration, promotion and distribution within HTS, with a specific focus on promoting risk reduction behaviours among adolescent and young adult clients;
vi. Promote HTS integration with other services at facility and community levels;
vii. Strengthen provider initiated testing and counselling, especially among children and early adolescents, especially with nutrition rehabilitation and other clinical services;
viii. Mobilise financial resources to facilitate scale up of the HTS services;
ix. Improve logistics and supply chain management for HIV testing reagents and other laboratory consumables and supplies;
x. Intensify HTS among couples, index cases and their social contacts;
xi. Ensure quality assurance and quality control in the provision of HIV testing and counselling services at all levels;
xii. Improve the generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of the HTS programme;
xiii. Mobilise financial resources to facilitate scale up of the HTS services;
xiv. Improve logistics and supply chain management for HIV testing reagents and other laboratory consumables and supplies; and,
xv. Intensify HTS among couples, index cases and their social contacts.

Table 5: HTS Targets

Indicator # 5.1:% of women and men aged 15-49 years who received an HIV test and know their results						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	7,484,377	7,634,065	7,786,746	7,942,481	8,101,331	8,263,358
% Targeted	55%	67%	70%	75%	85%	90%

Source: MoH (2016)

Indicator# 5.2: % of sexually active adolescents 15-19 and young adults 20-24 who had sex in the last 12 months who also had an HIV test (see condom indicators data above for the estimated populations)						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Females 15-19	50	60	70	80	85	90
Males 15-19	27	40	55	65	78	90
Females 20-24	60	65	70	75	85	90
Males 20-24	47	55	65	75	85	90

Source: MoH (2016)

4.2.6 Elimination of Mother to Child Transmission (eMTCT)

Zambia shares the international community's goal of achieving the Elimination of Mother-to-Child Transmission of HIV (eMTCT), with the ambitious target of reducing the mother-to-child transmission (MTCT) rate to less than one per cent by 2021. Substantial investments have been made in expanding prevention of mother-to-child transmission (PMTCT) services nationwide, yet more still needs to be done.

PMTCT programme challenges include: limited health care worker numbers and capacity; limited infant diagnosis capacity, including access to Early Infant Diagnosis (EID), EID testing uptake, results return, and documentation of final diagnosis; linkage to care and treatment; poor 12-month retention with an increasing number of children infected in the breastfeeding period; weak cohort monitoring systems for tracking mother-baby pairs along the PMTCT cascade of care; weak community support systems; lack of

confidentiality from health workers and limited quality assurance systems for HIV rapid testing. The NASF 2017 - 2021 will address the above challenges and prioritise eMTCT services to support the reduction in new HIV infections among paediatric patients.

Programme Objectives:

i. To eliminate new paediatric HIV infections and improve the survival of children and their mothers within the context of HIV infection; and,
ii. To introduce TB screening as part of an integrated approach for TB and HIV control efforts.

Programme Strategies:

i. Scale up services for early infant diagnosis of HIV to all eMTCT sites and expand routine opt-out testing in all facilities; strengthening linkage to treatment for infected infants;
ii. Integrate Early Infant Diagnosis of HIV with Expanded Programme for Immunisation (EPI) and other MNCH services;
iii. Expand the roll out of lifelong ART (Option B+) with emphasis on retention in care for mother-baby pairs to reach all eMTCT sites in the country;
iv. Promote and scale up male involvement in eMTCT programme;
v. Scale up HIV treatment and prevention into antenatal, intrapartum and postnatal care; providing and increasing adherence to treatment for HIV positive pregnant and breastfeeding women (PBFW);
vi. Expand and strengthen Sexual Reproductive Health Services (SRHS) for adolescents and young women, including targeted promotion of prongs one and two ;
vii. Increasing first antenatal attendance within three months of pregnancy and follow-up antenatal care visits through community outreach programmes with close collaboration with community-based health workers;
viii. Scaling up of viral load monitoring for all HIV positive PBFW; and,
ix. Strengthen implementation of provider initiated counselling and testing (PITC) within MNCAH services.

Zambia has an ambitious target of reducing mother-to-child transmission of HIV to less than 1% by 2021

Table 6: eMTCT Targets

Indicator # 6.1:% of HIV-positive pregnant women who receive antiretroviral therapy to reduce the risk of mother -to- child transmission						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	77,034	77,513	77,281	77,236	76,555	76,444
% Targeted	89%	89.5%	91%	95.4%	99.4%	100%
Indicator # 6.2: % of children born with HIV from mothers living with HIV						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	77,034	77,513	77,281	77,236	76,555	76,444
% Targeted	5%	3%	2%	2%	1%	1%

Source: SPECTRUM 2016

4.2.7 Treatment of HIV, AIDS, STIs and TB

Treatment, care and support in the context of HIV and AIDS encompasses a continuum of actions and interventions at various stages including Pre-ART, ART, TB/HIV co-infection, Viral Load Suppression, nutrition and psychosocial support. The continuum includes activities that are conducted primarily in static health facilities combined with outreach to sites that bring services closer to people as well as home and community based activities that support the individual patient and facilitate the work of health workers based in health facilities. In accordance with the new treatment guidelines, the NASF 2017 - 2021 has adopted a "Test and Treat" approach as recommended by WHO.

Programme Objective: To expand quality treatment coverage to reach all the PLHIV in order to ensure quality healthy lives, reduced new HIV infections, morbidity and mortality.

Programme Strategies:

i. Improve linkage to care, counselling, and diagnostics for persons diagnosed with HIV so as to timely initiate on ART and strengthen monitoring systems to track linkages
ii. Strengthen strategies to maximise treatment adherence and retention in care to fully realise the potential of treatment;
iii. Strengthen mechanisms for coordination of collaborative TB/HIV interventions;
iv. Address inequities in access to treatment to reach those left behind: infants, children, adolescent girls and boys, men, persons with disabilities and other key populations and strengthen targeted approach to retain them in treatment services;

v. Ensure adequate skilled health providers at all levels and throughout the entire treatment cascade;
vi. Scale up and strengthen community-based level diagnostics and community level service delivery models;
vii. Strengthen mobile ART services in rural areas and hard to reach populations; and,
viii. Support the food and nutrition component of the ART programme by, among other things, forging strong collaboration with food security and livelihood sectors and organisations such as Ministries of Agriculture; Livestock; and, Community Development and Social Services.

Table 7: ART Targets

% of HIV positive children currently receiving antiretroviral therapy

Indicator # 7.1:% of HIV-positive adults who know their status and are currently receiving antiretroviral therapy

	2016 Baseline	2017	2018	2019	2020	2021
Estimated population in Need	1,060,474	1,095,394	1,124,024	1,152,373	1,180,012	1,207,080
% Targeted	70.6%	73%	76%	79%	81%	83%

Indicator # 7.2: % of HIV-positive children (0 – 14 years) currently receiving antiretroviral therapy

	2016 Baseline	2017	2018	2019	2020	2021
Estimated population in Need	67,076	63,508	59,446	55,225	50,866	46,333
% Targeted	74%	75%	77%	79%	81%	83%

Source: SPECTRUM 2016

4.2.8 TB/HIV Co-infection

TB remains the leading cause of death among PLHIV. The percentage of identified HIV-positive TB patients on ART has increased over the years. TB/HIV co-infection programme efforts have ensured systematic enrolment of all HIV/TB co-infected patients on ART. The NASF 2017 - 2021 focuses at reducing the risk of TB in PLHIV.

Programme Objectives: To strengthen TB/HIV services including high-quality DOTS expansion and address multidrug resistant (MDR) TB.

Programme strategies:

i. Strengthen mechanisms for coordination of collaborative TB/HIV interventions;
ii. Scale up TB/HIV control in special settings and among all key populations
iii. Strengthen TB/HIV infection prevention and control measures in health care and community settings;
iv. Enable and promote operational research;
v. Promote orientation, training, mentoring and technical support for health care workers in TB/HIV interventions;
vi. Support coordinated TB case finding among PLHIV and ensure that partners of TB patients who are co-infected are tested for HIV;
vii. Strengthen coordination, linkages and referral systems between TB and ART Programmes;
viii. Mobilise and engage community health workers to support referral systems of patients between HIV and TB programmes.

Table 8: TB/HIV Co-infection targets

Indicator 8.1: % of HIV positive registered TB patients given anti-retroviral during TB treatment						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	17914	25267	29663	31985	34530	36636
	76%	85%	92%	100%	100%	100%

Source: SPECTRUM (2016)

4.2.9 Treatment Optimisation

HIV Treatment Optimisation (TO) is an intended process to enhance the long-term efficacy, adherence, tolerability, safety, convenience, and affordability of combination ART[7]. The ultimate goal of TO is to expand access to well-tolerated and effective lifetime HIV treatment.

Programme Strategies

To explore and scale-up workable cost effective differentiated models of care

i. Improve treatment outcomes as side effects and toxicities subside;

ii. Provides improved quality of drugs;

iii. Accelerate treatment access expansion efforts towards 90-90-90 targets.

[7] Conference on Antiretroviral Drug Optimisation (CADO)

Viral Load Testing

Viral load test is a lab test that measures the number of HIV virus particles in a millilitre of blood. These particles are called "copies." A viral load test helps provide information on the health status of an individual and how well antiretroviral therapy treatment controls the virus.

Programme Strategies:

i. Expand viral load testing sites and accessibility; and,
ii. Develop and strengthen a courier system for specimens from the point of collection to the reference laboratory to enhance optimal utilisation of the viral load testing machines and results.

Table 9: Viral Load Testing

Indicator 9.1: % of PLHIV who are virally suppressed aged 15 – 49 years

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	1,060,474	1,095, 394	1,124, 024	1,152, 373	1,180, 012	1,207, 080
% Targeted	52%	60%	65%	70%	80%	90%

Indicator 9.2: # of PLHIV who are virally suppressed aged 0 – 14 years

	2016 Baseline	2017	2018	2019	2020	2021
Estimated Population in Need	67,076	63,508	59,446	55,225	50,866	46,333
% Targeted	52%	60%	65%	70%	80%	90%

Source: SPECTRUM (2016)

4.2.10 Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is a method of preventing HIV infection by taking a pill every day. This HIV prevention tool is for people who do not have HIV but are at substantial risk of getting it. The pill used bears the brand name *Truvada* and contains two medicines (*Tenofovir* and *Emtricitabine*) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. When taken

consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92 per cent. PrEP is much less effective if it is not taken consistently.

This is a powerful HIV prevention tool which can be combined with condoms and other prevention methods to provide even greater protection than when used alone. The NASF 2017 - 2021 targets discordant couples and key populations.

Programme Objective

To prevent HIV infection in negative people who are at substantial risk of HIV exposure

Programme Strategies:

i. Implement appropriate, evidence-informed communication and advocacy strategies to increase both healthcare provider and public awareness of PrEP within the context of HIV prevention, without stigmatising the intervention and its potential users, nor increasing risky sexual behaviour;
ii. Offer and promote PrEP as an additional option in the context of combination prevention;
iii. Integrate PrEP into other HIV prevention programmes, policies and services as well as sexual and reproductive health, contraception and fertility planning services and antenatal care;
iv. Strengthen capacity for continuity care with patient on PrEP; and,
v. Appropriate Monitoring and Evaluation (M&E) systems need to be in place to monitor and evaluate provision, quality of care and impact of the PrEP programmes.

