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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
HBV	Hepatitis B Virus
ART	Anti-Retroviral Therapy
ABC	Abstinence, Be Faithful, and Use Condom
BCC	Behaviour Change Communication
BBSS	Biologic and Behavioural Surveillance Survey
CATF	Community AIDS Task Force
CBO	Community-Based Organisation
CBoH	Central Board of Health
CDC	Centers for Disease Control and Prevention
CSO	Central Statistics Office
CSW	Commercial Sex Workers
CT	Counselling and Testing
DATF	District AIDS Task Force
DACAs	District AIDS Co-ordination Advisors
DDCC	District Development Co-ordination Committee
DFID	Department for International Development (UK)
GDP	Gross Domestic Product
GIPA	Greater Involvement of People living with HIV and AIDS
GRZ	Government of the Republic of Zambia
FBO	Faith-Based Organisation
FANC	Focused Antenatal Care
FNDP	Fifth National Development Plan
HAART	Highly Active Anti-Retroviral Treatment
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HCP	Health Communication Partnership
HCV	Hepatitis C Virus
HMIS	Health Monitoring Information System
IDU	Injection Drug User
IEC	Information, Education & Communication
IMCI	Integrated Management of Childhood Illness
IP	Infection Prevention
IPV	Intimate Partner Violence
IS	Injection Safety
LCMS	Living Conditions Monitoring Survey
MC	Male Circumcision
MCP	Multiple and Concurrent Sexual Partners
M&E	Monitoring & Evaluation
MOE	Ministry of Education
MoFNP	Ministry of Finance & National Planning
MOH	Ministry of Health
MSM	Men who have sex with men
NGOCC	Non-Governmental Organisations Co-ordinating Committee
NAC	National HIV/AIDS/STI/TB Council
NAPCP	National AIDS Prevention & Control Programme
NASF	National HIV/AIDS/STDI/TB Strategic Framework 2006-2010
NGO	Non-governmental Organisation
OI	Opportunistic Infections

OPLA	Organisations of People Living with HIV and AIDS
OVC	Orphans & Vulnerable Children
PACAs	Provincial AIDS Co-ordination Advisors
PATF	Provincial AIDS Task Force
PDCC	Provincial Development Co-ordination Committee
PEP	Post Exposure Prophylaxis
PLHA	Persons Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
PWP	Prevention with Positives
SCC	Social Change Communications
STI	Sexually-Transmitted Infection
TB	Tuberculosis
TDRC	Tropical Disease and Research Centre
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's' Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation
ZAFOD	Zambia Federation of Disabled
ZANARA	Zambia National Response to HIV/AIDS
ZSBS	Zambia Sexual Behaviour Survey
ZDHS	Zambia Demographic Health Survey
ZNBTS	Zambia National Blood Transfusion Services
ZWAP	Zambia Workplace AIDS Partnership

Foreword

Zambia is one of the countries that has borne the brunt of the HIV and AIDS pandemic for more than 20 years now. While in the recent past the HIV prevalence rate has gone down (from 15.6% in 2001 to 14.3% in 2007), HIV still poses a great challenge to Zambia's social and economic development.

Fortunately, treatment is now available for those infected with HIV, so they can continue living healthy lives and contributing to national development. However, this treatment comes at a great cost to the country, hence the need to limit the number of people who get infected with HIV and subsequently need treatment. It is for this reason that prevention of HIV infection is of paramount importance. If new HIV infections are prevented, it will be easier and more affordable to keep those already infected on treatment. This will then translate into a healthier nation as both the infected and uninfected will be productive Zambians.

In order to articulate the importance of HIV prevention, the National AIDS Council, together with partners, has developed this strategy for the prevention of HIV and other STIs, to guide implementers on how they can optimally prevent new infections. This strategy takes cognisance of the fact that HIV and STI infections occur under various circumstances, including sexual, mother-to-child, and transmission through blood and other body fluids. These methods of infection have, therefore, been divided into focus areas for intervention. The other focus area dealt with in this strategy is counselling and testing, which plays a cardinal role in identifying those already HIV infected, as a point of entry for treatment, as well as providing a forum for counselling of those not infected to prevent infection. The focus areas for the HIV and STI prevention strategy, therefore, are:

1. **Prevention of sexual transmission of HIV and STIs (PST)**
2. **Prevention of mother to child transmission of HIV (PMTCT)**
3. **Counselling and testing (CT)**
4. **Prevention of HIV in health care settings**

These priorities were agreed on through a consultative process conducted in all the provinces of Zambia between 2007 and 2008. It is, therefore, hoped that all stakeholders involved in HIV prevention work will make use of this HIV and STI prevention strategy when planning and implementing their activities. The National AIDS Council realises that not every aspect of HIV prevention can be addressed in a document like this. However, we do believe that if the priorities set out in this strategy are addressed seriously, positive results will be attained. We, therefore, wish to encourage all stakeholders to buy into this HIV and STI prevention strategy as that is the surest way of halting the further spread of the pandemic.

Honourable Kapembwa Simbao (M.P.)
Minister of Health and Chairperson of the Cabinet Committee on HIV and AIDS

Acknowledgements

This first-ever HIV prevention strategy for Zambia, aimed at halting further spread of the pandemic, was developed through a participatory and consultative process of many stakeholders, including government, co-operating partners, National HIV/AIDS/STI/TB Council (NAC), Department for International Development (DFID), United Nations family, and the United States Government (USG) to whom we now express our heartfelt appreciation.

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Many thanks go to the Prevention Theme Group members who worked tirelessly to ensure that this prevention strategy is complete: Professor K. S. Baboo, University of Zambia – Chairperson; Ms Florence Mulenga, United Nations Population Fund (UNFPA) - Vice-Chairperson; Elizabeth Onjoro Meassick, Centers for Disease Control (CDC); Arlene Phiri, the focal point person at NAC; Sarah Ngoma, Kara Counselling and Training Trust; Elizabeth Serlemitsos, NAC; and Beatrice Chikotola, United States Agency for International Development (USAID). Though not part of the Theme Group, Dr Alex Simwanza, Director of Prevention and the Multisectoral Response at NAC, co-ordinated the NAC activities on the strategy.

Our gratitude goes to the Provincial AIDS Coordination Advisors (PACAs) and District AIDS Coordination Advisors (DACAs) who facilitated the field work, numerous participants at the consensus building workshop, as well as all the key informants and other respondents who provided their time and shared valuable information and insights.

Bishop Joshua Banda
National AIDS Council Chairperson

Executive summary

The current HIV prevention programme based on the abstinence, being faithful to one sexual partner and consistent and correct use of condoms (ABC) model, has brought about numerous positive developments in the country, including an increase in the age of sexual debut, a reduction in the number of sexual partners and an increase in the number of people using condoms. Despite such gains the HIV prevalence rate is still high and intensified efforts to reduce new infections and measures to halt further spread of the pandemic must be put in place. This first national HIV prevention strategy is aimed at reversing the tide of the pandemic. Data for this strategy were obtained from various sources, such as key informants, direct observations, field visits and literature review.

The strategy has incorporated various aspects, targeting the main contributing factors to the spread of the pandemic, including multiple and concurrent sexual partners with low condom use, low rate of male circumcision (MC), alcohol and drug abuse, harmful beliefs and practices, gender-based and sexual violence, stigma and discrimination, low risk perception, sexually-transmitted infections (STIs), high population mobility and poverty.

The strategy addresses many issues, notably accelerating prevention of sexual transmission of HIV through targeted behaviour and social change and communication interventions, scaling-up male circumcision, addressing multiple and concurrent sexual partners, scaling-up evidence-based prevention for higher risk populations (including young people), strengthening and expanding Counselling and Testing (CT) and Prevention of Mother-to-Child Transmission (PMTCT) sites, addressing alcohol and substance abuse, improving access to and availability of both male and female condoms, and addressing the relationship between population mobility, gender and HIV.

In identifying existing gaps and challenges, this strategy assesses the current response, visions, goals and guiding principles. The gaps and challenges that have been discussed include a weak co-ordination framework and leadership, inadequate resource mobilisation efforts, inadequate human resource, lack of male involvement, limited behavioural change communication (BCC) strategies, weak negotiating and life-skills, and limited monitoring and evaluation systems, particularly at sub-national level. The existing gaps and challenges must be considered by various stakeholders and all the partners involved in activities aimed at fostering HIV prevention. It is, therefore, incumbent upon government to provide effective leadership, strong commitment and political will to ensure that all stakeholders take ownership of this strategy.

INTRODUCTION

In 2001, African Health Ministers meeting in Gaborone made a declaration and prepared a Road Map Towards Universal Access to Prevention, Treatment, Care and Support for HIV and AIDS by 2010. Further, in 2005, the African leaders made an earnest appeal for concerted efforts in combating new HIV infections by declaring 2006 the year for the "Acceleration of HIV Prevention in the African Region". Following the declaration, the Initiative for the Acceleration of HIV Prevention in Africa was launched in Addis Ababa, Ethiopia, on 11th April, 2006. Zambia also launched this Initiative the same day. Despite these initiatives, the pandemic is still a serious threat to any meaningful socio-economic development in Sub-Saharan Africa, in general, and Zambia, in particular.

The continued high adult HIV prevalence rate of 14.3%[1], coupled with low numbers of people seeking to know their HIV status sends a strong message for Zambia to rethink and redirect prevention interventions. This first-ever comprehensive HIV prevention strategy is a call to donors and implementing partners to review the current prevention programmes and also (re)consider more effective and sustainable ways of preventing HIV infection and redirect current funding and activities to address recommendations outlined here. Through this strategy the National AIDS Council is calling for improved donor and implementer co-ordination to harmonise messages and to avoid duplication and partner competition. Prevention programmes should seek high efficiency, effectiveness and ensure equity in national coverage with other HIV and AIDS services. This HIV prevention strategy, therefore, attempts to outline the major priority areas and the interventions to be undertaken in addressing the high prevalence levels of the pandemic. The strategy should also facilitate attainment of global and national developmental targets such as Millennium Development Goals (MDGs), Fifth National Development Plans (FNDP) and the Vision 2030.

HIV Prevention in Zambia

The existing HIV prevention programme, based on the abstinence, being faithful to one sexual partner, and consistent and correct use of condoms (ABC) model, has resulted in a number of positive developments such as partner reduction, increase of age at first sexual debut and an increase in the number of people visiting voluntary counselling and testing (VCT) services. The medium age of sexual debut increased from 16.5 in 1998 to 19.5 in 2005 among males (aged 20-49) and 16.5 to 18.5 years among females (aged 20-49) while the percentage of sexually active people having sex with non-regular partners reduced from 24% in 1998 to 21.7% in 2005[2]. However, some challenges remain; only 43% of young people can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission[3]. In addition, vulnerability to HIV

[1] CSO, MOH, UNZA and TRDC, 2007 ZDHS, Preliminary report
[2] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 34, p. 123.
[3] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 133.

among the youth remains high with only 13% of all Zambians (aged 15-49) have ever been tested for HIV by 2005[4].

Generally, some increase in the utilisation of condoms has been recorded with non-cohabiting sexual partners. In urban areas, the number of people using condoms with non-regular partners increased from 48% in 2000 to 50% in 2005 among males and from 38% in 2000 to 46% in 2005 among females. However, condom utilisation with a non-cohabiting sexual partner is low among the youth (aged 15-24): 38.4% for males and 25.8% for females[5].

Although condoms are now readily available in many public outlets around the country, there is still a wide gap between what is needed for adequate coverage and what is available. For instance, it is estimated that between 2009 and 2010, about 200 million male condoms and 2 million female condoms are required to provide adequate national coverage. However, currently only 96 million and 500 thousand male and female condoms respectively are available (see Appendix 2). There is also the need for the public and private sectors to closely work together in the provision of the condoms.

The persistent high HIV prevalence in the country is a national concern and challenge. To contain the epidemic, Zambia must embark on intensive and targeted prevention interventions for both the young people and adults. Repositioning HIV information and skills for young people is necessary to help them put their knowledge into practice. Also, family, school and community environments should support safer behaviours.

Rationale

The HIV prevalence rate in Zambia remains high, even with the recent reduction from 15.6% in 2001/2002 to 14.3% in 2007[6]. While many interventions have been put in place to prevent new HIV infections, there have been serious gaps in the co-ordination and scale-up of these activities, resulting in a weakened response. It has therefore become imperative for the country to develop this first-ever comprehensive HIV prevention strategy that will help reduce the number of new HIV infections in the country.

Intensification of HIV prevention is the only sustainable way of supporting the treatment programme as failure to do so would mean more people needing treatment every year. Given the high cost of anti-retroviral drugs (ARVs) and the accompanying services, the government would need huge sums of money to put people on treatment, thus diverting resources from other developmental areas. As the anti-retroviral therapy (ART) programme advances more infected people will be living longer, thereby needing more support services.

This HIV prevention strategy is crucial to Zambia as it will also contribute towards the attainment of global and national targets such as the Millennium

[4] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 111.
[5] CSO, MOH and Measure Evaluation, 1998, 2005 Zambia Sexual Behaviour Survey, p. 124, 139.
[6] CSO, MOH, UNZA and TRDC, 2007 ZDHS, Preliminary report.

Development Goals (MDGs), the Fifth National Development Plan (FNDP) and Vision 2030 on HIV and AIDS.

The intent of the HIV prevention strategy is four fold:

- Identify the key drivers of the epidemic;
- Outline current prevention efforts, scope, effectiveness and coverage;
- Describe existing gaps and challenges; and,
- Offer recommendations on the key priority areas for HIV prevention.

This strategy document provides a roadmap for the Zambian government, in collaboration with donors and implementing partners, to consider a paradigm shift on HIV prevention. Through this strategy, the National AIDS Council is calling for improved donor and implementer co-ordination to avoid duplication and partner competition. This includes redirecting current funding and activities to increase efficiency, effectiveness and ensure equity in national coverage with HIV and AIDS services.

(For the description of the consultative process for the development of this strategy see Appendix 1).