4.3 Critical HIV Programme Enablers

Programme enablers are critical to the success of a comprehensive HIV programme and the attainment of Fast-Track targets. Critical enablers ensure equitable access and non-discriminatory access to HIV-related services and guarantee full involvement of local communities.

4.3.1 Leadership Commitment and Good Governance

The national HIV response needs commitment and good governance at national, provincial, district and community levels. Sustained political, civic, traditional, community and corporate leadership and commitment at all levels is essential to ensuring an effective and focused multi-sectoral response. The NASF 2017 - 2021 will seek to strengthen community-led initiatives and improve political leadership, commitment, accountability and good governance of the response.

Programme Objective

To improve and strengthen accountability, commitment and good governance of the national multi-sectoral HIV and AIDS response that ensures provincial, district and community led strategies

Programme Strategies:

a) Enhance political commitment and good governance;
b) Sustain leadership at all levels;

c) Enhance leadership, governance and oversight for implementing home-grown solutions to HIV and AIDS; and,
d) Focus investments where they matter most with sufficient quality and equity for enhanced decentralised delivery of HIV services.

4.3.2 Gender Equality, Equity and Empowerment

HIV in Zambia has a feminine face hence the need to take a strong stance on addressing gender inequality and GBV. Gender disparities among adolescents is even greater with girls in the 15 - 24 age group, twice as likely to be HIV-positive than boys of the same age group. In many communities, intergenerational sex places girls at high risk of exposure to the virus.

Gender-based violence has also been identified as a significant factor in gender inequality in Zambia, affecting all aspects of women and men's life including their access to and use of HIV services. The NASF 2017 - 2021 will seek to ensure that a gender dimension is included in all programme areas of the multi-sectoral response.

Programme Objective

To eliminate gender inequality and gender-based violence

Programme Strategies:

i. Support gender responsive and inclusive programmes to advance sexual reproductive health and rights;
ii. Implement community programmes to change harmful gender norms, negative stereotypes and concept of 'toxic' masculinity;
iii. Strengthen coordinated government response to HIV, GBV, early marriages, unplanned pregnancies, poor educational advancement of girls and child protection;
iv. Review the national plan of action on reducing HIV infection among women and girls;
v. Gender responsive monitoring and evaluation; and,
vi. Strengthen advocacy to operationalise existing policy and legal frameworks that address harmful gender and social norms.

Table 10: Gender Equality and Empowerment

Indicator 11.1: # of GBV cases reported annually						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	14,104,100	14,676,843	15,443,732	15,876,451	16,023,643	16,901,734
# Targeted	1,133	2,095	2,643	2,951	3,694	4,118
Indicator 11.2: # of Survivors receiving Post-GBV Care						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated Population in Need	14,104,100	14,676,843	15,443,732	15,876,451	16,023,643	16,901,734
# Targeted	18,126	19,363	20,765	21,984	22,764	23,069

Source: MoG (2016)

4.3.3 Policies, Laws and Human Rights

Government has continued to show strong political will and commitment to investing the necessary financial and institutional resources into the HIV and AIDS response. However, opportunities still remain to create a more enabling legal environment for providers and beneficiaries of HIV and AIDS services in the country.

Programme Objective

To enhance the enabling social, policy and legal environment to ensure the protection and promotion of human rights and dignity for all, with a special emphasis on historically excluded and marginalised groups.

Programme Strategies [8]:

i. Advocate for and promote legal reforms against laws and policies that hinder access to HIV services;
ii. Undertake legal literacy programmes to teach those who are living with or affected by HIV about human rights and the national laws relevant to HIV;
iii. Eliminate stigma and discrimination against PLHIV and other key and marginalised populations;
iv. Establish mechanisms for stakeholder engagements with the Zambia Law Development Commission to change discriminatory laws; and,
v. Sensitise law and policy makers on the need to enact laws, regulations and policies that prohibit discrimination and support access to HIV prevention, treatment, care and support services.

[8] Per R-NASF 2014 - 2016

4.3.4 Elimination of Stigma and Discrimination

Stigma and discrimination have been identified as a barrier to HIV prevention and uptake of care and treatment services. The socially excluded, poor and vulnerable people who are living with HIV are unlikely to access HIV and AIDS services thereby negatively impacting on the ability and aspirations to lead healthier and normal lives.

Programme Objectives

To mobilise and strengthen institutions, community support systems and PLHIV to address stigma and discrimination whilst at the same time instituting anti-stigma and discrimination programmes for key populations.

Programme Strategies:

i. Scale-up campaigns to reduce stigma and discrimination and promote uptake of HIV services and prevention interventions;
ii. Provide legal support services to ensure that PLHIV have access to justice when their rights have been violated;
iii. Implement programmes aimed at reducing stigma and discrimination against key populations and in the world of work;
iv. Reduce stigmatising attitudes in health care facilities and to provide health providers with the skills they need to ensure patients' rights to confidentiality, appropriate treatment and non-discrimination; and,
v. Conduct measurement of HIV related stigma through People Living with HIV Stigma Index studies.

4.3.5 Resource Mobilisation and Sustainable Financing

Zambia continues to be heavily reliant on donor funding. This calls for innovative approaches to raising domestic funding for the response. Innovative approaches for revenue generation need to be explored and implemented by the Government. Efficiencies in HIV and AIDS spending equally need to be promoted with corresponding accountability mechanisms strengthened to enhance partner confidence.

Programme Objectives

To localise the major share of the AIDS budget by 2020

Programme Strategies:

i. Increase domestic resource mobilisation by 2020;
ii. Strengthen donor confidence through enhanced efficiencies in resource utilisation; and,

iii. Advocate for legislation to broaden the net of domestic resource mobilisation from both state and non-state sources.

4.3.6 Positive Health Dignity and Prevention

Previously known as 'positive prevention,' Positive Health Dignity and Prevention (PHDP) is a concept of HIV prevention for and by People Living with HIV (PLHIV). The primary goals of PHDP are to improve the dignity, quality and length of life of PLHIV. If achieved, this will, in turn, benefit their partners, families and communities, including reducing the likelihood of new infections. It is built upon a broader foundation that includes improving and maintaining the dignity of the individual living with HIV. It supports and enhances the individual's physical, mental, emotional and sexual health, which, in turn among other benefits, creates an enabling environment that will reduce the likelihood of new HIV infections.

Programme Objective

To improve the dignity, quality and length of life of People Living with HIV

Programme Strategies:

i. Promote holistic health and wellness of PLHIV, including universal, equitable access to voluntary HIV counselling, confidential testing, care and support and timely access to voluntary treatment and monitoring;

ii. Address factors that undermine health and dignity of PLHIV, including: poverty and food insecurity; lack of mental and psychosocial support; lack of educational opportunity; social exclusion; gender inequality; and stigma and discrimination based on HIV-positive status;

iii. Scale-up and support existing HIV counselling and testing, care, support, treatment and prevention programmes that are community owned and led as well as increasing access to rights-based health services including sexual and reproductive health;

iv. Scale-up and support literacy programmes in health, treatment, prevention, human rights and law and ensure that human rights are promoted and implemented through relevant programmes and protections;

v. Ensure that undiagnosed and diagnosed PLHIV, along with their partners and communities, are included in HIV prevention programmes that highlight shared responsibility regardless of known or perceived HIV status and have opportunities for, rather than barriers to, empowering themselves and their sexual partner(s); and,

vi. Scale-up and support programmes that focus on community-driven, sustainable responses to HIV by investing in community development, networking, capacity building and resources for people living with HIV organisations and networks.

4.4 Synergies with Development and Other Sectors

4.4.1 Synergies within the Health Sector

The HIV epidemic has affected every aspect of development in Zambia. The NASF 2017 - 2021 represents a cost-effective and sustainable strategy of fully mainstreaming HIV into socio-economic development sectors to ensure all citizens are able to equally access relevant HIV services and support.

High impact interventions outlined in this section are services mostly delivered through the health sector. This section deals with health services that directly or indirectly related to HIV such as Post-Exposure Prophylaxis (PEP), Blood Safety, Viral Hepatitis infection and Psychosocial Support. These health sector services are important by themselves and also have a significant relationship with HIV and SRHR.

1. Post Exposure Prophylaxis (PEP)

The national HIV response has supported the Post-Exposure Prophylaxis (PEP) to prevent HIV infection from developing in people exposed to the virus. PEP is provided as a package of services: first aid care; counselling and risk assessment; HTS and depending on the outcome of the risk assessment, 28 days provision of ARVs with follow-up. This programme supports initiatives that create awareness about both occupational and non-occupational PEP to prevent HIV infection developing in exposed persons.

Programme Objective

To scale up PEP services and ensure that they are available and accessible to eligible people who have been accidentally or otherwise exposed to HIV and are given drugs to reduce the risk of primary infection.

Programme Strategies:

i. Integrate PEP into the minimum occupational health package for emergency workers and accident victims;
ii. Strengthen GBV care services including PEP for survivors of sexual assault;
iii. Scale-up community awareness on PEP; and,
iv. Intensify community-based advocacy work to sensitise communities on PEP services.

2. Viral Hepatitis Infection

Viral Hepatitis infection is widespread, affecting over 10 times the number of people infected with HIV. Zambia has a high prevalence of HBV infection, estimates vary from 4-8 per cent and data from the Zambia National Blood Transfusion Services (ZNBTS) suggests that prevalence is about five per cent although it varies across the country.

Programme Objective

To prevent and reduce the impact of viral hepatitis on people, society and the economy over the next five-year period in order to eliminate Hepatitis B Virus (HBV) as a public health threat by 2030.

Programme Strategies:

i. Scale-up awareness of Viral Hepatitis to increase knowledge of the general population and key populations on risks and protection from viral hepatitis;
ii. Strengthen strategies for enhanced knowledge and skills of health care providers in screening high risk populations;
iii. Support improved efforts for reducing stigma and discrimination associated with Hepatitis in the community; and,
iv. Reduce new viral Hepatitis infections through enhanced eMTCT; reaching more susceptible people in communities and prevention of health care related transmission.

3. Blood Safety

ZNBTS plays a very critical role in ensuring blood safety across all the 10 provinces of Zambia. Each regional blood bank has the capacity to test all donated blood for transfusion transmissible infections including HIV, Hepatitis B and Syphilis.

Programme objective

To ensure availability of adequate supplies of safe blood and blood products to all patients in Zambia

Programme Strategies:

i. Increase the annual blood collection to meet the national blood and blood products requirements;
ii. Develop and implement ICT Solutions to improve the management of the blood transfusion processes;
iii. Improve the clinical interphase in the blood transfusion chain;
iv. Operate an effective, nationwide Quality Assurance programme that ensures security of the entire blood transfusion process; and,
v. Strengthen the Monitoring and Evaluation function of ZNBTS.