BACKGROUND

Status of the HIV-epidemic in Zambia

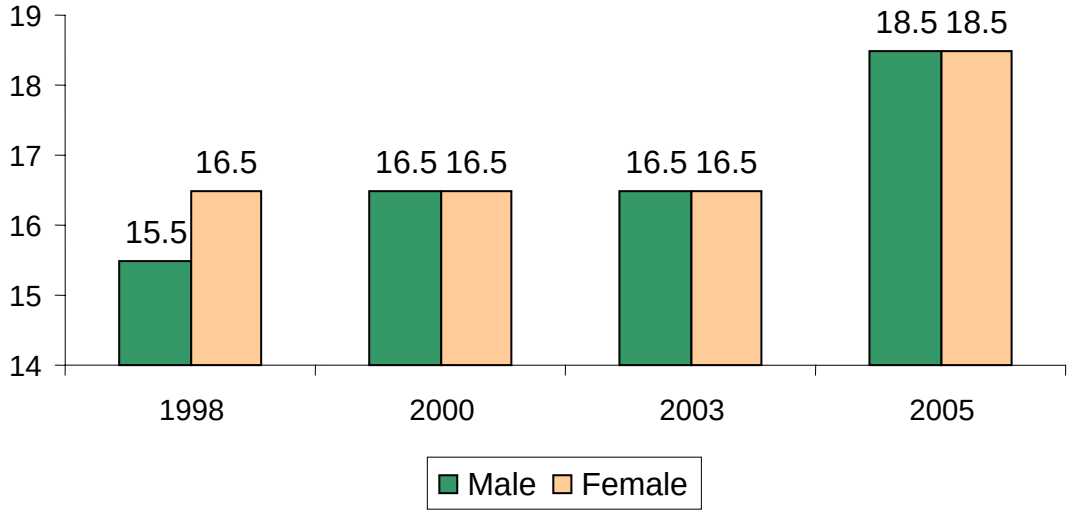
Zambia, with an estimated population of about 12.2 million[7], is one of the countries hardest hit with the HIV and AIDS epidemic in the world[8]. Although the basic knowledge about HIV and AIDS stands at 99% among the adult population (aged 15 to 49), according to the 2007 Demographic and Health Survey, the national prevalence rate reduced only slightly from 15.6% in 2001/2002 to 14.3% in 2007[9]. The prevalence rate has also remained significantly higher in urban areas (23.1% in 2001/2002 and 19.7% in 2007) compared with rural areas (10.8% in 2001/2002 and 10.3% in 2007)[10].

The epidemic is becoming increasingly feminine: while 12.9% of men aged 15-49 years were living with HIV in 2001/2002, 17.8% of the females aged 15-49 years were infected[11]. The 2007 data portray a similar picture with 12.3% of the men infected compared to 16.1% of the females.

The median age at first sex among young people aged 15 to 24 years old has continued to show a steady increase, from an average of 16 years (1998) to 16.5 years (2003) to 18.5 years in 2005 for both men and women[12] (see Figure 1).

[7] CSO, 2000 Census Projections.
[8] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007, page vii.
[9] CSO, MOH, UNZA and TRDC, 2007 ZDHS, Preliminary report.
[10] CSO, MOH, UNZA and TRDC, 2007 ZDHS, Preliminary report
[11] CSO, Central Board of Health and ORC Macro, 2003:236 - ZDHS 2001/2002.
[12] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 36.

Figure 1. Median age at first sex for youth aged 15-24, ZSBS 2005



Young people aged 15 to 24 years account for 7.7 percent of the HIV-positive population. The percentage of young people (aged 15-19) reporting having sex with a non-regular partner has decreased; in 2005, 80.2% of all respondents aged 15-19 years indicated they had no non-regular partner in the past year, compared to 77.8% in 2000[13]. Despite these positive developments, only 26.1% of young women 15 to 24 years old reported using a condom the last time they had sex with a non-regular partner[14].

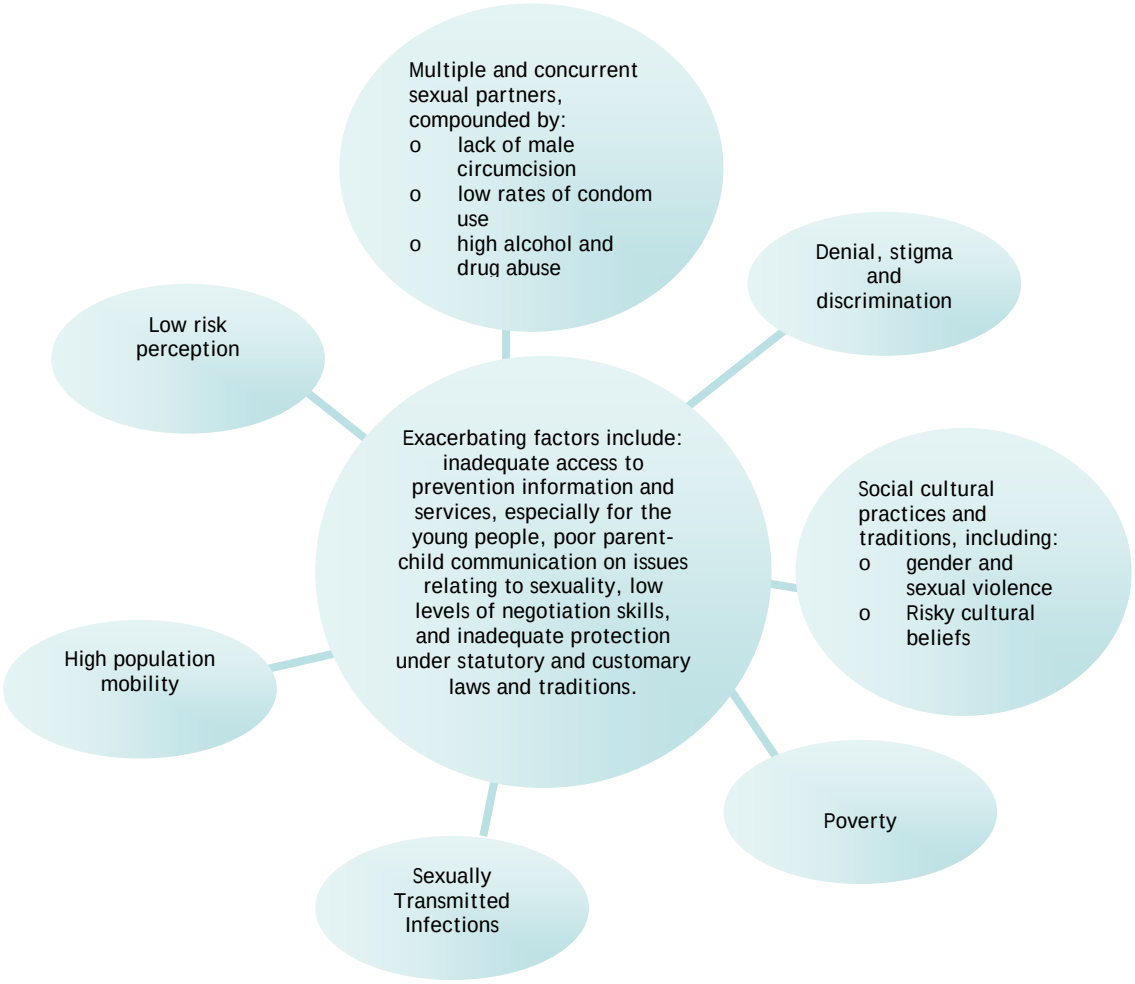
According to the 2008 UNGASS report, the number of adult HIV-related deaths was estimated at 97,494 in 2007[15]. The large numbers of people dying from AIDS-related illnesses has led to high numbers of children left as orphans. The projected total number of orphans is 1,320,026 in 2008. AIDS has also reduced the average life-span of people in the country. Although great strides have been made to reduce on the number of people dying from AIDS related illness, new infections must be averted and access to anti-retroviral therapy (ART) must be improved.

Factors influencing the spread of HIV

Zambia has engaged a number of processes to know and understand the national HIV epidemic. A study on the drivers of the epidemic in the country was carried out and national "Think Tank" meetings have been held. The key drivers identified through these works include: multiple and concurrent sexual partners; low male circumcision; low rates of condom use; untreated, especially ulcerating sexually-transmitted infections (STIs); denial, stigma and discrimination; socio-cultural practices and traditions; gender and sexual

[13] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 63.
[14] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey, p 64.
[15] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007.

violence; high alcohol and drug abuse; cultural beliefs; low risk perception; high population mobility; and poverty[16] (see also diagram below):



Multiple and Concurrent Sexual Partners

Having multiple and concurrent sexual partners (MCP) is a key driver of HIV infection in Zambia, exacerbated by low number of men who are circumcised and low rates of condom use, as well as high levels of population mobility. Separation from regular partners and social norms can lead migrants to engage in behaviours which increase vulnerability to HIV (e.g. alcohol abuse, unsafe casual or commercial sex). The 2007 Demographic and Health Survey reports that a number of respondents had two or more partners in the past 12 months before the survey with fewer women than men engaging in such behaviours: 6.5% for women compared with 19.8% among men for the never married; 0.5% for women and 19.6% for men among the married/living

[16] Helen Jackson, Rapid Consultancy Report on HIV Epidemic Drivers in Zambia. 2007.

together; and 5.7% for women and 27.3% for men among the divorced/separated/widowed.[17] During the field visits it was mentioned:

> *"A lot of people have relationships with more than one person. The poverty levels here are high. Women have many sexual partners as a way of survival; so I don't think they can change." (Copperbelt Province Informant, 2008)*

Low Prevalence of Male Circumcision

Zambia is one of the countries leading the region in the roll-out of adult male circumcision. Zambia has recognised the significant (although partial) HIV protection from male circumcision, based on data from randomised control trials. To date, over a hundred doctors have been trained and more than 15,000 men[18] have received medical male circumcision. The 2001/2002 Zambia Demographic and Health Survey indicated that only about 15% of the males were circumcised in Zambia. Acceptability studies, done both in Zambia and abroad, have shown that male circumcision is generally acceptable to communities if it is made safe, affordable and available. This service should be as near to the community as possible, yet conducted in a sterile environment by trained medical professionals. Significant work remains in finalising government policy and guidelines, building capacity, and scaling-up while maintaining the quality of clinical services and risk reduction counselling. Male circumcision services need to be done in the context of comprehensive male reproductive health services, which include counselling and screening for other male health risks. Mechanisms aimed at scaling-up male circumcision should emphasise the importance of partner reduction, consistent and correct use of condoms, effective management of STIs, and abstinence, where relevant.

Low Rate of Condom Use

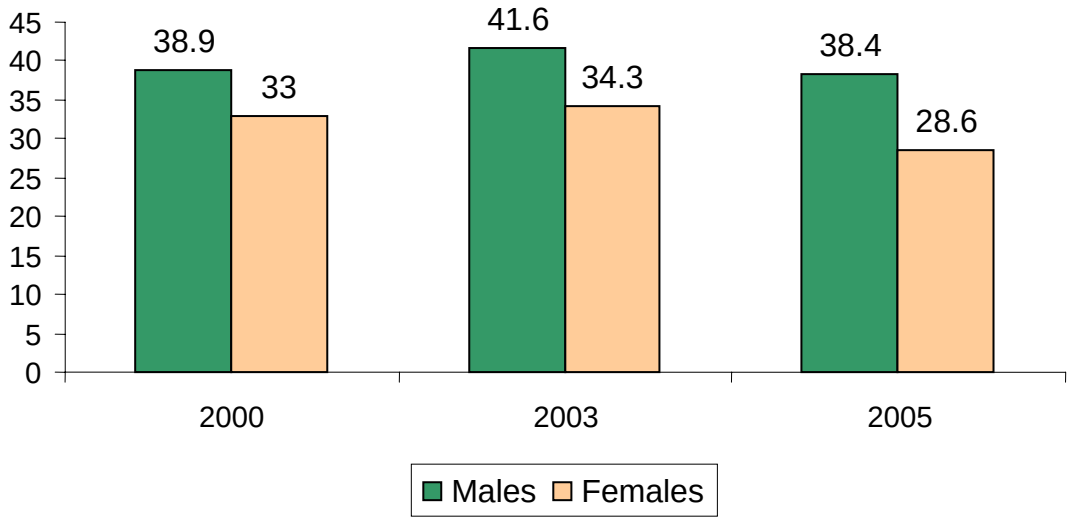
The use of condoms is part of HIV prevention strategies in Zambia[19]. However, research suggests that the level of condom use among people is low across Zambia (see Figure 2).

[17] CSO, Central Board of Health and ORC Macro, 2001/2002 ZDHS.

[18] Sources: Society for Family Health (2700 circumcisions), Dr. Kasonde Bowa (UTH – 3200 circumcisions, district and private hospitals- approximately 4000 circumcisions), Feb 2009.

[19] Gillmore M. R, Morrison DM, Richey CA, Balassone ML, Guiterrez L, and Farris M. Effects of a Skill-based intervention to encourage condom use among high risk heterosexually active adolescents, AIDS Education and Prevention, 1997.

Figure 2. Condom use during last sexual intercourse with non-regular partner by sex (ZSBS, 2005)



The data in the above chart notes that condom use in Zambia was significantly higher among males than females. The socialisation process predisposes women to a situation where they are unable to negotiate and demand for safer sex. This situation poses a challenge for females as they have less control of their sexual behaviour than males and often fall prey to risky male sexual advances. Studies further show that although awareness of HIV and AIDS prevention measures, like condom use, is high, this knowledge is not transformed into positive attitudes and behaviours like consistent and correct condom use[20]. This is likely, at least partially due to persistent myths about condoms, such as the common belief that HIV can pass through small pores in the condoms or that condoms are intentionally infected with HIV so that using them actually increase the risk among targeted groups. It has been reported that condom use must be nearly universal to achieve an impact on HIV prevalence, therefore, it is noted that consistent condom use has not been sufficient to curb the spread HIV. The field information further indicated that condom use among married couples was even more problematic:

> *"Married people do not generally use condoms because wives suspect us of having extra marital affairs. There are those that do not use condoms because their partners would take it to be a sign of mistrust. Their partners would say 'Why do you want to use condoms, do you suspect me of having HIV?' So to avoid this, the man will just do it like that [have unprotected sex]." (North-Western Province Informant, 2008)*

Alcohol and Drug Abuse

According to the information collected during field consultative meetings, in Zambia, local brews have traditionally been a part of community gatherings,

[20] Kim Longfield, Misconceptions, Folk Beliefs, Denial: Young Men's Risk for STI and HIV/AIDS in Zambia, Population Services International, 2003.

but were consumed in moderation and only by adults. Nowadays, most age groups have access to alcohol. Cultural controls on alcohol use have eroded, giving way to excessive drinking by both youth and adults. Factors contributing to young people's misuse of alcohol, among others, are easy access to the substance, peer-pressure, lack of recreational activities, unemployment, limited policy measures on consumption and abuse of alcohol, poor enforcement of the existing regulation, and diminishing parental influence on young people's behaviours. Moreover, migrants are vulnerable to drug and alcohol abuse, through exposure to the risks associated with mobility, including boredom, loneliness, and isolation from social structures.