Table 11: Blood Safety Targets

Indicator 11.1: # of safe blood units available for transfusion						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
# Targeted	150,000	156,000	152,000	168,000	174,000	300,000

Source: ZNBTS (2016)

4. Psychosocial Support for PLHIV

The increased effectiveness and availability of Highly Active Antiretroviral Treatment (HAART) during the past decade has resulted in thousands of PLHIV to survive and live healthy and longer lives. Psychosocial support is essential because it addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families and caregivers.

Programme Objective

To strengthen and support the ongoing psychosocial programmes targeted at HIV infected individuals, their partners, families and caregivers to help them cope more effectively with each stage of the infection and enhance the quality of life.

Programme Strategies:

i. Scale-up training on the provision of psychosocial support and ensure incorporation into the curriculum for various cadres of health care providers including training of community health workers;
ii. Strengthen and formalise home and community-based provision of basic psychosocial care by community volunteers and family caregivers; and,
iii. Build community capacities to provide counselling and support to ensure sustainability, continuity of interventions and community development.

4.4.2 Synergies with other Development Sectors

1. Education Sector

The Ministry of General Education has implemented a number of strategies related to HIV. Recently, the ministry revised the national school curriculum to ensure that Life Skills-Based Comprehensive Sexuality Education (CSE) is part of learners' performance assessment, among many other initiatives. In 2014, the MoGE recorded 16, 430 pregnancies among pupils (13, 327 primary and 3, 103 secondary). The ZDHS 2013-14 found that 5.2 per cent of adolescent girls aged 15-19 were pregnant during the survey. This would be approximately 44, 500 adolescent girls – hence the MoGE pregnancy data captures only around one-third of the annual number of adolescent pregnancies.

Programme Objective

To reduce the impact of HIV and AIDS in the educational sector

Programme Strategies:

i. Expand resources for, and strengthen, operation of school-based AIDS Action Clubs;
ii. Strengthen targeted guidance and counselling support for at-risk adolescents in primary and secondary schools and school to clinic based psychosocial support for adolescents living with HIV;
iii. Institutionalise linkages with the health and other sectors to increase access to HTS, ART and condoms for teachers, non-teaching staff and students in all learning institutions; and,

iv. Improve sexuality knowledge and information through integration of age appropriate comprehensive sexuality education in school curricula and peer-to-peer life skills activities in schools.

Table 12: Education Sector – indicators and targets

Indicator 12.1: CSE HIV Knowledge Levels of Learners (Based on National Exam Scores)						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
CSE Question Exam Scores Grade 7 (by sex)	**--**	**F – TBD** **M-TBD**	**X** **x**	**X** **X**	**X** **x**	**90%** **90%**
CSE Questions Exam Scores Grade 9 (by Sex)	**--**	**F – TBD** **M-TBD**	**X** **X**	**X** **X**	**X** **X**	**90%** **90%**
CSE Exam Scores Grade 12 (by Sex)	**--**	**F – TBD** **M-TBD**	**X** **X**	**X** **X**	**X** **X**	**90%** **90%**

Source: MoGE (2016)

Indicator 12.2: Scale up Comprehensive Sexuality Education Curriculums						
	2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
% of schools implementing CSE	**60%**	**80%**	**100%**	**100%**	**100%**	**100%**
% of schools with resourced and operational AAC	**x**	**x**	**x**	**x**	**X**	**100%**

Source: MoGE (2016)

2. Adolescents and Young People

Adolescents and young people are significantly at high risk of contracting HIV and AIDS. More efforts are needed to promote a combination of services within the high impact interventions which adolescents and young people can adopt. The NASF 2017 - 2021 recognised adolescent girls and boys aged 15-19, young women and men aged 20-24 as distinct vulnerable populations, who need a mix of targeted but differentiated programmes. Attainment of the Fast-Track targets will not be achieved without ensuring

universal access to HIV prevention, treatment, care and support services by adolescents and young - people.

Programme Objective: To support and provide adolescents and young people with adequate access to inclusive and responsive HIV/SRH services by 2021.

Programme Strategies:

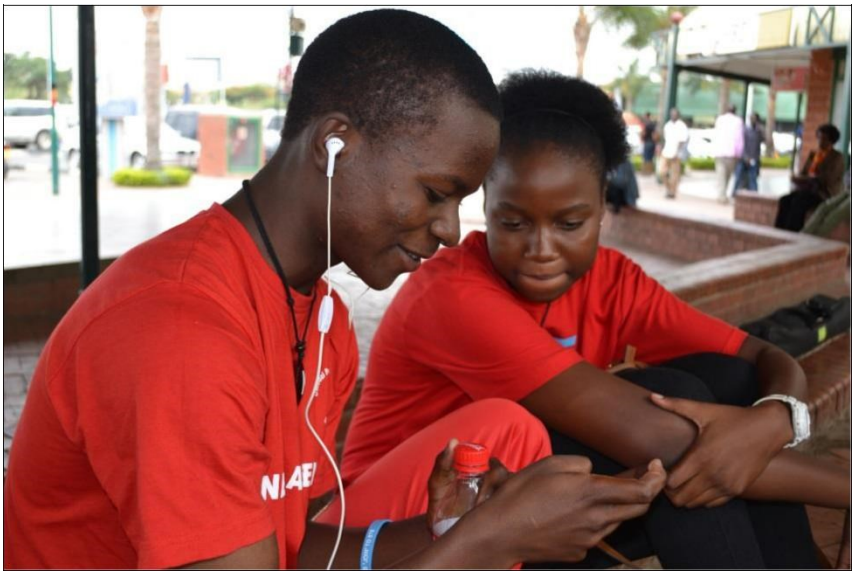
i. Scale up SBCC to raise adolescents' awareness and utilisation of available HIV/SRH services by addressing social, religious, cultural, economic, legal and political factors which hinder adolescents and young people access to HIV and SRH knowledge, skills and services;

ii. Improve the quality and targeting of HIV prevention, HIV treatment services and other STIs through integrated adolescent responsive HIV and SRHR programmes;

iii. Scale up a gender sensitive and adolescent responsive health service Platform to all high burden health facilities to increase access and utilisation of HIV and SRHR services;

iv. Strengthen the coordination of adolescent programmes at all levels; and,

v. Strengthen Monitoring and Evaluation systems in relation to adolescent's HIV/SRH programmes.



Adolescents and young people need comprehensive HIV prevention information

Table 13: Adolescents and Young People

Indicator 13:1 % Health facility coverage of adolescents friendly HIV/SRH Services					
2016 Baseline 24%	**2017**	**2018**	**2019**	**2020**	**2021**
	30%	50%	65%	75%	90%
Indicator 13:2: Number of all adolescents reached with HIV/SRH prevention services.					
2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
Baseline – TBD 20% - 340,000s	510,000 (55%)	720,000 (60%)	900,000 (75%)	1million (85%)	1.16 million (90%)
% of Adolescents Living with HIV Aged 15-19 utilizing ART services					
2016 Baseline – TBD	50%	60%	70%	80%	90%
Indicator 13:3: Number of youth led FBOs/CBOs actively participating in health related decisions and service provision					
2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
	55	65	75	85	90
Indicator 13.4: Number of policy and legal frameworks					
2016 Baseline	**2017**	**2018**	**2019**	**2020**	**2021**
	0	1	1	0	0

Source: National Adolescents Health Strategic Framework (2016 – 2020)

CHAPTER 5: HIV AND AIDS INTEGRATION AND SYSTEMS STRENGTHENING

5.1 Integration of HIV/AIDS, Sexual Reproductive Health and Other Services

Integration is the actual joining together and offering of a comprehensive set of SRH and HIV services or operational programmes to ensure and perhaps maximise collective health outcomes. Linking SRH and HIV services ensures that all people, especially adolescents and young adults, are provided with an integrated package of quality health services, that are confidential, free from stigma and discrimination and ensures that no-one is left behind. The NASF 2017 - 2021 will ensure that the Zambian HIV response is clearly and fully integrated with sexual and reproductive health.

Programme Objective

To strengthen the health service delivery system at national, provincial and district levels for the provision of HIV services integrated in SRH and other health care services

Programme strategies:

i. Advocate for building of new, and upgrading of, existing health facility infrastructures to be able to provide HIV, SRH and other health services with designated spaces for adolescent friendly HIV and SRH services;
ii. Scale-up national training of pre-service and in-service health workers on provision of integrated HIV and SRH and other services;
iii. Institute mechanisms for task sharing and mentorship for skills transfer to ensure delivery of the essential health package; and,
iv. Scale up the integration of HIV services with critical health programmes i.e. non-communicable diseases (NCDs), STIs, MCH, sexual and reproductive health.

5.2 Health Systems Strengthening

Zambia is committed to a continuous investment in the health sector as part of its efforts to improve access to quality health services by all its citizens (SNDP 2014-2016). The health sector has continued to record significant progress in most of the key areas of health service delivery. The NASF 2017 - 2021 provides for an evidence based quantification and forecasting of reproductive health commodities, ARVs and laboratory consumable supplies to ensure no service interruption which can demotivate potential clients. In this regard, operationalisation of the Regional Stores Hubs by MoH is a step in the right direction towards decentralisation of the logistics and supply chain management system among others.

Programme Objectives

To improve the capacity for equitable distribution, availability and accessibility of quality and comprehensive HIV and AIDS services in ways that are gender and human rights responsive and cost effective.

Programme Strategies/Interventions:

i. Support robust and evidence informed quantification and forecasting for reproductive health commodities, ARVs, condoms and laboratory consumables for HIV;
ii. Capacity improvements in Logistics Management Systems (LMS) both at the Medical Stores and the Regional Hubs to ensure accurate quantification, forecasting and timely distribution of reproductive health commodities;
iii. Scale-up innovative community-based (e-health) delivery modalities; and,
iv. Develop technical and operational capabilities for efficient management of complementary external resources earmarked for the national HIV response.

5.3 Community Systems Strengthening

Communities have enormous potential in demand creation, advocating for better services, supporting stronger health literacy, provision of home-based care, supporting PLHIV and orphans as well as challenging negative practices, such as alcohol and drug abuse, and stigma and discrimination.

Programme Objective

To contribute to HIV prevention, stigma reduction and continuum of care as close as possible to PLHIV, and the most affected, in order to maximise coverage and optimise adherence in addition to reducing loss to fall-out.

Programme Strategies:

i. Train and motivate community health workers and community-based organisations to promote and provide integrated HIV, SRH and other services at community level;
ii. Improve access to and rational use of quality essential products and technologies for HIV prevention, treatment and care services including condom promotion and distribution at community level;
iii. Integrate SBCC for HIV prevention, treatment and stigma/discrimination reduction at community level;
iv. Promote and strengthen the delivery of designated services for adolescents living with HIV as they transition from paediatric to adult ART services; and,
v. Establish and strengthen community evidence-based programming and M&E systems.

5.4 Social Protection

Social protection programmes have increasingly become HIV sensitive and their rapid scale-up is reaching more numbers of vulnerable households affected by HIV. Social protection, care and support programmes enable the HIV and AIDS response to more effectively address the underlying drivers of the epidemic,

reduce the social and economic barriers to universal access, contribute to reductions in new infections, increase treatment uptake and retention and help mitigate the impact of the epidemic. It can contribute to the prevention of further new HIV infections by reducing potential risky coping strategies such as sex for favours.

Programme Objective

To provide support to vulnerable households and individuals in order to reduce the impact of HIV and AIDS by 2021

Programme Strategies:

i. Provide social cash transfers to vulnerable households and to people affected and living with HIV to enhance cash and care interventions;
ii. Advocate for inclusive, enabling and HIV-sensitive social protection policy and regulatory environment;
iii. Improve collaboration among the major players in social protection programmes including ministries of Community Development and Social Services; Agriculture; Livestock; and, Local Government and Housing; and,
iv. Operationalise the Social Health Insurance Scheme.

Table 14: Social Protection Targets

Indicator 14: # of vulnerable people accessing social protection services such as Social Cash transfers and food security packs.

	2016 Baseline	2017	2018	2019	2020	2021
# Targeted	285,000	330,635	447,741	585,379	657,744	778,736

Source: MCDSS (2016)

5.5 Nutrition and Food Security

The need to ensure food security is an essential structural intervention to enhance HIV prevention, treatment, care and support. Food insecurity and HIV epidemics co-exist and exacerbate each other. Nutrition and food assistance can support uptake of HIV counselling and testing, HIV and TB treatment and adherence to HIV prevention and treatment services. Good nutrition helps people on treatment to recover from malnutrition, tolerate drugs and manage side effects. Nutrition and/or food support, therefore, will be an integral part of HIV and TB treatment regimens and broader AIDS responses.

Programme Objectives

To contribute towards the reduction of food insecurity in households made vulnerable by HIV and AIDS.

Programme Strategies:

i. Strengthen breastfeeding counselling messages for HIV exposed infants;
ii. Reinforce the importance of nutrition for treatment adherence; and,
iii. Strengthen district level and community level planning and coordination on nutrition and HIV services and enhance district financing.

5.6 Poverty Alleviation and Livelihoods

The capacity of vulnerable households to cope with the impact of HIV needs to be strengthened. Interventions such as sustainable businesses and livelihood development, improving household food security, food security packs, backyard and community gardens, small livestock schemes and reducing household risks and vulnerability are all important in the context of HIV. The NASF 2017 – 2021 will strengthen and support the capacity of PLHIV and their families through building relevant skills, improving access to credit, and building appropriate value chains and markets.

Programme Objectives

To support poverty alleviation efforts especially among people living and affected by HIV and AIDS with the ultimate goal of contributing to the reduction of new HIV infections

Programme Strategies:

i. Enhance knowledge on HIV-livelihood linkages;
ii. Promote integration of PLHIV networks in sustainable business development and livelihood empowerment initiatives focusing on adolescent girls and boys and young and vulnerable women and men;
iii. Promote economic empowerment of women using various economic and financial mechanisms and strategies; and
iv. Improve linkages between HIV service and social protection programme and other poverty alleviation strategies.

5.7 Mainstreaming HIV into Capital Projects

Government has embarked on large-scale infrastructure developments as part of its plans to improve socio-economic growth for the country. Amid these ventures, the Government recognises that without careful planning, such projects can fuel negative impacts such as the HIV epidemic.

The NASF 2017 - 2021 seeks to promote strategies to address the potential adverse effects of labour migrants and mobile populations involved in large infrastructure developments. The national response will develop and strengthen strategic partnerships among relevant institutions in order to mitigate health, social and developmental impacts associated with large scale infrastructure development projects.

Programme Objective

To strengthen the capacity of various sectors to understand, evaluate and respond to critical HIV risk factors

Programme Strategies:

i. Integrate HIV, gender and human rights aspects into capital projects eligible for Environmental Assessments;
ii. Affirm institutional mechanism for implementation of Environmental Management Plans (EMPs) and coordinated HIV response at all levels;
iii. Promote south to south and cross border cooperation on integration of HIV, related gender and human rights aspects in joint regional development initiatives;
iv. Develop an effective and efficient tracking system on utilisation of funds allocated to HIV and AIDS; and,
v. Promote a bold mass media HIV prevention campaign around capital project sites and surrounding communities.

Table 15: Mainstreaming HIV into Capital Projects – Indicators and targets

Indicator 15.1: % of major capital projects that have mainstreamed HIV, related gender and human rights in the planning and implementation phases of the project					
2016 Baseline	2017	2018	2019	2020	2021
>10%	30%	40%	50%	60%	70%

5.8 HIV and AIDS Workplace Policies and Practices

HIV has devastating impacts on the labour force and consequently on socio-economic development due to lessened productivity. Labour intensive sectors such as agriculture, mining, construction, transport, the military and other uniformed services are the most affected sectors in the country. Most of the workforce in these sectors are labour migrants who experience a lot of mobility in the context of their work.

Although the HIV pandemic is increasingly being addressed at the workplace, it is yet to be fully institutionalised. The NASF 2017 - 2021 seeks to ensure that mainstreaming of HIV and AIDS into workplaces is well guided and expanded to reach workforces in the public and private sectors.

Programme Objectives

To contribute towards a comprehensive package of HIV prevention, treatment, care and support interventions for both the formal and informal workforce

Programme Strategies:

i. Finalise and implement the national HIV and AIDS Wellness Workplace Policy and Public Sector Response Strategy;
ii. Generate strategic information that highlight investment choices and efficient use of resources earmarked for HIV and related gender response in the public sector;
iii. Revitalise Information, Education and Communication programmes in public and private sector workplaces, including the informal economy; and
iv. Develop and implement a Private Sector engagement and response strategy.

Both formal and informal workplaces need HIV and AIDS interventions as part of the national response

CHAPTER 6: COORDINATION, MANAGEMENT AND INSTITUTIONAL ARRANGEMENTS

6.1 Response Coordination and Management

The National HIV/AIDS/STI/TB Council is mandated to coordinate the response as prescribed by the NAC Act No. 10 of 2002. Coordination of the national multi-sectoral response takes place at four levels namely: national, provincial, district and community. Coordinating structures are multi-sectoral in nature and draw representation from Government, civil society organisations, development partners and the private sector.

Coordination and management of the response is critical as gaps between supply and demand for HIV services will be narrowed, duplication of efforts minimised, rational use of resources improved, and equitable distribution of resources and services realised. This process dictates the need to form strategic partnerships and alliances with stakeholders including civil society organisations, private sector, development partners, local authorities and communities. It is through improved coordination and monitoring that quality and comprehensiveness of services, accountability, harmonisation and alignment can be achieved.

However, the greatest challenge to improved coordination of the national response has been the lack of management authority of the coordination mechanisms. Membership of the various structures mandated to coordinate the national response is voluntary, with each member reporting through their organisation. This has resulted in weak coordination of the response. This is particularly true with regard to sharing of data with District AIDS Task Forces (DATFs).

Figures 7 and 8 below show the institutional arrangements for the coordination of the national response both at the national and sub-national levels.

Programme objective

To improve the efficiency and effectiveness of the national and decentralised coordinating structures of the multi-sectoral HIV and AIDS response

Programme strategies

i. Strengthen the capacity of the NAC to provide effective leadership of the national multi-sectoral response;
ii. Enhance public, private, civil society and media networks self-coordinating mechanisms;
iii. Promote and ensure quality and cost effective programming for higher impact;
iv. Institutionalise decentralised response coordination and management within Local Authorities;
v. Innovate and invest in strategic information generation and knowledge management, especially at sub-national level; and,
vi. Ensure HIV mainstreaming and capacity development in all sectors.

Table 16: Local Authorities with response coordination and management

Indicator 16.1: Number of Local Authorities with institutionalised multi sectoral response coordination and management within established structures					
2016 Baseline	2017	2018	2019	2020	2021
10	110	110	110	110	110
Indicator 16.2: Number of Local Authorities that have integrated costed high impact HIV and gender related responses into their medium to long-term strategic (or investment) plans 2017 - 2019					
2016 Baseline	2017	2018	2019	2020	2021
13	110	110	110	110	110

Source: NAC (2016)

Figure 6: Response Coordination and Management Framework at National to Provincial Level