A policy on alcohol is in draft, waiting finalisation and adoption by the government. One of the draft policy recommendations is to raise the drinking age above 18. A study on *Alcohol and HIV* conducted by Nkandu Luo in 2006 recommended that a multi-sectoral task force should develop policies and guidelines to address issues around alcohol and other substance abuse, especially their impact on HIV transmission, disease progression and ART adherence[21]. According to the study, excessive alcohol intake is linked with increased risk of STI and HIV infection; gender-based violence; non-adherence to ART; and more rapid progression of HIV among infected persons. Therefore, there should be closer monitoring of places selling and timing of consumption of alcohol. An informant said:

> *"Alcohol is sold everywhere: shebeen, taverns, houses, groceries. It's grocery but inside they sell Shake shake (local opaque beer) and other alcohol. They drink from taverns, bars, from the takeaways, at ceremonies such as siyemboka (girls; initiation ceremony), and even other drinking places". (Western Province Informant, 2008)*

To avert more high risk behaviour among young people, there is also the need to provide better employment opportunities and recreational facilities.

Stigma, Discrimination and Denial

Stigma and discrimination involve having negative feelings and attitudes against something or someone. A person at high risk of being HIV positive may deny such risk as the individual is unable to cope with the associated stigma. This situation is one of the challenges for HIV prevention; it keeps people from discussing issues related to HIV and AIDS and seeking care. Fear of being stigmatised and discriminated against may prevent people from knowing their HIV status. Fear is derived from lack of knowledge, moral attitudes, and perceptions about people living with HIV and AIDS (PLHA). This can lead to social rejection which, at times, can lead to physical seclusion and social exclusion. The driving factors for physical seclusion include; shame, gossip, or belief about witchcraft. Further, religious and moral beliefs lead some people to believe that having HIV and AIDS is the result of a moral fault (such as promiscuity or deviant sex) that deserves to be

[21] Nkandu Luo, Alcohol and HIV, 2006.

punished. Some portrayals of HIV and AIDS by the media may propel such negative perceptions.

Harmful Cultural Beliefs and Practices

Polygamy (as is often practiced), cross-generational sex, early marriages, transactional sex, acceptability of the concept of 'sugar daddies', dry sex, the traditional practice of sexual cleansing, including inheritance and some initiation ceremonies, facilitate the transmission of HIV. The field data further informed this strategy on sexual cleansing:

> "*Passing the ghost of dead spouse" to a stranger is also spreading the HIV. This is a practice where a person who has lost a spouse goes to another area to have sex with someone so as to rid themselves of their spouse's ghost. In cases where the spouse died of AIDS, the HIV may be passed on to the other person." (Western Province Informant, 2008)*

Also, early marriages for girls, sexual abuse of young girls and boys, and gender violence against women increase the risk for HIV infection. Having multiple and concurrent sexual partners is not uncommon in both urban and rural areas, including wife swapping among friends, in some cultural groups.

Gender and Sexual Violence

Power imbalances between men and women at household and community levels influence decision making process and access to information, goods, and HIV and AIDS services. Women are socialised into becoming mainly wives and mothers. The socialisation process predisposes women to a situation where they are unable to negotiate for safer sex. Social norms that perpetuate the dominance of male interests and lack of self-assertiveness on the part of women in high risk sexual relations put both men and women at increased risk of HIV infection. Women are taught never to refuse their partners' sexual demands, regardless of the number of extra-marital partners he may have or unwillingness to use condoms or to test for HIV. This is often the case even when the partner is suspected of having HIV or other sexually-transmitted infections (STIs). Culturally, men make the decisions regarding sex and women fear, or experience violence if they refuse sex with their partners. Such cultural beliefs limit women's opportunity to negotiate for safer sex.

The ZSBS 2005 reported that about 15.1% of females experienced forced sex. This was a slight decrease from the 16.3% of females who reported forced sex in 2003. In 2005, approximately 17.7% of urban females and 13.7% of rural females reported forced sex. Forced sex was most commonly reported among the 20-24 year age group (18.5%)[22].

The same 2005 ZSBS reported that most perpetrators of forced sex are husbands or live-in partners (67.5%). Other reported perpetrators are boyfriends (25.0%), male relatives (5.8%), former husband/boyfriend (2.5%)

[22] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey.

and stranger (1.7%)[23] . From this data, it appears that the majority of victims of forced sex knew their perpetrators. Therefore, there is a need to promote more discussion on intimate partner violence (IPV).

Men are also made vulnerable because of existing gender norms, which can encourage them to act in ways that put their health and well-being at risk. Some traditional male roles have an adverse effect on men's sexual behaviour, for example, encouraging multiple and concurrent sexual partners. The field data implicated both men and women in engaging in high risk sexual acts due to certain cultural practices:

> *"Initiation of girls also leads to the spread of HIV as nowadays the girls take long to get married after they are initiated. Since the initiation is like an advert for maturity, boys usually want to have sex with the girls after this ritual and the girls themselves want to practice what they have been taught. This sometimes leads to HIV infection." (Eastern Province, Informant, 2008)*

Low Risk Perception

Some Zambians believe that they are at no risk of getting HIV infection although they practice high risk behaviours. Anarfi (2005) also reported on Ghana that although awareness of AIDS and risk perception was high, this knowledge did not translate into positive attitudes and behaviours, for example, consistent condom use[24]. According to the 2001/2002 ZDHS, 64% of females and 70% of males think that they are at no risk of contracting HIV because of the following reasons: they trust their partner (73%); used condom always (34%); mutually faithful (9%) and partner looked healthy (8%)[25].

Additionally, Zambian youth may have knowledge about HIV and AIDS, but stigma remains a major hindrance towards applying that knowledge to their own personal risk assessment for behaviour change. Society regards it as taboo for parents to discuss sexual matters with their own children, for example, parents would prefer to refer their children to their grandparents or other elders to discuss sexual issues instead of them handling the matter**.** However, as Zambia becomes more urbanized and nuclear families become the norm, those elderly people are not often available to provide guidance on sexuality. When they are available, many older adults do not feel that they have adequate knowledge themselves about HIV to discuss such matters with young people. Furthermore, many young people are exposed to media portraying high risk behaviours and negative role models.

> *"Videos showing western values have spoiled the young people because they want to practice what they see in these films. There is therefore a need for tighter laws on age limits in films." (Lusaka Province Informant, 2008)*

[23] CSO, MOH and Measure Evaluation, 2005 Zambia Sexual Behaviour Survey

[24] Anarfi, J.K. and Antwi. P. Street Youth in Accra City: Sexual Networking in High Risk Environment and its implications for the spread of HIV/AIDS. Health Transition Review, 5, 131-151. 1995

[25] CSO, Central Board of Health and ORC Macro, 2001/2002 Zambia Demographic and Health Survey

High Population Mobility

Population mobility, whether forced or voluntary, is increasing globally. Social, economic and political factors at places of origin or destination influence the risk of HIV infection. Poverty and exploitation, separation from regular partners and social norms, as well as language barriers and poor living conditions make mobile populations vulnerable to HIV infection. This is exacerbated by limited access to HIV prevention and care services.

Zambia is characterised by high levels of population mobility, both cross border and internal. Mobile populations include refugees, long distance truck drivers, mine workers, seasonal agriculture workers, construction workers, cross-border traders, fishmongers, uniformed security personnel, private and public workers and barter traders. Absence from home may increase the tendency to engage in multiple and concurrent sexual partners, for emotional and psychological satisfaction, monetary or material favours. High economic growth, in sectors like the mining and production industries also prompt high levels of transactional sex.

Sexually-Transmitted Infections

Sexually-transmitted infections (STIs) are a major public health problem in Zambia as up to 10% of outpatient attendances are STI related[26]. The 2001/2002 ZDHS shows that 7% of women and 8% of men in the 15-19 age group have syphilis. Herpes Simplex Virus-2 (HSV-2), which causes genital herpes and is widely prevalent in Southern Africa, including Zambia, is associated with a two to three-fold elevated risk of HIV acquisition and transmission. Other bacterial STIs that facilitate HIV transmission are also common. The 2005 Biologic and Behavioural Surveillance Survey (BBSS) indicates that STI prevalence among sex workers is 56.9%, excluding HIV, and 86.2% with HIV.

Free treatment for STIs is offered at all government clinics and health centres, but generally paid for in private facilities. There is, therefore, need to improve public-private partnerships so that free STI medication is made available for free through private facilities, as well. Due to the risk it poses for HIV infection, there is need for community awareness of the dangers of STIs, especially during pregnancy so that pregnant women seek services for effective diagnosis, and complete treatment for all sexually-transmitted infections (STIs). Partner notification should be strengthened. Furthermore, there are limited youth friendly sexual and reproductive services to address STIs among young people.

Poverty

Poverty levels in Zambia have remained high with the overall poverty incidence estimated at 64% in 2006[27]. While it is important to recognise the link between HIV and those with a higher income/higher education level, the realtionship between HIV and AIDS and poverty has been well established[28].

[26] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007.
[27] CSO, 2006. Living Condition and Monitoring Survey.
[28] Ministry of Health and Central Board of Health, GRZ, 2005 Zambia Antenatal Clinic Sentinel Surveillance Report, 1994-2004.

The HIV and AIDS epidemic in Zambia is occurring within a context of high poverty. The following table shows the trend of poverty situation in Zambia.

Table 2.1: Poverty Situation in Zambia, (2002-2006)

Indicator	Measure	2002	2004	2006
National Incidence	%	67.0	68.0	64.0
Incidence of Extreme Poverty	%	46.0	53.0	51.0
Rural Poverty (% of Rural Population)	%	72.0	78.0	80.0
Urban Poor (% of Urban Population)	%	28.0	53.0	34.0

Source: Ministry of Finance and National Planning – Economic Report 2004 and LCMS Report, CSO, 2004 & 2006**.**

The epidemic has worsened poverty and food insecurity among affected families, which would in turn contribute to increased sexual risk behaviour and vulnerability to HIV even among young girls. During the field visits it was heard:

"There is no food here. So when a young girl brings money home the mother is happy. Some others ask their daughters why they don't go out and find food like their friends. Mothers do not ask questions when their daughters bring home food purchased by selling sex. They are just happy to have a meal for that day." (Luapula Province Informant, 2008)

It was also heard in Central Province that:

"The poverty levels here are high and women are having many sexual partners as a way of survival. Sometimes a woman has many sexual partners because she needs financial support. The more men she has, the more money she will make." (Central Province Informant, 2008)

Gaps and Challenges

Prevention is central to the overall HIV and AIDS control and management strategy that effectively leads to a reversal in the extent and effects of the pandemic. To effectively implement the HIV Prevention Strategy, it is important to identify and find a way forward in dealing with the main existing gaps and challenges. These include:

1. **Weak Co-ordination and leadership –** The HIV and AIDS sector has numerous local and international actors, including civil society and the private sector. However, there is a challenge in coordinating these

partners which outstretches the coordinating and leadership capacity of NAC. In addition, there is weak collaboration and linkages between community-based and facility-based organisations and other institutions providing HIV prevention services. While decentralised structures are well established in all provinces and districts, a serious co-ordination gap still remains at community level.

The existing national tracking mechanisms are not effective in monitoring and evaluating the utilisation of resources. In addition, there is weak leadership to prioritize and mobilise the available resources for prevention programmes. Furthermore, the local traditional, religious and civic leaders do not have the necessary, knowledge, capacity and skills to champion prevention in their communities.

2. **Human Resource Limitations –** The Zambian health sector is operating at 50% of the work force required to deliver basic health services[29]. Many institutions including the private sector and community-based service providers face inadequate trained human resources in all aspects, such as skills in management, behaviour change communication (BCC), counselling, especially for children, community and social mobilisation, and monitoring and evaluation. The sub-national structures, especially, rural and hard-to-reach areas also need to have trained personnel. At the facility level, shortages are most acute in rural health centres where the average vacancy rate is 71.5% compared with 29% in urban health centres and 52% in hospitals[30].

3. **Limited HIV Prevention Interventions –** Confidential CT and PMTCT services are critical elements in HIV prevention. Currently CT and PMTCT are offered in 1028 and 863 sites respectively[31]. However, there is limited access to these services in rural and hard-to-reach and remote areas. With only 15% (about 900,000) of the 15 to 49 age group ever tested for HIV, the rest remain to be reached. There are also inadequate linkages and integration of PMTCT in reproductive health and ART services, lack of infrastructure and equipment to support scale-up of PMTCT and infant and young child feeding services particularly in rural areas.

   Inadequate availability, accessibility and/or affordability of both male and female condoms remain a serious challenge especially in rural areas. According to the 2008 National Multi-Sectoral AIDS Programme Workplan, the projected national need for male condom, for a period of two years (2009-2010) is about 200 million. It is estimated that about 96 million male condoms are likely to be secured, leaving a gap of 104 million. Similarly there is a shortfall in the provision of female condoms;

[29] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007.
[30] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007.
[31] MOH and NAC. 2008. Zambia Country Report, Multi-sectoral AIDS Response Monitoring & Evaluation Biennial Report, 2006-2007.

out of 2 million condoms needed, only about 500,000 are likely to be secured (see also Appendix 2).