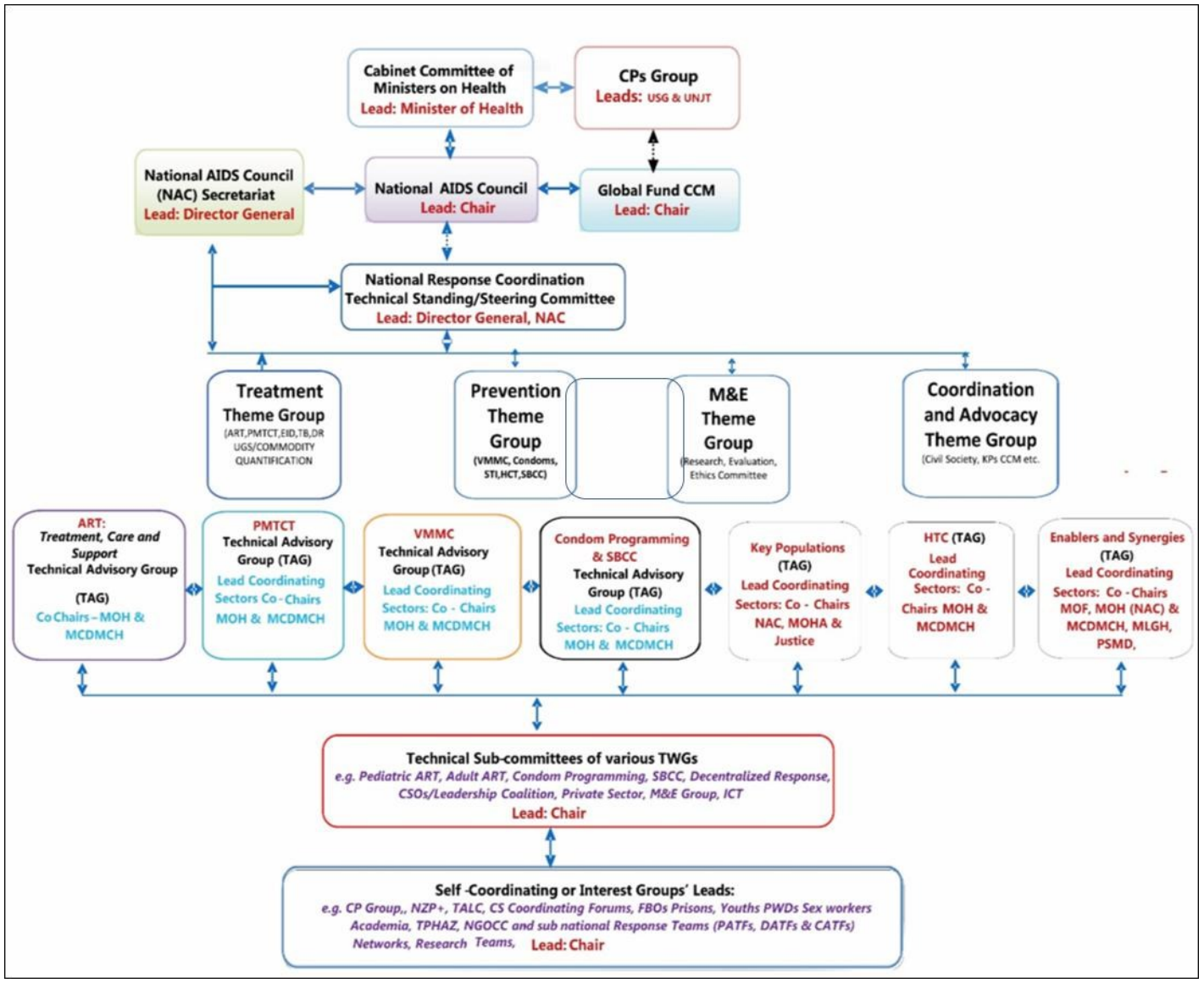
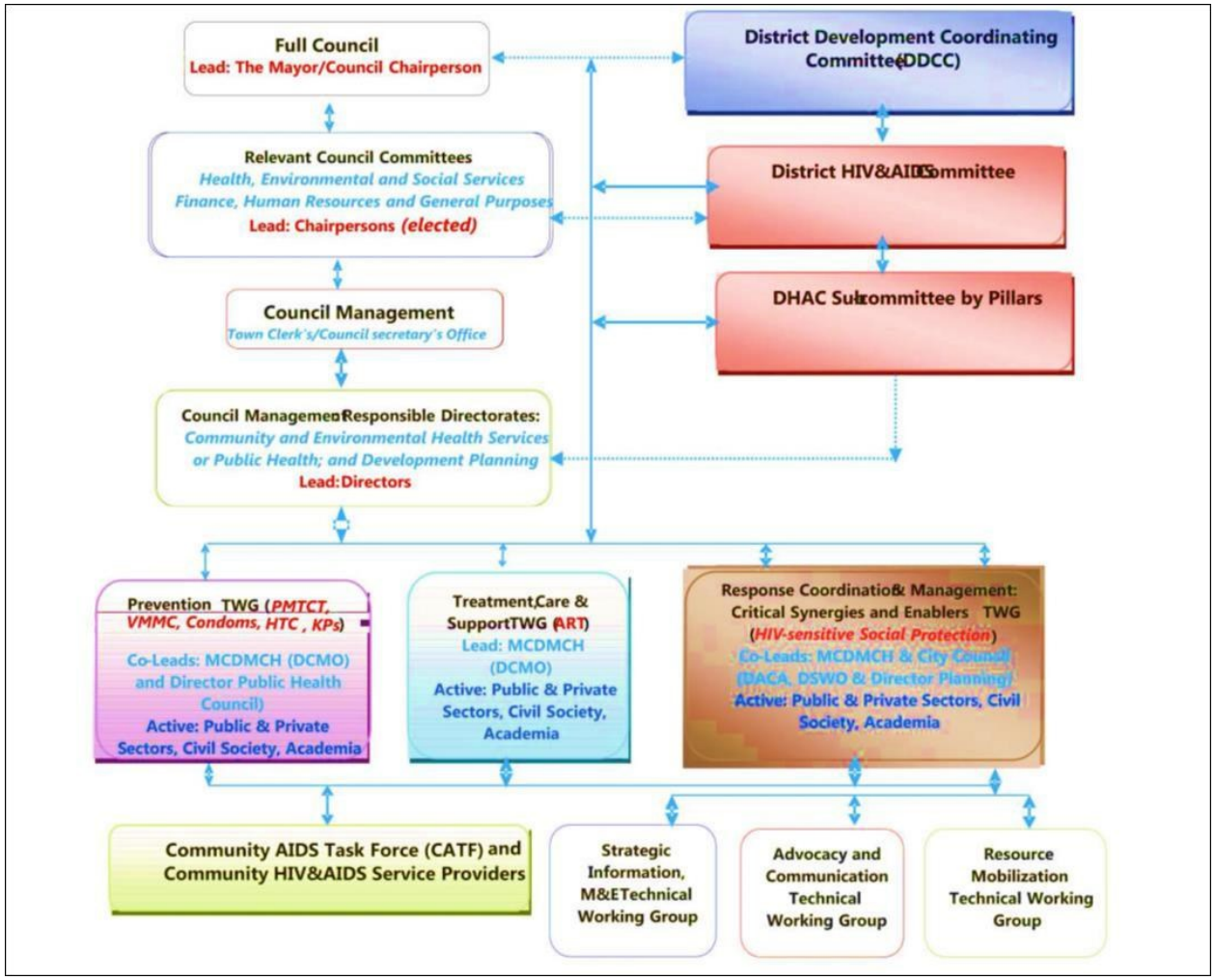


Figure 7: Response Coordination and Management Framework at District Level



6.2 Costing of the NASF 2017 - 2021

6.2.1 Methodology

The cost and expected impact of the NASF 2017 - 2021 interventions were modelled on the basis of Zambia's previous projections of the epidemic, generated within Spectrum AIM[9] and updated with the latest ZAMPHIA findings and applying the Goals model[10] for the impact and cost projections. For the current analysis, Goals were updated to reflect actual coverage for all HIV programmes at the end of 2016, and updated antiretroviral (ARV) and laboratory costs (2016), and other programme unit costs with the most recently available costs (refer to Appendix for the unit costs and their sources). No primary data collection

[9] National HIV/AIDS/STI & TB Council (2013) and updated "AIM projection Zambia 2016_NATIONAL Final" (April 2017).

10 Avenir Health, 2017. Spectrum and Goals Model: www.avenirhealth.org

was undertaken to generate unit costs and, thus, only those interventions with available unit costs and included in the Goals model had the NASF targets applied to them and were costed, while a few were omitted, as per the list below. Costs and impact were not discounted and costs are reported in 2016 US$.[11]

Table 17: NASF 2017 - 2021 interventions excluded in the cost estimates

Nutrition and food security	Gender Equality and Empowerment
Resistance testing	Policies, Laws and Human Rights
Integration of HIV/AIDS, Sexual Reproductive Health and Other Services	Stigma reduction (integrated into all efforts)
Psychosocial support for PLHIV family and community strengthening—required further definition and detailed ingredient costing	Adolescents—address social, religious, cultural, economic, legal and political factors, advocacy for increased access to services, peer-to-peer support/networks etc. Promote the participation of adolescents and young adults in sport and fitness programmes.
Community Systems Strengthening—requiring further definition and detailed ingredient costing	Workplace programmes
Poverty Alleviation and Livelihoods	Mainstreaming HIV into Capital Projects
Leadership Commitment and Good Governance	TB interventions (ART costs for TB/HIV co-infected persons included under the ART costs)
Health Systems Strengthening—requiring further definition and detailed ingredient costing	OVC support

The average cost per person per year on ART was estimated to range from US $267 to $270 per annum over the period 2017 - 2021. Personnel and facility overhead costs were based on Zambia's MATCH 2.0 study (CHAI, 2014) and combined with the most recent ARV prices and changing laboratory costs as viral load (VL) tests replace CD4 counts in the national ART monitoring protocol. Of the total ART programme cost per patient-year, the ARV drugs cost around $150 (56 per cent of the total), staff (22 per cent) and laboratory tests (12 per cent. The ARV quantities and pricing were based on quantifications undertaken by JSI in 2016 and should be updated with 2017 estimations.

[11] Applying an average annual exchange rate of 9.014 (Oanda, 2016).

6.2.2 Estimated Resources Required to Achieve the NASF 2017 - 2021 Goals

The estimated resources required for the NASF implementation for the five years are presented in Table 21 and Figure 9 below.

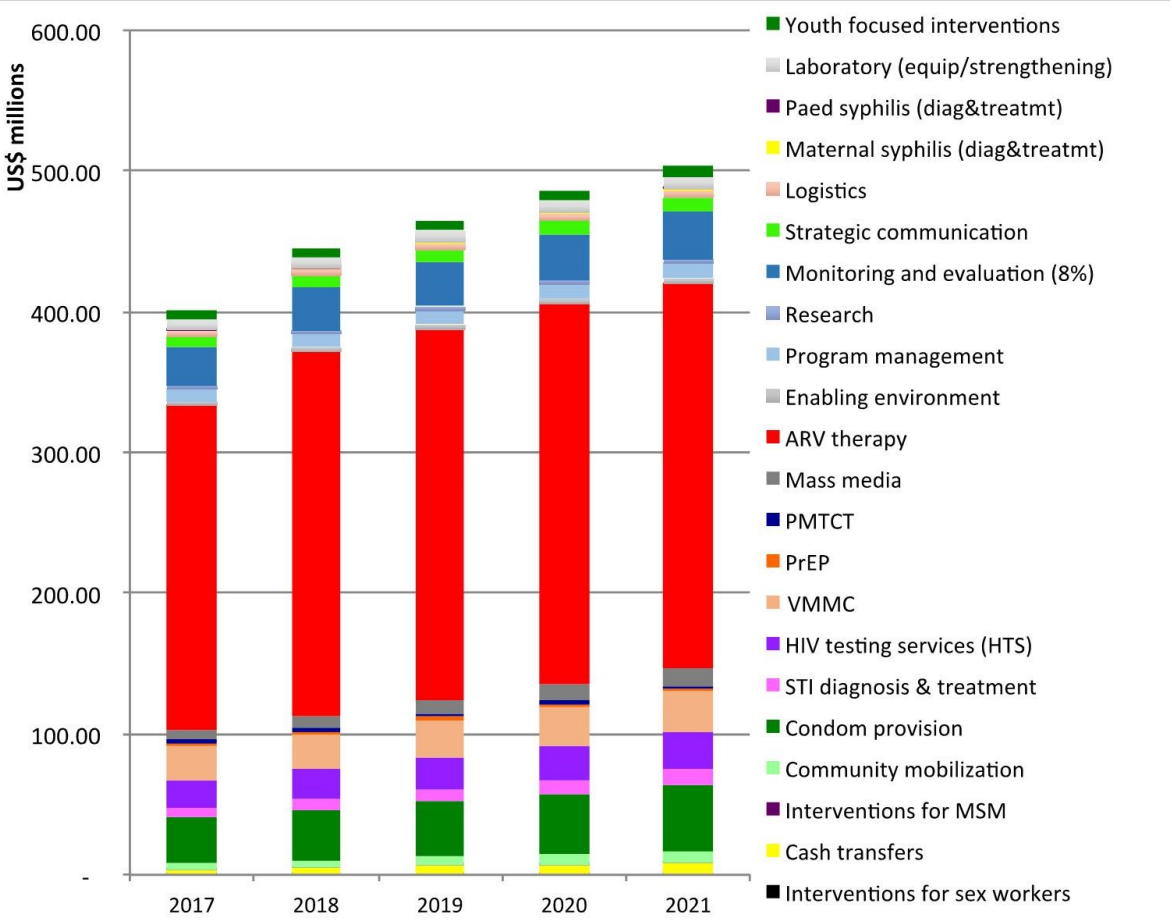
Table 18: Estimated resources required for the NASF interventions (US$ million, 2016 prices)