The current national minimum blood requirement is estimated at 100,000 of screened blood units per year. However, only about 65,000 to 80,000 units of blood are secured yearly leaving a gap of 20,000 to 35,000 units per year (see also Appendix 2).

In some cases post-exposure prophylaxis (PEP) guidelines are not available in the health facilities to guide provision of the service. Even in situations where PEP guidelines are available, utilisation is hampered by a number of factors such as lack of awareness and access to PEP services in the community, and limited availability of PEP kits.

Although youth friendly services are available in some health facilities, these services should be in communities where they can be more available to the youth. However, services available are not comprehensive enough to carter for the diverse sexual and reproductive health needs of out-of-school youth.

4. **Inadequate male involvement –** Men play critical roles in decision-making processes at household and institutional levels. However, data gathered during the consultative process of developing this Strategy indicate that male involvement in HIV programmes is minimal. This creates a big gap considering that men are the major decision makers even regarding health seeking behaviours. Field visits conducted in areas where “male taking action” programmes are implemented, and men have been involved in the design, implementation and evaluation of HIV programmes, revealed better results.

5. **Inadequate behaviour change communication (BCC) strategy and lack of social change approaches –** The existing BCC and advocacy strategies lack continuity and are often inadequate in coverage and content. For instance, men are not effectively targeted and there are insufficient materials in local languages. The current BCC activities do not adequately challenge cultural, age, and social norms at the community level.

6. **Inadequate incentives among volunteers –** A number of people involved in the fight against the pandemic are poor and with limited employable life-skills. Relying on their patriotism and voluntary contribution of their time and labour is not sustainable. There is no policy and structure to guide partners to standardise issues surrounding volunteers and how they should be motivated and sustained.

7. **Drug and alcohol abuse –** There is no policy to enforce monitoring of alcohol purchase and consumption. There is also laxity in enforcing the existing laws and other legal statutes regulating operations of the alcohol industry regarding age, opening and closing hours of public drinking

venues. Poor collaboration among enforcement agencies is also a barrier.

8. **Limited family-centred services –** Prevention services are more individual and institution focused; not supportive of a family oriented service delivery approach. This hinders continuum of care at the family and community levels.

9. **Limited life-skills –** Young people, women and other vulnerable groups engage in high risk sexual behaviours due to limited life-skills. These include negotiating and vocational skills which increase self assertiveness and economic empowerment. There are also limited skills in gender analysis and planning in the country.

10. **Inadequate monitoring and evaluation system –** Multiplicity of data collection formats exists within the public sector and between public and private sectors. Data collection, analysis and usage are limited, especially at sub-national level, which limits consolidation and sharing of information at provincial, district and community levels. There is also an inadequate gender-responsive monitoring and evaluation system at all levels of planning and implementation.

CURRENT RESPONSE

In response to the fight against HIV and AIDS, in 2006 the Government of the Republic of Zambia, through the National AIDS Council and other stakeholders, developed the National HIV and AIDS Strategic Framework (NASF 2006-2010) to guide the implementation of HIV prevention activities based on the following vision, mission, goals and guiding principles.

Vision: A nation free from the threat of HIV and AIDS.

Mission: The national multi-sectoral response, coordinated by the National HIV/AIDS/STI/TB Council (NAC), is committed to controlling HIV and AIDS by integrating HIV and AIDS into the work of every partner and our development agenda. We will scale-up prioritised actions which are rapid and responsive to the needs of the local communities to be served.

Goals: Prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2010.

Key Principles: The nation will adhere to these guiding principles as the core values of the HIV and AIDS response:

(i) **Adoption of a human rights approach** which requires that the rights of the people of Zambia, to equality before the law and freedom from discrimination, are respected, protected and fulfilled. This means that all the strategies and interventions are *people-centred* and *culturally sensitive*, supporting and empowering communities, families and individuals to develop their own

competencies and to learn from the experience of others. There must also be strong *political commitment and leadership and engagement* so as to promote *good governance, transparency and accountability* at all levels and in all the sectors.

(ii) **Greater and meaningful involvement of People Living with HIV and AIDS (GIPA)** at all levels of the response.

(iii) **Gender equity and HIV** issues are interconnected.

(iv) HIV and AIDS interventions should be **pro-poor with HIV and AIDS mainstreamed** in the national development agenda, sector policies, plans and budgets of the country in order to ensure *sustainability*. The interventions, in other words, are aiming at poverty reduction and eradication.

(v) Controlling HIV and AIDS needs the involvement of everyone through the **multi-sectoral response and partnership** in the design, implementation, review, monitoring and evaluation of the National AIDS Strategic Framework (NASF) in order to ensure success and effectiveness of the response. This is in keeping with the nationally supported **"Three Ones" approach:** One national co-ordinating authority, one strategic framework, and one monitoring and evaluation framework.

(vi) Implementation of the strategy shall be in line with the National **Decentralisation** Policy to ensure maximum participation by communities and to strengthen the leadership by the District Development Co-ordination Committees (DDCC).

(vii) It is essential that the national response to HIV and AIDS be guided by ethically sound, current **scientific and evidence-based research** bringing out **best practices** and using a **public health approach** to guide prioritisation and selection of the most cost effective interventions.

Prevention and Promotion Activities

The current HIV prevention response in Zambia is based on 8 strategic objectives and cross cutting issues:

- Preventing of sexual transmission of HIV with special emphasis on youth, women and high risk behaviours;
- Preventing of mother-to-child transmission;
- Preventing of HIV transmission through blood and blood products;
- Preventing of HIV transmission in health care and other care settings and promoting of access to post exposure prophylaxis (PEP);
- Improving access to and use of confidential counselling and testing;
- Mitigating stigma and discrimination against HIV;
- Preventing transmission through Intravenous drug use; and,
- Supporting the development and participation in HIV vaccine clinical trials.

Prevention of Sexual Transmission

Zambia is promoting the ABC approach to prevention; abstinence for youth and the unmarried; be faithful to one uninfected partner, for the married segment of the population; and, correct and consistent use of condoms for sexually active youth and adults. Partners implement these activities through behaviour change communication (BCC) using different mass media channels, life-skills activities for youth, distribution of both male and female condoms as well as peer-education and youth-friendly services. Prevention activities are also implemented through schools, workplace programmes and are integrated with other health care services such as STIs management, maternal and child health (MCH) and counselling and testing. Currently about 3 million out-of-school and 1 million in-school youths need to be reached by the BCC messages. The field data revealed that over a million copies of various print materials targeting the youths have been distributed countrywide, to inform them about the existing preventive measures and care services.

Workplace Policies and Programmes

While the public sector is still the major employer in the country, the private sector now accounts for a significant proportion of the formally employed workforce in Zambia[32]. The design and implementation of workplace programmes in companies and business have been largely supported by a private sector network known as Zambia Workplace AIDS Partnership (ZWAP) whereas workplace policies and programmes in the public sector are implemented by respective line ministries. The mainstay of HIV work in the private and public sectors is largely dedicated to prevention initiatives implemented through the workplace and host communities where they exist. Closer linkages among these sectors are needed for an effective combat of the pandemic.

Prevention of Sexually-Transmitted Infections (STIs)

STIs are still a major public health problem in Zambia, as up to 10% of all out-patient attendances at health institutions are related to STIs. Gonorrhoea, syphilis and chancroid are among the most common infections. Chlamydia trachomatis, trichomonas vaginalis and yeast infection of candida albicans are common in female patients, while men often experience an inflammation of the glans penis (balanitis) and the prepuce (posthitis). The 2001-2002 ZDHS shows that 7% of women and 8% of men in the 15 to 49 age groups have syphilis. The high prevalence of STIs in Zambia continues to make severe demands on Zambia's already stretched human and economic resources

The presence of untreated STIs increases the chance of HIV transmission during unprotected sex between an HIV positive and HIV negative person. The Ministry of Health has initiated community and clinic-based interventions to help control the spread of STIs. Free treatment of STIs is offered at all government clinics and health centres, complemented by efforts to raise community awareness of the dangers of STIs, especially during pregnancy.

Prevention of Mother-to-Child Transmission (PMTCT)

The national programme for the prevention of mother-to-child transmission (PMTCT) of HIV follows the World Health Organisation (WHO) endorsed four-prong approach: primary prevention of HIV, with a focus on pregnant women;

[32] CSO, 2004 Living Conditions and Monitoring Survey.

prevention of unwanted pregnancies among HIV positive women or women of unknown status; prevention of HIV transmission from infected mothers to their babies; and care and support to HIV infected families.

By June 2007, 863 health facilities were providing PMTCT services representing over 50% of health facilities in the country. The scaling-up of PMTCT services resulted in an increase of pregnant women completing prophylaxis from 14,071 in 2005 to 25,578 in 2006 and 35,314 by September 2007. However, the human resource capacities at facility and community levels are still inadequate to meet the current needs. To address this shortage, government has introduced direct entry into midwifery training and embraced public-private partnership for training health personnel, such as nurses.

In addition, Polymerase Chain Reaction (PCR) is currently used for early infant diagnosis of children parentally exposed to HIV.

The Government, in collaboration with various stakeholders, supports the following PMTCT activities:

- counselling and testing, including couple counselling;
- prophylactic ARV treatment;
- male involvement;
- screening and treatment for STIs;
- community mobilisation and adherence support follow-up;
- referral for CD4 count; infant feeding, and family planning;
- follow up of mother infant pair;
- Cotrimoxazole prophylaxis child health;
- training both community volunteers and health care providers;
- development and distribution of information, education and communication (IEC) materials; and,
- condom promotion and distribution.

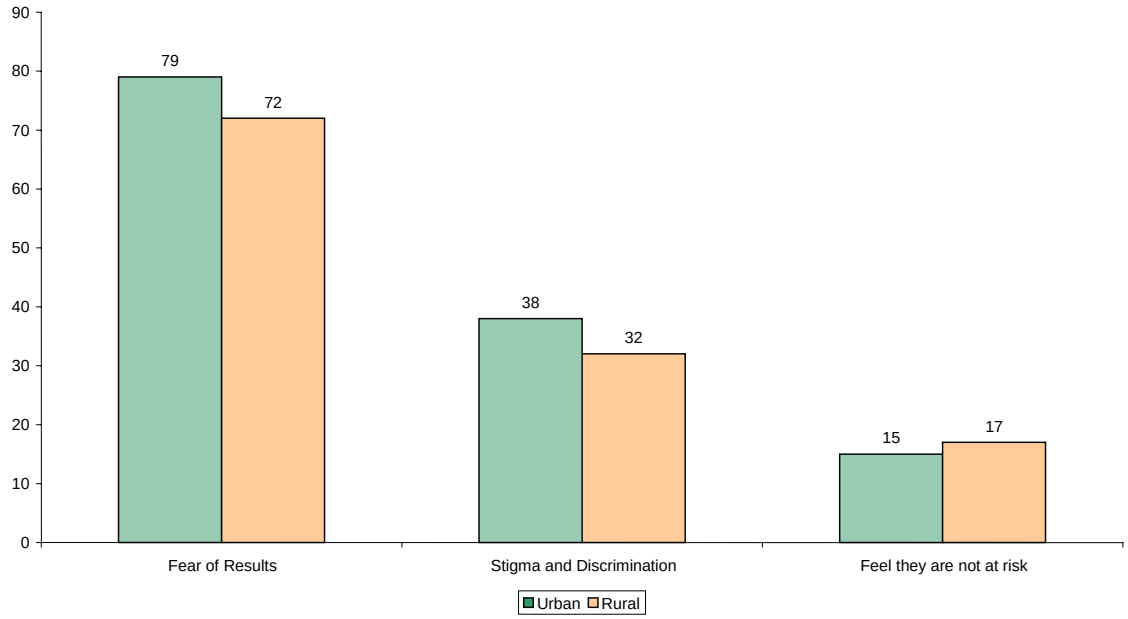
Counselling and testing (CT)

The number of CT sites (both static and mobile) has increased from 450 in 2005 to 1023 by end of 2007. However, this increase in testing sites has not been accompanied by a corresponding increase in the people accessing CT services. In 2007, the percent of people aged 15-49 who received an HIV test in the last 12 months and knew their results was 15.4%[33]. More women, at 18.5%, were reported to have received the HIV test and know their results than men, at 11.7%. The 15-19 years age group accounted for the smallest percentage accessing the service with only 10.2% reported having tested for HIV and knowing their results.

The 2005 Zambia Sexual and Behaviour Survey (ZSBS) reports fear of stigma and discrimination as one of the reasons for people not seeking to know their HIV status. Figure 3 further presents reasons for not seeking to know their HIV status.

[33] CSO, MOH, TRDC and UNZA, 2007 ZDHS

Figure 3: Reasons some people avoid visiting a VCT facility, by Residence, ZSBS, 2005



Counselling and testing has been scaled-up focusing on:

- development of necessary guidelines, including quality assurance/quality improvement;
- training;
- establishing logistics for HIV commodity procurement;
- community mobilisation;
- promotion of couple counselling and testing, family-based counselling and testing, workplace CT;
- PCR test for children under eighteen months; and,
- development and distribution of BCC/IEC materials.

In March 2006, the Government of the Republic of Zambia (GRZ) issued national HIV CT guidelines calling for routine, opt-out HIV testing, and use of finger prick testing when appropriate in all clinical and community based health service settings. These guidelines encourage using rapid HIV tests, and emphasise that testing be routine, but voluntary and based on informed consent.

To strengthen the CT component further, in 2006, the Government of the Republic of Zambia declared June 30 a national voluntary counselling and testing (VCT) day to increase access to CT services and encouraged testing across the country.

Prevention of HIV in Health Care Settings

Prevention of medical transmission of HIV can be achieved through provision of safe blood, training of health care providers, improved medical practices and provision of post-exposure prophylaxis (PEP). The areas of emphasis include:

- blood safety;
- handling and processing of sharp instruments;

- handling and disposal of clinical waste; and
- provision of commodities and supplies, including management of logistics and procurement of injection safety (IS)/ infection prevention (IP) commodities.

Blood and Blood Products

Zambia National Blood Transfusion Services (ZNBTS), responsible for blood safety in Zambia, focuses on 4 core strategies: capacity building through training; systems strengthening through purchase of commodities; providing technical assistance; and targeting repeat negative donors.

Country-wide there are nine screening centres of international standards, and 117 blood transfusion service outlets. To ensure safe storage of collected blood, all the 9 provincial hospitals now have large special blood refrigerators. About 81 small refrigerators have also been procured for storing blood at district level and in selected private institutions.

By 2008, 710 individuals had been trained on blood safety. The national need for safe blood is 100,000 units. Currently about 80,000 units of blood are collected and screened for HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV)[34] using the World Health Organisation standard. This leaves a 20% percent gap towards meeting the national need for blood (see also Appendix 2). Due to proper targeting of repeat negative donors, discarded blood percentage has reduced from 9.54% in 2003 to 3.14% in 2008.

Infection Prevention and Injection Safety

Unsafe injections, together with other unsafe but largely preventable medical practices, account for a small but significant percentage of new HIV infections in Zambia (up to five per cent) and also contribute to transmission of hepatitis B and C. Unsafe injections result when injections are given with used syringes or needles that are not sterile; when poor injection technique is used, such as recapping of used needles or use of contaminated multi-dose dilutants or reconstituted drugs; or when sharps are improperly discarded. Unnecessary injections result when an injection is not medically indicated, or is given where other alternatives (medically equivalent, acceptable and available) are most appropriate such as a tablet. Therefore, issues of injection safety (IS) and infection prevention (IP) are critical elements in HIV prevention.

HIV programmes need to promote sound infection control in health-care settings, including the use of auto-disposable syringes for injections and immunisations to prevent re-use; providing and ensuring that health care workers are trained on infection control as well as provided with gloves and other protective equipment to prevent accidental exposure to HIV infection during the course of their work; the safe disposal of sharp instruments or equipment and hand washing should be emphasised as a criticle part of practice.

Current infection prevention (IP) and injection safety (IS) activities focus on:

- policy and guidelines development and implementation;

[34] MOH, 2006 Zambia National Blood Transfusion Service

- capacity building and training;
- procurement of commodities;
- implementation of post-exposure prophylaxis (PEP);
- behaviour change;
- monitoring and evaluation;
- community mobilisation;
- waste management; and,
- monitoring and evaluation.

The IP/IS activities in Zambia, also include work with communities and their respective leaders to foster behaviours that reduce the risk of medical transmission of HIV, including reducing provider and consumer bias for injections and staying away from clinical waste disposal sites. There arises, therefore, the need to update the guidelines with current best practices and to re-disseminate, and to provide further training to prevent medical transmission of HIV. There is also the need to integrate IP/IS activities in the annual work plans.

Promotion of access to post-exposure prophylaxis (PEP)

It is important to ensure that post-exposure prophylaxis is available to health care workers that may accidentally be exposed to HIV and clients that have experienced sexual violence (abuse and/or assault). Generally, post-exposure anti-retroviral therapy is limited and should be expanded to all health facilities. Even where it is available, it is poorly accessed due to lack of awareness of its existence and stigma. It is also important to target non-clinical or traditional care settings (such as traditional practitioners and associations like the Traditional Health Practitioners Association of Zambia -THPAZ) with information on the availability of the services, standard guidance and techniques for capacity building.

Mitigate Stigma and Discrimination against People Living with HIV and AIDS (PLHA)

Stigma and discrimination are serious threats to the fight against the pandemic. According to 2001/2002 ZDHS, about 64% of women and 61% men believed that a worker who has AIDS should not be allowed to work. People living HIV and AIDS are stigmatized and experience discrimination. About 61% of women and 53% of men reported that they would not buy vegetables from a shopkeeper with AIDS. About 39% of women and 30% of men believed that the status of a family member who is HIV positive should not be revealed to other people. About 8% of women and 10% of men reported that they were unwilling to care for a relative with AIDS. Many people who are living with HIV and AIDS are usually stigmatized and discriminated. In the area of prevention, stigma and discrimination prevents people from discussing issues related to HIV and AIDS. The silence leads to people not knowing the facts about HIV and AIDS and it prevents people from knowing what to do in order to avoid getting infected.

Zambian youths may have knowledge about HIV and AIDS, but stigma still remains an important hindrance towards applying that knowledge to their own personal risk assessment for behaviour change. For instance, 64% of girls

and 70% of boys think that they are not at risk of contracting HIV and AIDS[35]. Stigma serves as a barrier to lasting behaviour change among youths and interferes with their ability to correctly estimate their own status. Society regards it as taboo for parents to discuss sex-related matters with their own children. For example, parents would prefer to refer their children to their grand parents to discuss sexual related issues instead of them handling the matter**.**

Multi-Sectoral response to HIV and AIDS

The country has long realised the importance of adopting and using a multi-sectoral approach in all efforts aimed at mitigating the epidemic. The health sector, in particular, is involved in joint programming with other private and government sectors and there are several committees established to facilitate such co-operations at all levels. For instance, at the national level, partners involved in the response are organised using self-co-ordinating groups, theme groups, sector advisory groups, partnership forums, co-operating partner groups, and the UN Joint Team.

At sub-national level, partnerships are organised through the Provincial AIDS Task Forces (PATFs), District AIDS Task Forces (DATFs) and the Community AIDS Task Forces (CATFs) which are part of the Provincial Development Co-ordination Committees (PDCC), the District Development Co-ordination Committees (DDCC) and Neighbourhood Health Committees (NHCs) respectively. The role of these partnerships is to ensure effective planning and co-ordination of budgeting and implementation of the multi-sectoral response.

[35] CSO, Central Board of Health and ORC Macro, 2001/2002 Zambia Demographic and Health Survey

VISION, MISSION, GOAL, STRATEGIC OBJECTIVES, GUIDING PRINCIPLES AND PRIORITY AREAS FOR 2009-2014

Vision: Avert new HIV infections in Zambia

Mission: Strengthen partnerships and co-ordination for the efficient provision of integrated evidence-based HIV prevention services, behaviour change communication and social normative change to all Zambians. This will be achieved by building sustainable delivery systems and strengthening local community participation.

Goal: Reduce HIV incidence by 50% from baseline by 2014[36].

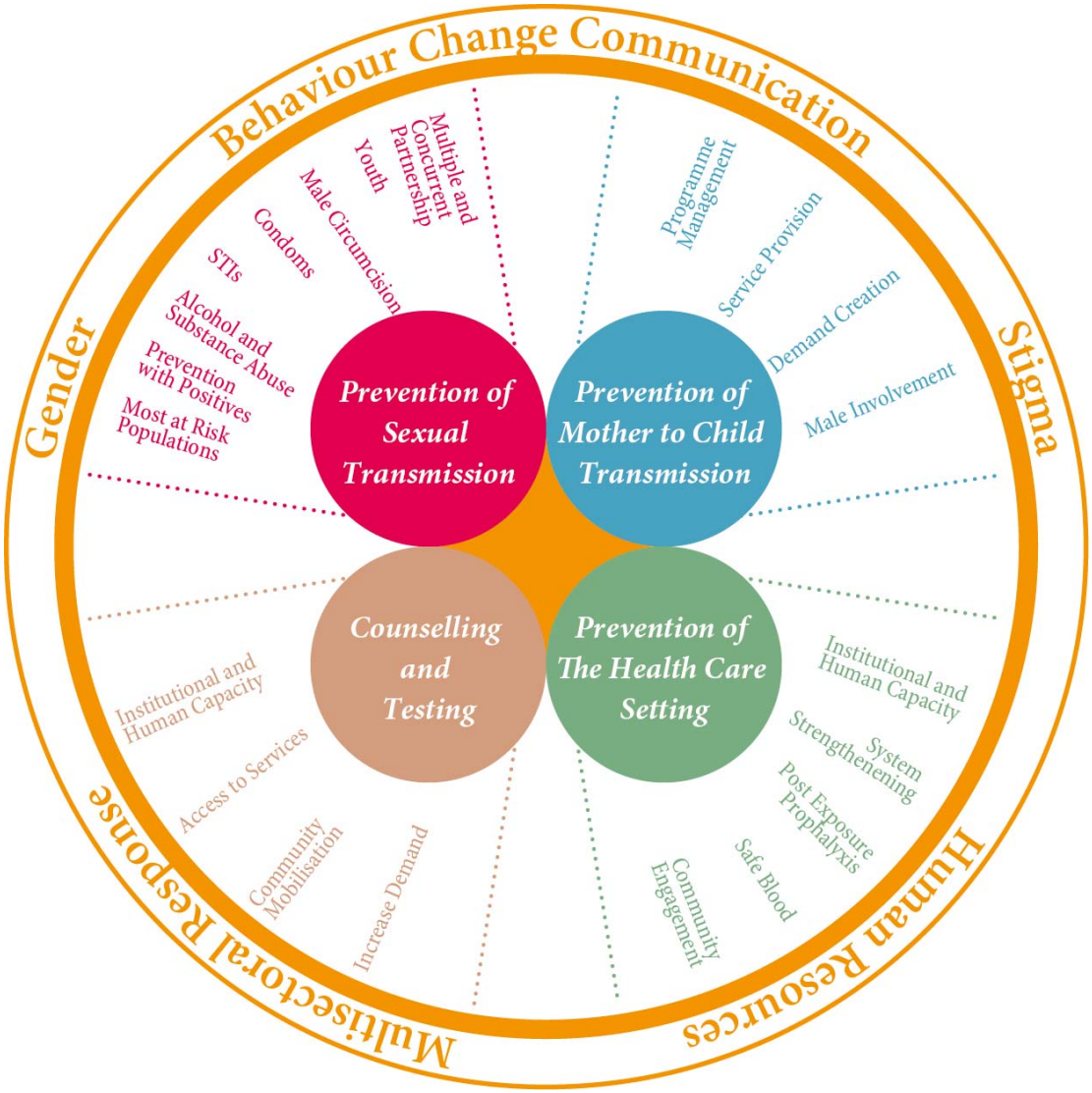
Strategic Objectives

1. Intensify and accelerate prevention of sexual transmission through targeted communication and mobilisation for social and behaviour change and clinical interventions;
2. Scale-up access to and use of quality PMTCT services particularly in peri-urban, rural and hard-to-reach areas;
3. Integrate prevention in all aspects of care at health facility level; and,
4. Scale-up access to and use of CT services and address stigma and discrimination.

Guiding Principles: The National HIV Prevention Strategy is guided by the following principles:

1. **Community involvement and leadership** in HIV prevention activities including greater and meaningful involvement of people living with HIV and AIDS (GIPA) in policy development and programme design, planning, implementation, and monitoring and evaluation.
2. **Targeted, localised and culturally accepted social and behaviour change** strategies in HIV prevention initiatives.
3. **Evidence-based** programming and replication of best practices in HIV prevention to guide prioritisation for funding and implementation.
4. **Standardised messages, incentives and training** across prevention activities.
5. **Multi-sectoral response and partnerships** in programme design and service delivery.
6. **Gender sensitive programming** and service delivery.
7. **Human Rights** approach to HIV prevention.

[36] It has been modelled that there were 80,000 new HIV infections in 2008, therefore, this strategy aims to reduce the number of new infection to 40,000 in 2014.



PRIORITY AREAS FOR SCALING-UP HIV PREVENTION

For each strategic objective, there is a description of "indicative core strategies", which have been developed, based on present, emerging best practices, and identified gaps. It is intended that the range of strategies, documented in the NASF Supplemental Framework and Operational Manual, will continuously be improved. The following are the prevention priority areas for 2009 to 2014:

1. Prevention of sexual transmission of HIV
2. Prevention of mother-to-child transmission (PMTCT) of HIV
3. HIV prevention in health care setting, including post-exposure prophylaxis (PEP)
4. Counselling and testing

Re-prioritisation of the prevention response

It is observed that in the NASF 2006-2009, there were eight strategic objectives, under the theme of prevention, namely:

- Preventing of sexual transmission of HIV with special emphasis on youth, women and high risk behaviours;
- Preventing of mother-to-child transmission;
- Preventing of HIV transmission through blood and blood products;
- Preventing of HIV transmission in health care and other care settings and promoting of access to post exposure prophylaxis (PEP);
- Improving access to and use of confidential counselling and testing;
- Mitigating stigma and discrimination against HIV;
- Preventing transmission through Intravenous drug use; and,
- Supporting the development and participation in HIV vaccine clinical trials.

Under this strategy, these priority areas have been refined and reduced to four.

- Prevention of sexual transmission of HIV
- Prevention of mother-to-child transmission (PMTCT) of HIV
- HIV prevention in health care setting, including post-exposure prophylaxis (PEP)
- Counselling and testing

This is justified by the combined results of the Zambian Mid-Term Review of the NASF, as well as an analysis of the changing evidence supporting prevention. Thus, there was a merging of the strategies of prevention through blood and prevention in the health care setting, as these correspond with each other. These were prioritised as third, because, while it is widely accepted that there are high risks in transmission through blood or contaminated materials in a health care setting, these are relatively low risks in the context of the incidence rates according to the modes of transmission.

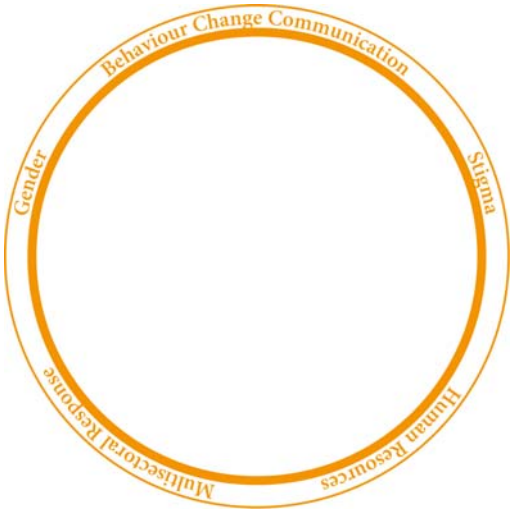
Similarly, counselling and testing, per se, does not prevent HIV. It is an important point of entry for counselling for behaviour change, as well as for a point of entry into treatment. Because of the long standing association of CT with prevention, it remains in this strategy, but it is viewed as a lower "prevention" strategy, as compared to the prevention of sexual transmission (the number one driver of the epidemic in Zambia) and prevention of mother to child transmission, also a widespread driver of the epidemic.