NASF Intervention	2017	2018	2019	2020	2021	% over period
Maternal syphilis (diagnosis treatment t)	0.60	0.62	0.65	0.67	0.69	0.1%
Paediatric syphilis (diagnosis & treatment)	0.01	0.01	0.01	0.01	0.02	0.003%
Youth focused interventions	6.64	6.98	7.34	7.70	7.90	1.6%
Interventions for sex workers	0.48	0.50	0.51	0.53	0.55	0.1%
Cash transfers	3.33	4.39	5.92	6.52	7.78	1.2%
Interventions for MSM	0.02	0.03	0.03	0.03	0.03	0.01%
Community mobilisation	4.91	5.73	6.60	7.53	7.80	1.4%
Condom provision	32.06	35.51	39.47	43.38	47.63	0.0%
STI diagnosis & treatment	6.87	7.75	8.68	9.67	10.71	8.6%
HIV testing services (HTS)	19.29	20.94	22.69	24.54	26.47	1.9%
VMMC	24.03	25.10	26.22	27.39	28.90	4.9%
PrEP	1.62	1.72	1.83	1.95	2.07	0.4%
PMTCT	2.98	2.99	2.92	2.82	2.73	0.6%
Mass media	7.31	8.48	9.74	11.07	12.48	2.1%
Blood safety	0.13	0.13	0.14	0.14	0.15	0.03%
ARV therapy	230.79	258.50	262.96	270.25	272.97	56.3%
Enabling environment	2.71	3.02	3.15	3.29	3.41	0.7%
Programme management	8.81	9.80	10.22	10.70	11.08	2.2%
Research	2.37	2.64	2.75	2.88	2.98	0.6%
Monitoring and evaluation (8%)	27.11	30.16	31.46	32.93	34.09	6.8%
Strategic communication	7.79	8.67	9.04	9.47	9.80	1.9%
Logistics	4.07	4.52	4.72	4.94	5.11	1.0%
Laboratory (equip/strengthening)	6.78	7.54	7.86	8.23	8.52	1.7%
Total (US$ millions)	400.70	445.75	464.91	486.66	503.86	100.0%

Note: High level unity costs by EQUIP

The bulk (56.3 per cent) of the anticipated resources over the five years will be required for treatment and care, as the Test and Treat (T&T) policy is rolled out and the 90-90-90 targets are achieved. The prevention interventions together will take up 28.7 per cent, including the cash transfers (1.2 per cent), PrEP (0.4 per cent at low coverage), syphilis (maternal and paediatric) diagnosis and treatment (0.1 per cent), condoms (8.6 per cent), HIV testing services (HTS) at 4.9 per cent, and VMMC (5.7 per cent). The programme enablers total 14.9 per cent, including monitoring and evaluation (estimated at 6.8 per cent), programme management (2.2 per cent) and laboratory strengthening (1.7 per cent).

Figure 8: Estimated resources required for the NASF interventions (US$ million, 2016 prices)



Importantly, in the longer-term projections (e.g. EQUIP, 2016: T&T cost estimates to 2030), the costs will eventually begin to plateau around 2025 due to the impact of both the prevention efforts as well as the preventative effect of the T&T scale-up. The longer-term impact of infections and deaths averted are also important to consider beyond the relatively short five-year NASF period. The breakdown of the ART programme costs are provided in Table 20 below, noting that the ARV quantities and prices need to be updated to 2017 estimates.

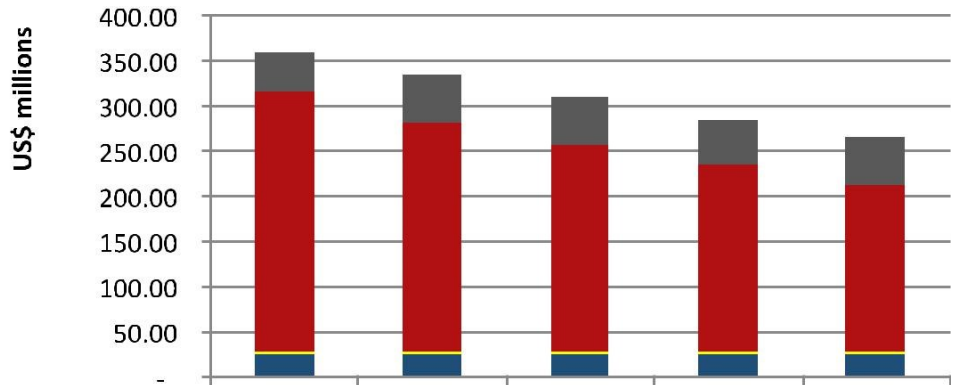
Table 19: Breakdown of the ART programme costs (US$ million, 2016 prices)

ART cost components	2017	2018	2019	2020	2021
VL costs	11	18	23	27	27
ARV costs	132	147	149	152	153
Other labs	17	14	12	9	10
OI screening & treatment	3	4	4	4	4
Personnel	50	56	56	58	59
Nutrition	0	0	0	0	0
Equipment	11	12	13	13	13
Building maintenance	1	1	1	1	1
Training	2	2	2	2	2
Running & other facility costs	3	4	4	4	4
Total ART costs (US$m)	231	259	263	270	273

6.2.3 Funding Landscape and Potential Financial Gap

Considering the available future funding for the HIV response in Zambia, the recently approved PEPFAR Country Operational Plan (COP) has committed a total of US$ 301 million to Zambia for October 2017 to October 2018. However, not all the planned annual PEPFAR interventions are listed in the NASF and hence the funds for those interventions are not included in the funding landscape shown in Figure 10 below. The COP 17 amount was matched to the NASF year 2018, and for the following years (2019-2021) a reduction of 10 per cent was assumed to the total PEPFAR funding (hopefully a conservative assumption). The funding anticipated from the Global Fund (GF) was assumed to be the indicative within-allocation amount provided by the GF in the Zambian Allocation Letter (December, 2016), excluding the potential Catalytic funding (December 2016) for the period 2018 to 2020, and split equally between the three years, with a similar amount assumed available for 2021. The Ministry of Health's budgeted amounts for ARVs till 2020 were included, with a similar amount assumed for 2021 as was budgeted for 2020. An indication of the UN agencies core and non-core funding for their co-ordination, advocacy, policy development and other activities, was provided and this was split equally in the five years. This amount has not been validated with the UN agencies.

Figure 9: Projected available funding for the HIV response in Zambia (US$ million, 2017 - 2021)

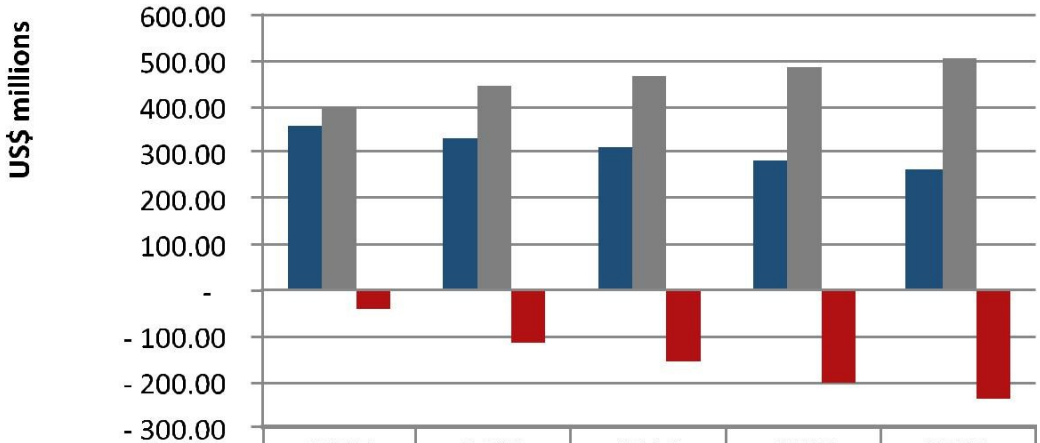


	2017	2018	2019	2020	2021
Global Fund	44.24	52.43	52.43	52.43	52.43
PEPFAR (assuming 10% ann reduction)	287.15	252.38	227.14	204.43	183.98
Other UN sources of funding	4.28	4.28	4.28	4.28	4.28
GoZ (ARV budget only)	24.15	24.26	24.36	24.47	24.57

Sources: PEPFAR COPs 2016+2017, for 2018-21 assumed 10% annual reduction in USG funding, and excluded budgets for non-NASF interventions (e.g. OVC, management). GF allocation letter 2017, GoZ (MOH communiqué), UNAIDS for UN funding.

Comparing the potentially available funding with the anticipated resources needed for the NASF, there could be an increasing funding gap experienced, as shown by the red bars in figure 11 below, growing from US$ 40 million in 2017 to almost US$ 240 million by 2021. This growing gap is due primarily to the assumed reductions in the PEPFAR funding, as well as the increasing resources needed for the treatment programme and the other NASF objectives.

Figure 10: Possible funding gap for the NASF (US$ millions, 2017 - 2021).



	2017	2018	2019	2020	2021
Total available funding	359.83	333.35	308.22	285.61	265.26
NASF resource need	400.70	445.75	464.91	486.66	503.86
Potential total funding gap	(40.87)	(112.40)	(156.69)	(201.05)	(238.60)

Sources: PEPFAR COPs 2016+2017, for 2018-21 assumed 10% annual reduction in USG funding, and excluded budgets for non-NASF interventions (e.g. OVC, management). GF allocation letter 2017, GoZ (MOH communiqué), UNAIDS for UN funding.

Since NASF represents an ambitious, comprehensive vision for Zambia, with a range of high impact interventions as well as important social and programme enablers, the anticipated resources required to achieve all its goals are high and it would appear that the available funding will fall short of the total need, with an increasing gap in the later years.

The Government of Zambia will need to consider alternative, and innovative, funding options to meet the finding gap, as well as mobilising other development partners and the private sector to make increased contributions towards the national response.