Prevention of transmission through injection drug use has been minimised in this strategy. At this stage, the available data suggests that this is not a large enough problem in Zambia to merit the attention of significant human or financial resources. It is agreed that more research is needed in the area (as well as in the area of men who have sex with men (MSM)).

There is slow progress in the development of a vaccine. Therefore, it was agreed that the strategy of investing in vaccine research was eliminated. This can certainly be revisited at a later date, if the evidence suggests it.

CROSS CUTTING ISSUES

Cutting across these four priority areas are a set of key issues which need to be taken into consideration throughout the planning and implementation of any interventions under this new strategy. These are as follows:



Behaviour Change Communication (BCC)

Behaviour change communication (BCC) is central to HIV prevention. Countries where reversals in the HIV prevalence in general populations have been recorded, changes in behaviour have been the key, as infection is more often than not a consequence of human behaviour. Unfortunately, the sensitive nature of human sexuality has made many people avoid open and frank discussions around HIV prevention. However, it is important to note that for this strategy to achieve its goal, there is need for people to be open and frank about the issues that lead to HIV infection. It is also important for all stakeholders to realise that these open discussions, which ever form they take, have to translate into raising people's personal risk perception.

All the strategies outlined in the sections below can only be meaningful if people adopt low risk behaviours, such as abstaining from premarital or extra marital sex; reducing their multiple and concurrent partnerships, preferably sticking to one mutually faithful partner; using condoms correctly and consistently; going for male circumcision, PMTCT, counselling and testing; and seeking early treatment for STIs. BCC is, therefore, the cornerstone of a sustainable response to HIV and AIDS as it helps people avoid either new or secondary HIV infection through adoption of safer behaviours.

Partners working in HIV prevention, therefore, have to invest in programmes that help people get correct and accurate information, as well as skills to act on that information. Behaviour change interventions, including production and distribution of various BCC/IEC materials, radio and television programmes, peer-education, community drama, life-skills education for in- and out-of-school young people, role modelling, etc should be supported and sustained. Once low risk behaviour has been adopted, on-going support and encouragement is required for its maintenance.

BCC interventions need to be appropriately targeted to individuals, families, and communities for effectiveness and sustainability. It is also important to remember that in sexual relations, a new HIV infection is a result of an infected person having unprotected sex with someone who is uninfected. Therefore, BCC targeting PLHA should be an integral part of prevention programmes. Similarly, every client/patient contact is an opportunity for on-going prevention counselling.

Stigma and discrimination

Stigma and discrimination is the single most devastating challenge in the fight against HIV and AIDS, as it can result in denial and it creates a barrier in accessing services. Stigma exists at various levels namely individual, family and community levels. There is often self-stigma and denial of risk. Factors that contribute to stigma and discrimination include lack of knowledge, moral attitude, and perceptions that caring for PLHA is a waste of time, as HIV and AIDS is incurable and, therefore, associated with death. Stigma and discrimination leads to silence, denial and blaming of others. As a result of this, people delay in accessing services such as prevention, counselling, testing, treatment, care and support. It also contributes to lack of social discourse and a weak enabling environment for behavioural change.

Addressing stigma and discrimination is, therefore, a crucial part of this strategy as it will help people confront their fears, assess their risk, and access prevention services. To that effect, prevention programmes should incorporate activities that inform and educate people on the devastating effects of stigma and discrimination, as well as encourage them to access the HIV and AIDS services that are now readily available and/or encourage them to support others in risk reduction and care seeking behaviour. Greater and meaningful involvement of PLHA (GIPA) principles should be mainstreamed through all activities. This also addresses the perceptions that caring for PLHA is a waste of time.

Specifically, some of the measures that should be considered in addressing stigma and discrimination include:

- Engage local religious and traditional leaders and community members to openly discuss the values and beliefs that underlie stigma and provide programmes that address improved personal and realistic risk perception.
- Create a safe environment to openly discuss the values and beliefs that underlie stigma among youths, adults, parents, teachers, community leaders etc.
- Effectively use the media and BCC strategies to create a climate that is more open and supportive to prevent youths from ignoring HIV and AIDS as a risk and not remaining in denial.
- Use more positive images as role models (e.g. nationally recognised celebrities that youth respect in athletics, music etc) to eliminate stigma and discrimination against HIV and AIDS.
- Equip peer-educators to address stigma in the ongoing programmes at all levels, namely national and sub-national and community.
- Facilitate and support community initiatives which develop anti-stigma activities and address knowledge gaps in order to reduce fears around HIV and AIDS.
- Design and develop BCC materials in various local languages to reach out to all groups exposed to high risk of infection such as disabled, incarcerated, commercial sex workers, and men having sex with men. Promote positive living and engagement of people living with HIV and AIDS in the design, development and implementation of anti-stigma

programmes.
- Stress the confidentiality of HIV-test results. This would encourage more people to visit counselling and testing (CT) services.

Inadequate human resource

As prevention activities are being scaled-up, it is important to remember that this will escalate the already existing challenges of human resources in prevention, as well as treatment, care and support. The current staffing levels in health facilities are inadequate to meet the demands of providing not only prevention, but other services as well. This underpins the importance of multi-sectoral response in addressing the pandemic.

Programmes like PMTCT, safe blood collection and injection safety need more trained personnel for them to function optimally. As counselling and testing centres are being opened across the country, there is need for more lay counsellors to take on the added work of counselling clients in all facilities. Traditional Birth Attendants (TBAs) should be trained in counselling and safe delivery practices so they can take on some of the demands created by the scaling-up of services.

In September 2008 the Ministry of Health launched its plan to address the human resource situation. This includes the standardisation of human resource conditions of service for motivation and retention purposes. This will allow for recruitment and retention of more health care workers, thereby improving service provision in the health facilities. The government and co-operating partners, therefore, need to address this challenge with urgency in order to accommodate the effective delivery of prevention services.

Multi-sectoral response

One of the mandates of the NAC is to co-ordinate the multi-sectoral response to HIV and AIDS, including prevention activities. This, therefore, means for this strategy to be effective, there has to be buy-in from all the partners in the multi-sectoral response. Partners involved in prevention activities have to contribute to the implementation of this strategy, using their comparative advantage. Public, private and civil society organisations, including those that are faith-based, all have to play their part in ensuring that prevention programmes are carried out as articulated in this strategy.

This, in effect, means that no partner in the multi-sectoral response should attempt to undo the work that others are doing. Partners must carry out programmes that they are comfortable with, without negatively impacting on the work of others. The multi-sectoral response means all partners are working towards one goal, using their comparative advantage to reduce the incidence of HIV in Zambia.

Gender Issues

The effectiveness of the national HIV prevention strategy will be improved by approaching the HIV and AIDS programming from a gender perspective. According to UNAIDS, one of the key lessons learnt from the HIV and AIDS response is the need to address gender inequality. The control of the spread of HIV and AIDS is dependent on having strategies that empower women economically. Gender should also be integrated into HIV prevention strategies

and action plans since gender is a cross-cutting issue in all sectors of society. Other issues that are critical in addressing the spread of the pandemic include conjugal mobility, societal marital customs and practices, perceived gender roles, social structures, customary decision making patterns, the position of women and socialisation of children within the family.

Community-based initiatives, using traditional and religious leaders, and innovative behaviour change communication strategies should be applied to bring about awareness when addressing factors promoting gender imbalances and dangerous cultural practices that put women and girls at risk of HIV infection. For instance, where widow/er inheritance is insisted upon, HIV testing should be enforced before this occurs.

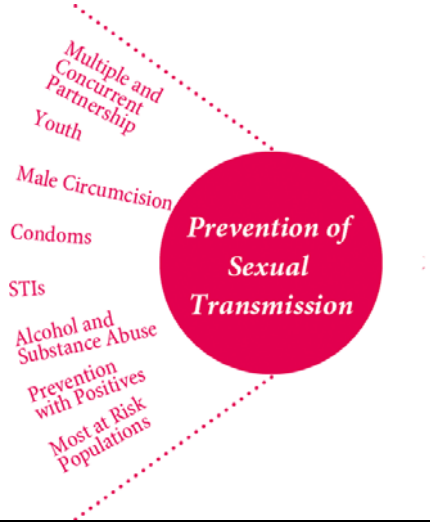
Other strategies to address gender concerns include: the provision of comprehensive sex education that promote human rights and gender equality as well as promotion of increased enrolment, retention of girls in schools; provision of life-skills for young people in- and out-of-school; creation and expansion of community services such as recreation, education and health; and initiation ceremonies for both boys and girls should include appropriate prevention information on HIV. There is also need to implement initiatives to economically empower women living with and affected by HIV and AIDS.

Dissemination of information about gender-based violence, including rape and incest, post-exposure prophylaxis and opportunities for counselling is equally an important approach. There is also the need to create awareness campaigns about the dangers of multiple and concurrent sexual partners (MCP) at community and individual levels. Norms need to be created that discourage gender-based violence (GBV) and provide support to women in violent relationships. Furthermore, legal support and sensitization programmes should be established to ensure that women have the equal right to inherit property and to earn income, thus being free from sexual exploitations.

THE CORE STRATEGIES

The following are the four priority strategies for the prevention of HIV transmission in Zambia. Each strategy is followed by indicative interventions. There is a logical framework for monitoring at the end of the document.

PREVENTION OF SEXUAL TRANSMISSION



STRATEGIC OBJECTIVE 1	INDICATIVE CORE STRATEGIES
Intensify and accelerate prevention of sexual transmission through targeted communication and mobilisation for social and behaviour change and clinical interventions	1. Reduce multiple and concurrent sexual partnerships (MCP). 2. Scale-up evidence-based prevention for young people. 3. Strengthen and scale-up male circumcision (MC) services as part of the national comprehensive prevention package and in the context of comprehensive male reproductive health services. 4. Make affordable, quality male and female condoms widely available and accessible throughout the country. 5. Strengthen and scale-up activities on prevention and management of Sexually-Transmitted Infections (STIs). 6. Address the role of alcohol and substance abuse in HIV transmission through a comprehensive response that combines individual, community and environmental approaches. 7. Integrate prevention interventions with other HIV and health care services, with special attention to prevention with positives. 8. Expand coverage of a core package of comprehensive prevention interventions for vulnerable groups (prisoners, persons living with disability and other vulnerable groups).

Core Strategy 1.1: Reduce Multiple and Concurrent Sexual Partnerships

Indicative Interventions

I. Expand training and support to traditional, religious and other local opinion leaders, who provide moral authority in communities. This will stimulate community dialogue about HIV prevention and advocacy for safer sexual behaviours, with special focus on reduced rate of multiple and concurrent sexual partners, male circumcision, increased consistent and correct condom use, and changing male norms that sustain sexual networks and contribute to a culture of sexual violence against women and girls.
II. Shift the paradigm from knowledge to motivation and sustained behaviour change, i.e. provide support for trying new behaviours and help evaluate benefit of new behaviour (sustaining behaviour change).
III. Expanded training and support to:
    a. Individuals to balance knowledge and options for change,
    b. Couples to provide skills for achieving change,
    c. Religious and traditional leaders so that they can help couples to enhance communication in marriage settings.
IV. Develop and implement interventions to address MCP & transactional sex; intervention to focus more on risk perception (not equating risk to promiscuity, rather awareness of sexual networks, high infectivity in early stages, repeat HIV testing, faithfulness & partner reduction).
V. Identify credible gender role models, at all levels of society and across different sectors, to advocate for partner reduction; discourage risky behaviours including alcohol abuse; and recognise men who are faithful partners as successful and respected citizens.
VI. Draw on emerging best practice combination strategies from the region and within, such as the Swaziland “Secret Lover” campaign and the South Africa “OneLove” Campaign.
VII. Expand mechanisms at the provincial and district levels for funding informal community groups to support community mobilisation and grass-roots initiatives and to promote safer and more responsible behaviour.
VIII. Develop and implement targeted education on high risk perception and increase risk self-assessment.
IX. Expand interventions to increase partner notification and disclosure.

Core Strategy 1.2: Scale-up evidence-based prevention for young people

Indicative Interventions

HIV and AIDS Education for In-School Young People

I. Update, strengthen, and scale-up curriculum and skills-based HIV and AIDS education for in-school young people to include developmentally appropriate and grade-based school HIV and AIDS education as a dedicated subject within the school schedule, to supplement the current strategy of integrating HIV prevention education across study areas, including the incorporation of HIV and AIDS and life-skills as an exam subject.
II. Include parents and guardians in BCC programmes.
III. Link the in-school programmes to RH services.

IV. Promote career guidance to preoccupy the young people and to provide hope.
V. Link the school-based prevention activities to PLHA support groups.
VI. Train a core cadre of HIV and AIDS educators (teachers, administrators, managers and peer educators) as mentors and advocates for adult/youth dialogue on sexual matters.
VII. Strengthen and expand Anti-AIDS Clubs.
VIII. Establish linkages of school-based prevention activities with other HIV and AIDS support services. Such services should be supported by an enabling and protective environment.
IX. Ensure that laws are enforced to reduce the incidence of sex between teachers and students.
X. Identify and empower positive role models to encourage early adoption of safer sexual behaviour that can also influence adult behaviour later in life.

HIV and AIDS Education for Out-of-School Young People

In the Zambian context, a youth is defined as any young person in the age range of 18-35 years. However, in this document, out-of-school youths refers to all young people who are not in formal education including adolescents and teenagers. HIV prevention interventions should be targeted to reach all the different age groups. HIV vulnerability is 3-5 times more in young females than young males of the same age group[37]. Therefore, prevention strategies should have a stronger focus on young females to reduce their vulnerability and build self esteem and empower them.

I. Strengthen out-of-school youth networks (youth organisations, church youth fellowships, and other community structures that support young people) to adapt and roll-out an appropriately modified version of the school curriculum to reach high risk out-of-school young people at scale.
II. Incorporate sex education into school curricula at an earlier age.
III. Develop and implement multimedia based approaches on safer sex and risk self-assessment.
IV. Stimulate interactive dialogue on safer sex, including increased communication between partners by using community based education approaches such as drama, debates, one-on-one sessions, peer-education and small group discussions.
V. Address issues of sustainability relating to peer-education, by developing strategies to institutionalize recruitment of new peer educators on a regular basis to address the natural turnover of peer-educators as they “age out.”
VI. Strengthen and expand community youth and adolescent reproductive health and HIV and AIDS services.