6.3 Recommendations to Facilitate Achievement of the NASF 2017 - 2021 Goals

The following main recommendations arise from this rapid costing exercise:

i. Explore strategies to reduce ARV drug costs, including pooled procurements, longer-lasting drugs, reduced resistance drugs, or improved stock management to reduce wastage;
ii. Address with urgency any obstacles limiting the scale-up of testing and treatment initiation, as T&T will require dramatically increasing numbers of patients on treatment in the later years and hence bring the costs down eventually;
iii. Improve other efficiencies in service delivery;
iv. Explore differentiated models of delivery that could address the bottlenecks and reduce programme costs;
v. Targeted HIV testing strategies to reach HIV positive people;

vi. Improve programme monitoring to generate timely, national-level indicators of coverage, including expenditure data;
vii. Invest in health systems development such as strategic information, supply chain, infrastructure, laboratory capacity;
viii. Explore innovative resource mobilisation options for sustaining the ART programme and the national response, including greater contributions from the private sector in Zambia;
ix. Focus on the high impact investments, as per the Zambian Investment Case, to ensure the optimal use of constrained resources;
x. Apply for the Global Fund's catalytic funding and make the required concomitant commitment from public sources;
xi. Consider options, such as Social Investment Bonds, to attract investors to fund aspects of the response; and,
xii. Ensure continued commitment and coordination by the Government, PEPFAR and the Global Fund to provide adequate and long-term resources.

6.4 Monitoring and Evaluation of the NASF 2017 - 2021

Monitoring and Evaluation of the multi-sectoral response requires greater coordination of all players in the national HIV response in order to allow for optimal utilisation of available meagre resources, sharing of experiences and foster evidence-based reporting aligned to the provisions of the NASF 2017 - 2021. The National HIV/AIDS/STI/TB Council through the Policy and Planning Directorate will be responsible for the overall monitoring of the national multi-sectoral response. At the highest level, the M&E system for the national response will be monitored using multiple data sets from multiple data systems within the broader Health Information System (HIS) held by the Ministry of Health and NAC. These data sets converge where it is intended and are used to generate information products that support strengthening the national response. Data collection and analysis will continue to be undertaken using the following tools:

i. **Health Management Information System (HMIS):** This is the largest and most important M&E tool in Zambia. It provides for all clinical health related data on all diseases including HIV and AIDS. This tool has in the recent past been undergoing some upgrading to conform to latest developments in data capture and indicator tracking;

ii. **NACMISONLINE:** This is an online stakeholder management and activity reporting system, which helps NAC and its partners to understand a number of M & E information details. The development of the NACMISONLINE system was supported throughout by NAC, the United Nations Joint Team, Centres for Disease Control and Prevention (CDC) and Volunteer Services Overseas (VSO). The system also includes an online Stakeholders Activity Reporting Form (SARF) that automatically generates graphs at district, provincial and national levels;

iii. **Zambia Demographic and Health Survey (ZDHS):** This is a robust instrument for tracking changes in knowledge and behaviours at a national level. This survey is conducted every five years, with the last having been conducted in 2013/2014;

iv. **Cohort Studies:** Cohort studies are conducted for various purposes to monitor a group of individuals with similar characteristics to assess effectiveness of a service delivery programme or behaviour that may occur to a particular group of individuals when exposed to a specific event or situation;

v. **Education Management Information Systems (EMIS):** The EMIS system collects HIV and AIDS data on various indicators for both learners and teachers. The primary objective is to assess the effectiveness of the Comprehensive Sexuality Education (CSE) in schools;

vi. **National Commitments and Policy Instrument (NCPI):** The NCPI covers four broad areas of policy, strategic planning, prevention, human rights, and care and support. A separate index is calculated for each policy area using specific policy indicators and calculating the overall per cent score. The relevance of this tool is in the computation of the National Composite Policy Index covering gender, workplace stigma and discrimination, human rights, CSO involvement, prevention, TCS, integration, mitigation services and M&E;

vii. **Sentinel Surveillance Surveys:** 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 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 while the rest of the samples are sent to the University Teaching Hospital (UTH) and the Tropical Diseases Research Centre (TDRC) for HIV testing. These surveys are relevant because they help in the determination of the incidence and prevalence of syphilis in women of reproductive age group in sentinel populations;

viii. **Financial Expenditure Tracking:** Financial surveys are useful for showing how efficiently and effectively HIV and AIDS funds are utilised to achieve set national targets;

ix. **Workplace Surveys:** These surveys provide information on the extent to which workplaces develop policies to protect and mitigate the impact of HIV and AIDS on their respective employees. These surveys, which are relevant and critically important for the preservation of people's human rights, are conducted on an annual basis;

x. **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, where the relevance lies;

xi. **Zambia Sexual Behavioural Survey (ZSBS):** The ZSBS is carried out to monitor the extent to which HIV prevention programmes are successful;

xii. **Biennial Global AIDS Monitoring (GAM) Report:** The Biennial GAM Report is prepared to report on specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators. The report is one fulfilment of Zambia's signatory status to the 2016 Political Declaration of Commitment on HIV and AIDS at the United Nations High Level Meeting on HIV and AIDS (UNHLM);

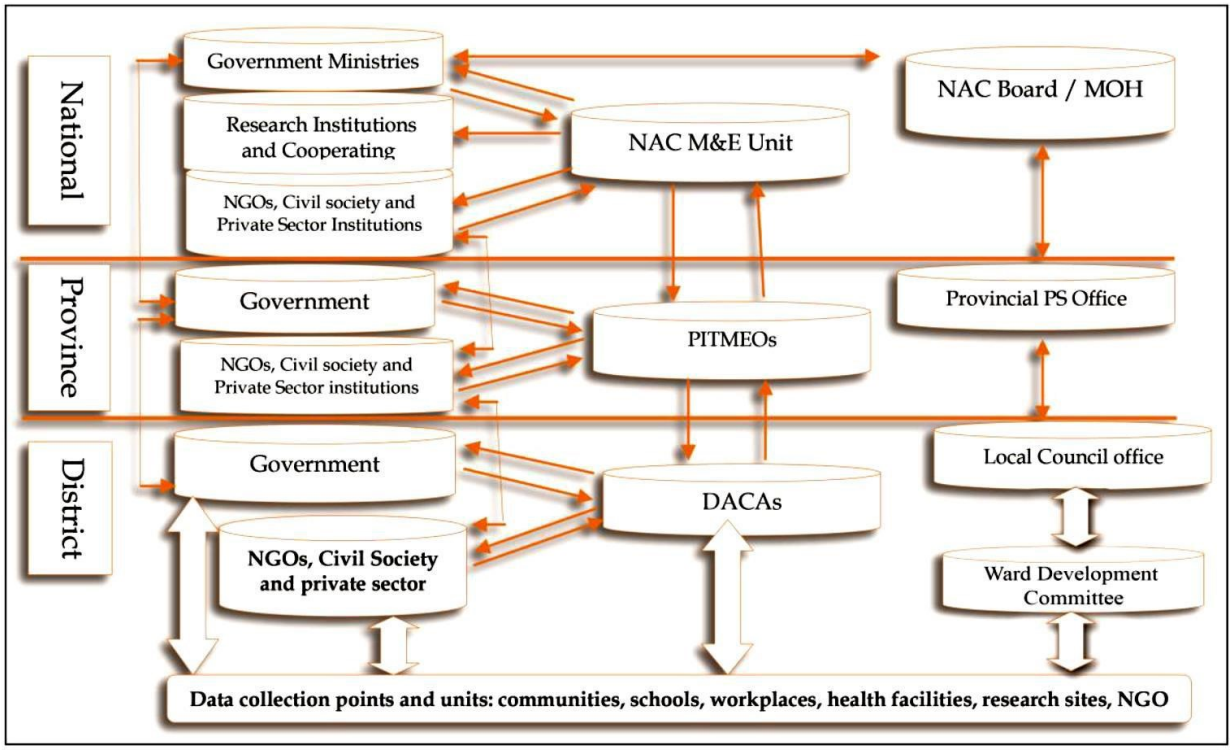
xiii. **The Joint Annual Review Process (JARP):** The JARPs bring the Government of the Republic of Zambia, NAC, and its partners together to review, on a regular basis, the performance of the national HIV response; and,

xiv. **SPECTRUM:** This is a suite of easy to use policy models which provide policy makers with an analytical tool to support the decision-making process. SPECTRUM as a software has seven sub-components - DemProj, FamPlan, Project Child Survival, AIDS Impact Model, Costs Implementing and HIV/AIDS programme, Resources for the Awareness of Population Impacts on Development and the Safe Motherhood Model. The SPECTRUM tool is relevant in the determination of the indicators with respect to determining the number of new infections, PMTCT, and ART annually.

6.5 Reporting

At national, provincial and district levels reporting on the core set of indicators shall be done through standardised reporting tools. The NASF 2017 - 2021 will emphasise and promote data use at the level of collection. All data submitted to the next level shall be quality assured and signed off by designated officers to certify that the data are accurate. Data flow will continue to be guided by the figure below:

Figure 11: Data Flow Arrangement



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Annexure 1: NASF 2017 - 2021 Core Indicators and Targets

a. Impact Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
1	HIV prevalence among women and men aged 15-24	HIV prevalence	Number of men and women testing HIV positive	Total number of men and women tested	F: M: (DHS 2014)		Household surveys	Every 5 years	Province, sex, age, SES, location
2	HIV prevalence in key populations	Monitor levels of infection in these groups over time	Number of key populations testing HIV positive	Total number of people (key populations) tested	27.4% prison inmates (IBSS 2011)' 56.8% FSW (IBBS, 2015)	<15% <10%	Special surveys	Periodic	Province, sex, age,
3	HIV Incidence	Actual number of new HIV infections in the population	Number of new infections arising in a defined population	Total number of people in that population	0.70% (2016)	0.40% (2021)	ZAMPHIA	Periodic	Province, Sex, Age
4	TB Prevalence	The actual number of TB cases at a given point in time (reported as number per 100,000 population)	Number of people with TB disease at a given point in time	Total population at the same given point in time	338/100,000 (2013)	362/100,000 (2021)	TB Prevalence Survey Report	Every 5 years	Province, Age, Sex, HIV status
5	TB Mortality	TB attributable deaths (Reported as number per 100,000)	Number of people who died as a result of TB disease	Total population	20/100,000 (WHO 2016 Report)	15/100,000 (2021)	Spectrum Modelling Estimates	Annually	Province, Age, Sex, HIV status
6	Per cent of	Success of HIV and	Adult	Total adult	9%	4%	Spectrum	Annually	Province, Sex,

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	adult mortality due to HIV and TB	TB programmes	mortality attributable to HIV and TB	mortality from all causes	(2010)	(2021)	Modelling Estimates		Age – from TB, HIV
7	% expressing accepting attitudes towards PLHIV	Levels of HIV and TB stigma and discrimination	People expressing accepting attitudes towards PLHIV	Total people surveyed	27% (2014)	90%	ZDHS IBBS	Every 5 years	Province
8	Domestic and international HIV and TB spending	Commitment and absorptive capacity	N/A	N/A	$283 million NASA (2013)	$800 million (2021)	NASA	Every 2 years	National, provincial

i. ART Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
9	Per cent of people initiated on ART	Treatment coverage and retention	People on ART who are alive	Total number of people initiated on ART	70.6% Adults 74% Children (2016)	83% Adults 83% Children (2021)	Cohort Analysis ART Registers	Annual	Province, Sex, Age
10	Per cent of co-infected TB patients initiated on ART	ART coverage for TB patients	Number of co-infected TB patients started on ART over a given	Total number of TB patients who tested HIV positive over the same given	60%	90%	NTP Reports	Annually	Age, sex, province

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
			period	period					
11	% of PLHIV who are virally suppressed aged 15– 49 years	Viral Load Suppression	Number of PLWH who are virally suppressed	Total number of PLWH who are on ART	52% (2016)	90% (2021)	ZAMPHIA	Annually	Age, Sex
12	% of exposed individuals provided with PrEP in accordance with national guidelines in the last 12 months	PrEP	Number of exposed individuals provided with PrEP	Total number of exposed individuals	<10%	90%	HMIS	Annually	Age, Sex, Province

ii. PMTCT Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
13	Infants born to HIV-positive mothers who are HIV-positive at 6 weeks, 12 months	Success of PMTCT programme, by determining the per cent of babies born HIV positive	Number of babies born to HIV-positive women who are HIV positive	Total number of live births to HIV-positive women	5%	<1%	HMIS	Quarterly	Province

iii. Condoms Indicators

	Indicator	WhattheIndicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation

	Indicator	WhattheIndicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
14	Male and female condom distribution	Reach of condom distribution programme	Number of male and female condoms distributed	Total number of men and women eligible to use condoms	M:57 m F:2 m (2016)	M:129 m F:8 m (2021)	HMIS MLS NACMIS	Quarterly	Province, Private/ Public sectors
15	% men and women aged 15- 19 & 20-24 reporting the use of a condom with their sexual partner at last sex	Success of prevention programmes in achieving a high number of protected sex acts	Number of young women and men reporting condom use at last sex	Total number of young women and men surveyed	M: 40% F: 34% (ZDHS 2013/ 2014)	M: 90% F: 90% (2021)	ZDHS	Every 5 years	Province, Gender, Age

iv. VMMC Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
16	Number of sexually active males (15-49) medically circumcised	Reach of male circumcision programme	Number of sexually active males medically circumcised	Sexually active HIV negative males	10% 308,328 (2016)	20% 192,610 (2021)	HMIS VMMC Programme	Quarterly	Province, Age

v. STIs Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
17	% males and females and who	STI prevalence among males and	Number of males/females treated	Total number of sexually active	15%	<2%	HMIS	Annual	Male, Female,

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	reported an STI in the past 12 months	females in the past 12 months	for STIs in the past 12 months	males/females in the past 12 months	(2016)	(2021)			Province

vi. HTS Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
18	Number and per cent of men and women15-49 counselled and tested for HIV	Reach of the HCT programme	Number of people who have been tested for HIV	Total number of people in the population	67.3% 7,684,377 (2016)	90% 8,263,358 (2021)	HMIS HTS Reports	Quarterly	Province, Gender, Age
19	Per cent of TB patients tested for HIV	Uptake of HIV testing by TB patients	Number of TB patients with unknown or previously negative HIV status over a given period, who are tested for HIV	Total number of TB patients with unknown or previously negative HIV status registered over the same given period	77% (2016)	100% (2021)	NTP Reports	Annually	Age, Sex, province

vii. SBCC Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
20	% adolescents girls and boys, aged 15-19 with comprehensive	Composite indicator of adolescents knowledge of HIV – necessary for	Number of adolescents 15-19 – by sex – who correctly know 3 HIV modes of	Total number of adolescents aged 15-19	M: 42% F: 39%	M: 90% F: 90%(2021)	DHS	Every 5 years	Province, Gender, Age

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	knowledge of HIV	behaviour change	transmission and 2 misconceptions	surveyed	(ZDHS 2014)				
21	% women and men aged 15-49 years who have had sexual intercourse with more than 1 partner in the last 12 months	Measure of multiple sexual partners	Number of women and men reporting more than 1 sexual partner in the last 12 months	Total number of women and men surveyed	M: 2% F: 16% (DHS 2007)	M: 1% F: 8%	DHS or other surveys	Every 5 years	Province, Gender, Age
22	Number of people reached by HIV prevention communication messages at least twice a year	Reach of communication programmes	Number of people who recall being reached by 2 or more communication messages about HIV prevention	Total population	380,000 (2016)	>600,000 (2021)	U-report IBBS	Every 5 years	Age, gender, location

viii. TB Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
23	Per cent of people screened for TB	Population coverage of TB screening	Number of people screened for TB symptoms	Total population	87%	100%	NTP Reports	Quarterly	HIV status, age sex, province
24	Per cent of newly diagnosed HIV positive people	IPT coverage	Number of newly diagnosed HIV positive people started on IPT	Total number of newly diagnosed HIV positive people eligible for	45% (2016)	90% (2021)	IPT Register	Quarterly	Age. Sex, province

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	started on IPT			IPT*					
25	Case detection Rate (Smear positive)	The programme's capacity to detect people with infectious TB disease (source of infection)	Number of newly diagnosed smear positive TB detected in a given period	Total population	74%	90%	NTP Reports	Annually	Age. Sex, HIV status, province
26	TB Treatment success rate	The success of the TB programme in ensuring treatment compliance	Number of TB patients registered in a specified period who are cured or completed treatment	Total number of all TB patients registered in the same period	90%	100%	NTP Report	Annually	Age, Sex, HIV status, province
27	TB case fatality rate	The success of the TB programme in preventing deaths	Number of all TB patients who died during TB treatment	Total number of all TB patients registered in the same period	<5%	<2%	NTP Report	Annually	Age, Sex, HIV status, province

*HIV positive eligible for IPT=HIV+ screened for TB minus HIV+ screened for TB confirmed with active TB

b. Programme Enabler Indicators

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
28	Number of Community Based	Prevalence of CBD agents for	Number of established and	Total number of CBD	4,120	9,240	NACMIS	Annual	Province

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	Distributor Agents established and active	SRH and HIV commodities	active CBD		(2016)	(2021)			
29	Proportion of women who have experienced physical or sexual violence from an intimate partner in the last 12 months	Progress in mobilisation of society to address gender and sexual equality and address gender-based violence	Number of women who reported physical or sexual violence from an intimate partner in the last 12 months	All women	1,133 (2016)	4,118 (2021)	Survey GBVSS (2013-2016)	Every 5 years	Province, Age
30	Increased domestic financing of the HIV and AIDS response	Ability to mobilise resources for the HIV response locally	N/A	N/A	$44 million (2016)	$150 million (2021)	MOH budget NCPI	Every 2 years	Province
31	Timely reports on the AIDS response that meet national, regional and international reporting obligations	Progress towards "One M&E System" that meets national, regional and international reporting obligations	Number of reports submitted	Total number of reports to be submitted annually	Annual GAM Report Spectrum	Annual GAM Report Spectrum	Programme Data	Annually	Province

c. Synergies with other sectors

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
32	% of exposed individuals provided with PEP in accordance with national guidelines in the last 12 months	Reduction of primary infection among people who have been accidentally or forcibly exposed to HIV	Total number of people accidentally or forcefully exposed to HIV and received PEP	Total number of people accidentally or forcefully exposed to HIV	<20% (2016)	90% (2021)	HMIS VSU Annual report	Annual	Male, Female, Province
33	# of vulnerable people accessing social protection services such as Social Cash transfers and food security packs.	Access to Social Protection Services by vulnerable people	Number of people accessing Social Protection services	Total number of vulnerable people eligible to access social protection services	285,000 (2016)	778,736 (2021)	Social Welfare department report	Quarterly	Province, Sex, Age,
34	Number of safe blood units available for transfusion	Availability of safe blood supply	Number of safe blood units	Total number of blood units collected	150,000 Units (2016)	300,290 Units (2021)	Laboratory Records	Quarterly	Province
35	Number of schools with trained guidance and counsellors actively providing the needed services to at-risk adolescents in primary and secondary schools and	Number of schools with trained guidance and counsellors	Number of schools with trained guidance and counselling teachers	Total number of schools	6,000 (2016)	8,000 (2021)	EMIS	Annually	District Province

	Indicator	What the Indicator Measures	Numerator	Denominator	Baseline Values	Target Values	Data Source	Frequency	Disaggregation
	psychosocial support to adolescents living with HIV								
36	Number of schools implementing comprehensive sexuality education	Roll out of CSE and knowledge of HIV among learners and teachers	Number of schools implementing the CSE	Total number of schools	<9,674 (2016)	9,674 (2021)	EMIS	Quarterly	Province
37	% of major capital projects that have mainstreamed HIV, related gender and human rights in the planning and implementation phases of the project	HIV mainstreaming in capital projects	Number of capital projects mainstreaming HIV	Total number of capital projects annually	<30% (2016)	90% (2021)	NACMIS	Annual	District, Province

Annexure 2: Unit costs used in the resource needs estimate

HIV Intervention	Unit Cost (US$)	Year	Notes / Source:
Mass media (per person reached)	$396	2014	NAC 2014 World AIDS Day Budget; Veronica Muntanga MCDMCH Kitwe (AHCF Campaigns 1- 16th Oct 2014), Nyimba & Lunga district; Mafinga VCT reports
HST/HCT	$5.43	2014	Cost per person tested = $5.43. (Brivine MCDMCH HTC data from HMIS 2014 - VCT data only; $45.73 per person found +ve).
Male Condoms	$0.62	2013	Per male condom distributed; MOH Facility-based Condom Programming Strategy & Operational Plan 2014-2015 (2013); used in R-NASF Costing (2014)
Youth in school	$203	2013	Per teacher trained. Resource Needs Model (RNM, 2013)
Interventions for sex workers	$28	2016	Per person found positive; Corridors of Hope Project, FHI 360; Joseph Kamanga
Outreach for MSM	$35	2015	Goals default
Medical male circumcision	$105	2014	Service delivery cost fell from $86.25 to $81.66 with PrePex (Estimating cost efficiency of PrePex circumcision devise in Zambia; IAS 2014)
ART	$267	2017	PPPY average at facility only; MATCH 2.0, 2014; excludes HCT ("cost of ART delivery"). Updated with 2016 drug costs. Adjusted for phased VL introduction but other costs constant in US$.
PMTCT	$47	2016	Only Nevirapine cost (mother's ARV costs is included under ART)
STI diagnosis & treatment	$43	2013	Per person treated. Rough SA estimate, to be updated with MOH data
PrEP (oral for young women)	$230	2016	HE2RO estimates for young women. Lower costs for KPs
Cash transfers	$10	2017	Per person per month. Min.of Community Services, 2017.
Syphilis diagnosis	$4.42	2014	Screening, rapid test and confirmatory test, includes personnel - HE2RO estimates, 2014.
Maternal syphilis treatment	$1	2016	SA NICD, 2016.
Paediatric syphilis (symptomatic) treatment	$12	2016	SA NICD, 2016.
Paediatric syphilis (asymptomatic) treatment	$0.51	2016	SA NICD, 2016.
Enabling services (PM, EE, SI, research, logistics)	8%		Goals default settings (as percentage of total cost).
M&E	7%		Suggested by NAC