Other Strategies for HIV Prevention in Young People

I. Utilise multiple channel mass media campaigns that are research-based and of adequate intensity, and interpersonal and community-based approaches, where radio and television access are limited, to

[37] CSO, Central Board of Health and ORC Macro, 2001/2002 Zambia Demographic and Health Survey

influence youth attitudes and behaviours, and to reinforce interpersonal communication to maintain safer behaviours and risk reduction strategies, including male circumcision. Interpersonal and community based approaches are needed everywhere to reinforce mass media campaign, even where there is access to radio and television.

II. Build the capacity of parents and other caregivers for closer communication with and supervision of adolescents in their care to influence youth values, attitudes and behaviours.
III. Prioritise school enrolment for orphaned youth, recognising the protective influence of schools in reducing young people's risk behaviours.
IV. Strengthen and expand Ministry of Sport Youth and Child Development resource centres at district level to integrate reproductive health and HIV and AIDS services.
V. Link HIV prevention interventions with micro finance institutions and business to start up youth programmes.
VI. Advocate for an enabling environment for the promotion of ABCs in schools.
VII. Information on ABCs to be included in the school Parent-Teacher Associations (PTAs).

Message Content for Young People

I. Emphasise self-esteem and skills that support abstinence and delayed sexual debut for younger youth and others who are not yet sexually active and return to abstinence for those who have experienced sexual debut.
II. Provide information about partner reduction, male circumcision and condoms, to prepare youth for their transition to sexual activity.
III. For sexually-active and older youth, provide information about the full range of HIV prevention strategies, including access to reliable sources of condom supplies and referrals to services for male circumcision, Sexually-Transmitted Infections (STIs), HIV counselling and testing, and other sexual and reproductive health services.
IV. Involve community members in open dialogue with youth to directly address the drivers of the epidemic, including partner reduction, harmful cultural practices, cross-generational and transactional sex, and the need for normative change around specific risk factors for young people.
V. Challenge gender norms, including addressing the risks of men having sex with men (MSM) and the vulnerability of young girls and women.

Core Strategy 1.3: Strengthen and scale-up male circumcision services as part of the national comprehensive prevention package and as part of comprehensive male reproductive health services.

Indicative Interventions

I. Provide rights-based male circumcision (MC) within a context of comprehensive male sexual and reproductive health services, in order to promote understanding of the partial protection MC confers and address potential dis-inhibition. MC services should include provider-

initiated HIV counselling and testing and linkages to HIV care and treatment for clients found to be HIV-infected.

II. Develop and implement MC policy statement and guidelines. These should consider both sexually active and inactive adults and youth, for sort-term results, and children and neo-natal infants for long term impact.
III. Build institutional and human capacity to provide quality MC services.
IV. Strengthen and scale-up provision of MC services (education, sexual and reproductive health counselling and HIV testing, clinical services, including STI screening, and condom distribution).
V. Strengthen the national procurement and logistics system for MC commodities and supplies.
VI. Develop and distribute age specific IEC/BCC information materials for male circumcision including public education campaigns to explain the risks and benefits of MC and to place circumcision within the larger prevention and male reproductive health contexts. This should also address myths and mis-information on MC.
VII. Conduct more research on the social context and acceptability of MC among both Zambian men and women, and consult with traditional leaders and community groups on the cultural acceptability of MC.
VIII. Provide targeted services to populations and age groups likely to experience high HIV incidence in the near future, e.g., young adult males and military recruits, but also plan for the long term by integrating neonatal male circumcision services into MCH.
IX. Engage traditional circumcisers, initiators and traditional leaders with a view to improve the safety of current practices, including infection control, and to change post-circumcision cultural practices and teaching about male sexual privilege that contributes to HIV transmission.
X. Integrate MC indicators in the current NASF and Health Management Information System (HMIS) monitoring and evaluation frameworks.
XI. Develop and implement quality assurance interventions for MC programmes.

Core Strategy 1.4: Make affordable quality male and female condoms widely acceptable, available and accessible throughout the country

Indicative Interventions

I. Make both male and female condoms widely available and easily accessible through a range of public and private outlets, including both subsidised social marketing and free distribution to meet the needs of different populations including sexually active youths
II. Build partnership among stakeholders to ensure an adequate supply of condoms, especially female condoms, and to strengthen the supply chain to ensure uninterrupted supplies at all types of outlets, especially in rural and hard-to-reach areas.
III. Develop and implement mass media campaigns that promote condom use and increase demand for public sector condoms, and support high profile, ongoing, non-brand specific, national and community communication to address misinformation about condoms and the distrust people have about their effectiveness.

IV. Standardise messages around condom use and benefits/failures.
V. Strengthen the national procurement and logistics system for female and male condoms and distribution points.
VI. Include the female condom on the Ministry of Health's essential drug list.
VII. Provide intensified risk reduction counselling for PLHA and discordant couples, linked to reliable sources of accessible and affordable condom supplies and other sexual and reproductive services.
VIII. Promote innovative mechanisms for effective condom programming. This entails creating linkages and collaboration amongst partners.
IX. Launch a high visibility, multi-faceted initiative to promote the use of female condoms, and through training, empower public and private service providers to provide comprehensive and quality prevention services.
X. Develop and implement an evidence-based comprehensive condom programming strategy with full participation of all stakeholders.
XI. Develop and implement deliberate strategies to provide free condoms to health facilities and community-based organisations (CBOs), especially in rural and hard-to-reach areas.
XII. Regularly monitor accessibility to both male and female condoms.

Core Strategy 1.5: Strengthen and scale-up activities on prevention and management of sexually-transmitted infections

Indicative Interventions

I. Strengthen and scale-up STI services in public and private health facilities.
II. Strengthen links with school health services and integrate family planning (FP), STI & HIV and AIDS services.
III. Develop BCC and social change communication (SCC) strategies to address issues of safer behaviours, including partner reduction and condom use, through behaviour change communication to reduce the incidence of STIs.
IV. Integrate HIV and STI services, including cross-referral for HIV testing and counselling of STI and TB patients.
V. Strengthen prevention, management and treatment of STIs by engaging populations involved in high-risk behaviours, such as commercial sex workers and mobile populations; integrate STI management in mobile health units, provide a comprehensive package of services, including: prompt and correct diagnosis and treatment of STIs, safer-sex counselling, condom promotion, counselling and routine offer of testing for HIV, counselling for possible HIV acute infection, partner notification and treatment, and reduction in multiple and concurrent sexual partners.
VI. Provide diagnosis and treatment of STIs as a routine part of preventive care for people living with HIV.

Core Strategy 1.6: Address the role of alcohol and substance abuse in HIV transmission through a comprehensive response that combines individual, community and environmental approaches

Indicative Interventions

I. Strengthen stakeholder involvement in the finalisation and adoption of the alcohol policy, e.g., Drug Enforcement Commission (DEC), Ministry of Health (MOH), National HIV/AIDS/STI/TB Council (NAC), Ministry of Education (MOE), concerned non-governmental organisations (NGOs) and the alcohol industry.
II. Conduct quantitative research on the prevalence of alcohol misuse, as well as qualitative research on the reasons for alcohol abuse, and the environmental factors associated with increased risk of infection.
III. Create a coalition to advocate at the highest policy levels for better enforcement of existing laws regulating the production, hours of operation for establishments, sale, taxation, licensing of bars, availability of alcohol, especially prohibition of alcohol sales to minors and long distance truck drivers.
IV. Encourage traditional, civic and religious leaders to take the lead in regulating alcohol in their areas, and in promoting prevention of alcohol misuse.
V. Develop mass media campaigns and messages (individual, community and national levels) to reduce alcohol-related HIV risk behaviours by utilising social and behaviour change communication and community mobilisation techniques. There is also the need to develop localised communication campaigns utilising social change communications strategies.
VI. Expand and strengthen existing support services for alcoholics and other substance abusers.
VII. Include primary prevention of alcohol and drug abuse in the Ministry of Education (MOE) curriculum at all levels. The Drug Enforcement Commission (DEC) should provide technical assistance in developing this component of the curriculum.
VIII. In risk reduction counselling with patrons of bars and other high-risk venues, address the role of alcohol and other substance use in risky behaviour, in particular, the impact of alcohol on individuals' decision making process (i.e. whether or not to have sex, and/or to use a condom, and to use condoms correctly and consistently) and its effect at family and community levels.
IX. Involve all stakeholders in propagating positive messages & support to those affected.
X. Develop and implement interventions for workplaces and the hospitality industry.
XI. Advocate for inclusion of all drugs as illegal substances under the Narcotic Drugs and Psychotropic Substance Act.
XII. Conduct further research on the prevalence of injection drug use in Zambia and include harm reduction strategies, such as needle exchange programmes, if merited.

Core Strategy 1.7: Integrate prevention interventions into other HIV and health services, with special attention to prevention with the positives (PWP)

Indicative Interventions

I. Incorporate prevention counselling for HIV infected persons into the counselling and testing, PMTCT and ART guidelines.
II. Work closely with CT and clinical care settings to identify discordant couples and provide ongoing prevention counselling and support.
III. Promote correct and consistent use of both female and male condoms among the PLHA.
IV. Scale-up a clearly defined, standardised, minimum preventive package in clinic and community-based settings for HIV-positive persons who know their status. All treatment and care sites should incorporate this package of PWP interventions. Appropriate job aids should be developed for health care providers to support taking this approach to scale.
V. Greater involvement of PLHA in development and implementation of PWP initiatives.
VI. Involve traditional, civic and religious leaders, traditional healers, medical health care providers, and lay counsellors to take the lead in HIV and PWP activities and messages.
VII. Develop and implement legal framework on wilful transmission of HIV and AIDS.
VIII. Develop and implement rights based approaches for HIV prevention for PLHA.
IX. Develop and implement interventions to encourage HIV partner notification and disclosure.

Core Strategy 1.8: Expand coverage of a core package of comprehensive prevention interventions for mobile populations and vulnerable groups (prisoners, persons living with disability and other high risk groups i.e injection drug users (IDU), men having sex with men (MSM) and sex workers))

Indicative Interventions

I. Involve umbrella bodies that support vulnerable groups such as the Zambia Federation of the Disabled (ZAFOD) for people with disabilities in the response, and use them as a link and entry point for all HIV prevention messages and design of specific interventions for vulnerable groups.
II. Support targeted outreach to provide comprehensive, tailored, risk reduction counselling for the disabled, incarcerated and mobile populations including: accurate information about condoms and where to obtain them; promotion of correct and consistent condom use; reduction in number of concurrent sexual partners; training in skills related to condom negotiation and realistic risk perception.
III. Scale-up quality user-friendly static and mobile HIV prevention services and information for the vulnerable groups such as disabled, incarcerated and other vulnerable groups.
IV. Integrate appropriate skills, messages, and communication channels

for HIV prevention services for people with disabilities in management of sexually-transmitted infections (STIs); HIV counselling and testing (CT), care and treatment; and reproductive health and family planning, other health-related services. These services should be provided on-site, or through strong referral systems to other facilities, and should be easily accessible to vulnerable populations.

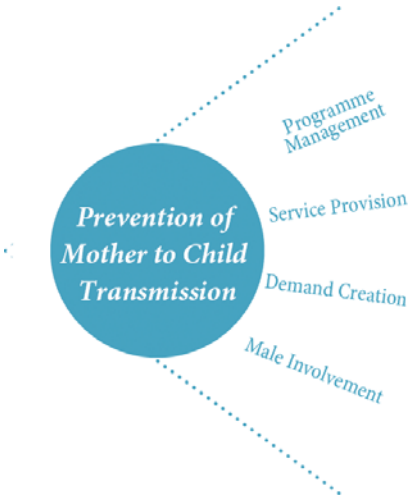
V. Strengthen partnerships and collaboration in the provision of services to vulnerable groups, such as women, orphans, vulnerable children and disabled persons, including linkages with income generating activities and other support organisations.

VI. Provide information, commodities and services for social and behaviour change to prisoners to address issues of MSM, non-sterile tattooing procedures, injecting drug messages and programming, including the provision of condoms, sterile tattooing instruments, and provision of bleach. Explore the appropriateness of harm reduction strategies, such as needle exchange.

VII. Develop prevention programmes for migrants, mobile workers, their families, and surrounding communities, particularly at sites with high numbers of migrants and mobile workers (cross-border areas, mining and agricultural sites). Programmes should address the environmental factors which influence the vulnerability of migrants including gender, social and cultural isolation, and separation from families.

VIII. Advocate for strategies for MSM and provide appropriate prevention interventions, such as condom distribution in prisons.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) OF HIV



The prevention of mother-to-child transmission (PMTCT) and paediatric HIV care programme in Zambia takes a comprehensive strategic approach to HIV prevention in infants based on the four-pronged WHO-promoted PMTCT approach: primary prevention of HIV among women of child bearing age; prevention of unwanted pregnancies among HIV positive women or women of unknown status; prevention of HIV transmission from infected mothers to their babies; and care and support to HIV infected families.

STRATEGIC OBJECTIVE 2	CORE STRATEGIES
Scale-up access to and use of PMTCT services	1. Strengthen programme management and co-ordination of PMTCT services at health facility and community levels. 2. Strengthen provision of comprehensive prevention of mother-to-child transmission and paediatric HIV prevention services, including primary prevention of HIV, primary prevention of unwanted pregnancy, prevention of transmission from mother to child, and strengthening referral networks for care, support and treatment at all levels of the health care system. 3. Increase demand and uptake for PMTCT services. 4. Increase male involvement in PMTCT services.

Core Strategy 2.1: Strengthen programme management and co-ordination of PMTCT services at health facility and community levels

Indicative Interventions

I. Strengthen human resources capacity at all levels of implementation by providing training and technical support to enhance provision of quality PMTCT services.
II. Strengthen health facilities to provide quality PMTCT services country wide, by improving infrastructure, equipment, supplies, and the national logistics management information system.
III. Expand integration of PMTCT with antenatal, family planning and other MCH related activities.
IV. Review and revise existing national policy and guidelines, and training curricula as needed, and update the national guidelines and paediatric HIV training curricula to include provider-initiated HIV testing for pregnant women and their children.

Core Strategy 2.2: Strengthen provision of comprehensive prevention of mother-to-child transmission and paediatric HIV prevention services, including primary prevention of HIV, primary prevention of unwanted pregnancy, prevention of transmission from mother to child, and strengthening referral networks for care, support and treatment at all levels of the health care system.

Indicative Interventions

I. Strengthen the linkages between PMTCT services and paediatric HIV treatment, care and support services.
II. Develop and implement a package for nutritional support for HIV positive pregnant and lactating women. Also, implement a follow-up schedule to improve feeding programme for HIV-exposed infants.

III. Scale-up provider-initiated testing based on best practice model to increase early diagnosis of HIV and to ensure follow-up care for HIV-exposed children.
IV. Implement the infant and young child feeding guidelines and support structures at community level to increase adherence to these guidelines.
V. Strengthen and scale-up the family-centred approach to increase access to prevention of mother-to-child transmission and paediatric HIV care services, including stigma reduction within the family and harnessing family support.
VI. Strengthen the use of under-five child health contacts to maximise follow-up of HIV-exposed infants and provide them with access to early infant diagnosis.
VII. Provide integrated management of childhood illness (IMCI) and paediatric HIV guidelines to first-level health care providers to improve referral systems for continuum of care.
VIII. Scale-up the provision of cotrimoxazole prophylaxis for all HIV-exposed and HIV-positive mothers and infants.
IX. Strengthen referral networks for mothers and children that require other HIV and AIDS services within and between health facilities, and between the community and health facilities.
X. Improve co-ordination and networking among civil society organisations, public and private institutions working in PMTCT and paediatric HIV treatment, care and support services.

Core Strategy 2.3: Increase demand and uptake for PMTCT Services

Indicative Interventions

I. Integrate the package of services for prevention of mother-to-child transmission (PMTCT) and paediatric HIV care services into the routine maternal and child health package.
II. Increase access to: CD4 testing services by mothers; PCR testing of children, by increasing number of testing centres and improving the dried blood spot sample referral system.
III. Establish and strengthen linkages with other services available at community level, such as nutrition, psycho-social support services and income generation activities.
IV. Train all health care providers to adopt the provider initiated testing “opt-out” approach.
V. Increase the number of prevention of mother-to-child transmission (PMTCT) sites in the country, by expanding PMTCT services to all health facilities offering antenatal care services, and scaling up mobile PMTCT services.
VI. Integrate PMTCT programmes component of ART, CT, focused antenatal care (FANC), STI management, safe delivery, post natal and TB at all PMTCT sites as well as across partners for effective referral and continuity of care.
VII. Promote community mobilisation and involvement in PMTCT and paediatric HIV care service provision by training and working through community-based workers and volunteers, lay counsellors, Traditional

Birth Attendants (TBAs), adherence supporters, and developing partnerships with community-based organisations.

VIII. Develop BCC strategies that will help mobilise communities to take up PMTCT services.

Core Strategy 2.4: Increase male involvement in PMTCT services

Indicative Interventions

I. Develop and implement behaviour change communication strategies and gender sensitive IEC materials to promote male involvement in PMTCT programmes.

II. Promote couple counselling and testing, condom promotion, STI screening and treatment services.

III. Integrate couple counselling and testing in family planning and male reproductive health services.

IV. Work with traditional and other community leaders, including organisations providing male involvement programmes and action groups to influence male participation in PMTCT services.

V. Train all health care providers and community volunteers in positive attitudes to support male participation in reproductive health services, including PMTCT.

HIV PREVENTION IN HEALTH CARE SETTINGS

STRATEGIC OBJECTIVE 3	CORE STRATEGIES
Integrate prevention in all aspects of care at all health care settings	1. Build institutional and human capacity for HIV prevention in the health care setting, with a focus on infection prevention and injection safety. 2. Strengthen the health care system by improving logistics management for the procurement and maintenance of equipment such as blood refrigerators, vehicles for mobile outreach, safety boxes, and incinerators. 3. Provide PEP for health care workers and victims of sexual abuse.

	4. Promote provision of safe blood and blood products 5. Promote community awareness and engagement/empowerment.

Core Strategy 3.1: Institutional and human capacity development for HIV prevention in the health care setting, with a focus on infection prevention and injection safety.

Indicative Interventions

I. Recruit and train more health care providers to address HIV prevention in health care setting.
II. Train health care providers in management of infectious materials, treatment of medical waste (e.g. proper processing of used instruments, disposal of medical waste), and logistics management.
III. Improve infrastructure to enhance prevention of medical transmission of HIV through renovations, and provision of equipment and supplies.
IV. Update guidelines on injection safety and infection control as needed.
V. Provide supportive supervision for quality assurance.

Core Strategy 3.2 Systems Strengthening

Indicative Interventions

I. Strengthen the health care system by improving logistics management for the procurement and maintenance of equipment such as blood refrigerators, vehicles for mobile outreach, safety boxes, and incinerators.
II. Strengthen collaboration between public and private health systems for the improved access, through mobile outreach and blood services.
III. Improve the referral systems between the health facilities and communities to enhance HIV prevention in the health care setting, such as blood transfusion services.

Core Strategy 3.3: Provide PEP for health care workers and victims of sexual abuse

Indicative Interventions

I. Make PEP available to health care workers and victims of sexual violence (abuse and/or assault) at all levels of the health care system, including public, private and mission hospital by end of 2010.
II. Print and distribute current PEP IEC materials to all health care facilities in appropriate languages.
III. Develop and distribute languages, age and gender sensitive/appropriate IEC materials on PEP.
IV. Train health care providers in provision of PEP services, including routine CT.
V. Promote development of workplace policies and implementation of workplace programme for health workers in public and private health facilities.

Core Strategy 3.4 Blood Safety and Blood Products

Indicative Interventions

I. Expand coverage of screening of blood and blood products.
II. Establish a strong referral link for blood donors who test positive for HIV, hepatitis and/or syphilis to the appropriate services. Establish close collaboration with ART centres in order to facilitate the referral of blood donors who test HIV positive for follow up care, treatment, and support.
III. Integrate blood donation information with IP/IS community mobilisation and education.
IV. Integrate HIV prevention messages at all points of health service provision.
V. Train health care providers in blood safety.
VI. Improve infrastructure to enhance prevention of medical transmission of HIV through renovations where necessary, and provision of equipment and supplies.

Core Strategy 3.5 Community Engagement and Empowerment

Indicative Interventions

I. Expand training and support to all traditional and religious leaders and other local opinion leaders, who are sources of moral authority in their communities. These leaders should be trained and supported to stimulate community dialogue about blood and advocate for safer low risk behaviours. The focus should be on changing community perception regarding blood donation to further reduce on HIV infection.
II. Provide continuing support to these leaders in discouraging traditional cultural practices that increase HIV risk, while reinforcing cultural practices that are protective.
III. Expand mechanisms at the provincial and district level to get small amounts of funding to informal community groups (chiefs and headmen, faith-based leaders, etc.), who can serve as catalysts in mobilizing communities and supporting grass-roots initiatives to promote empowerment and behavioural change.

COUNSELLING AND TESTING

STRATEGIC OBJECTIVE 4	INDICATIVE CORE STRATEGIES
Scale-up access to and use of CT services	1. Build institutional and human resources capacity to provide routine quality CT services including procurement and logistics management. 2. Scale-up access to CT services. 3. Promote community mobilisation and involvement in the promotion and delivery of CT services. 4. Conduct targeted BCC/IEC interventions to increase the demand for CT.

Core strategy 4.1: Build institutional and human resources capacity to provide quality CT services

Indicative Interventions

I. Improve infrastructure for provision of quality routine CT services by building new structures within the health facilities, refurbishing and rehabilitating existing structures including certification of CT sites.
II. Train, retrain and retain health care providers and community volunteers, such as youth counsellors, lay counsellors, to provide static and mobile CT services to focus on counselling for prevention.
III. Engage and train traditional leaders, traditional initiators, religious leaders and other community volunteers in the family-centred approach, including couple, child and general counselling, to promote HIV-testing.
IV. Scale-up training for health care providers and lay counsellors in child and youth counselling, including rapid HIV testing.
V. Adopt educational and community development satellite approaches (schools, community centres and halls) to role out the training in CT, to include more lay counsellors.

VI. Strengthen the national logistic management system and ensure timely forecasting, quantification, procurement and distribution of HIV-test kits.
VII. Review CT training manuals for health care providers and community volunteers.
VIII. Train and retrain health care workers and community counsellors and peer-educators/volunteers in the use of national and international standards and guidelines for routine CT.
IX. Disseminate standard operational procedures, guidelines and protocols for quality routine CT services, including monitoring their use.
X. Strengthen monitoring and evaluation systems at all levels, including reporting for CT services in both public and private sectors.

Core strategy 4.2: Scale-up access to CT services

Indicative Interventions

I. Expand both static and mobile CT services throughout the country especially in rural and hard-to-reach areas.
II. Integrate routine CT with other services such as STI, MCH, TB, and in-patient and out-patient services.
III. Develop and distribute BCC/SCC materials.
IV. Scaling-up peer-education, role modelling, and psychosocial counselling.
V. Integrate preventive counselling for both positive and negative clients.
VI. Scale-up paediatric counselling facilities and develop CT guidelines and protocols for children.
VII. Implement quality assurance and quality control guidelines for CT.
VIII. Strengthen referral system between community and facility-based activities.
IX. Promote family-based CT approaches with emphasis on couple counselling, disclosure and partner notification.
X. Develop and scale-up community counselling or group health education CT techniques.
XI. Establish and scale-up youth and adolescent friendly CT services especially in rural and hard-to-reach areas, with a focus on interpersonal communication and counselling for prevention of HIV.

Core strategy 4.3: Community mobilisation for the promotion and delivery of CT services

Indicative Interventions

I. Develop and implement gender and culturally sensitive SCC/BCC strategies.
II. Involve community and religious leaders in community mobilisation and advocate for community involvement.
III. Engage private sector in community mobilisation.
IV. Establish and scale-up male action groups for promotion of access to CT services.
V. Strengthen NAC structures at local level to facilitate its co-ordination mechanism for CT services at community level.

Core Strategy 4.4: Conduct targeted SCC/BCC/IEC interventions to increase demand for CT

Indicative Interventions

I. Develop and distribute in appropriate languages (including local), age and gender sensitive and specific IEC materials on CT.
II. Develop, strengthen and implement community radio programmes on CT.
III. Strengthen interpersonal communication on CT.
IV. Develop and implement interventions for risk perception and reduction at facility and community levels.
V. Scale-up adult and youth SCC/BCC interventions for the promotion of CT, using best practice models.

CO-ORDINATION FRAMEWORK

The implementation and co-ordination of the strategy requires the support and cooperation at provincial, district and regional levels. The process also requires strengthening of capacity and skills in lead organisations including NAC, NGOs, FBOs and other implementing partners. This also includes working through the decentralised structures of NAC and the various partners who have decentralised structures. The capacity building efforts should ensure that organisations implementing HIV prevention programmes are equipped with necessary information and skills. This entails developing and using effective information, education, and communication, community mobilisation and behavioural change strategies. The approaches should also take cognisance of the most vulnerable groups that are exposed to high risks of infection.

Build capacity for effective prevention programming

Provision of technical leadership and coordination of implementing partners are hallmarks of strong national prevention programmes. There is a need to build capacity of various institutions, including government structures, NGOs, FBOs and CBOs, to lead the national response and to harmonize high quality HIV prevention communication and services at scale.

Research

In a context of limited resources it is necessary to continuously review and further prioritise certain components of this strategy. This requires timely, representative, relevant, accurate and reliable research data. Target population priorities should be based on consideration of epidemiological profiles, needs assessments, resource inventories and gap analysis. Prioritization within this strategy should be based on the potential impact of activities on the epidemiologically most at risk behaviours.

For example, the National HIV and AIDS Strategic Framework (NASF) 2006-2010 includes “Support development and participation in HIV vaccine clinical trials”. Unfortunately, recently, several international vaccine clinical trials were stopped prior to their planned completion, either for lack of efficacy or possible enhanced risk of HIV acquisition. The failure of many current promising candidates has led the vaccine field to return to basic scientific research in

order to identify alternative approaches to vaccine development. While this strategic document acknowledges the importance of vaccine development, it is not a major priority area. Similarly, injection drug use has not been identified as a major driver of the epidemic in Zambia. It is recognised that further research in this area is desirable, in the meantime, it is not justified as a priority strategy.

Quality Assurance

The quality and responsiveness of behavioural change interventions are critical to the effectiveness of prevention programmes in reducing HIV transmission. The focus has too often been on numbers reached rather than programme quality and impact (evidence-based interventions, established best practices, sufficient dose and intensity).

Quality assurance is especially important in community outreach activities, where maintaining clear and consistent prevention messages and quality assurance across a large number of partners remains a major challenge. Programmes should follow best practices, for example, to the extent feasible, prevention interventions should be based on behaviour change theory. In many instances, programmes can tap into existing standards and guidelines or other quality assurance resources for prevention programming.

Implementing partners often use a wide variety of curricula, materials, and approaches, not all of which meet quality standards, to target similar populations and outcomes, with consistent messages. Standardisation of similar approaches and more sharing of quality programme tools should be encouraged, together with capacity building in how to manage quality in such areas as skills-based HIV education for young people, community drama and workplace programmes.

Financing the strategy and national ownership

The allocation of resources to prevention interventions should closely follow the profile of the epidemic, especially with respect to the modes of transmission, age and geography. There is a need for saturation of coverage of areas with highest prevalence, such as the line of rail. It is also important to take into account the benefits of each intervention. In order to reduce overall HIV incidence, prevention programmes need sufficient resources to go to scale and achieve sufficient coverage to have population-level impact. The NAC will coordinate all efforts of stakeholders and cooperating partners in ensuring availability of adequate resources to effectively implement the strategy. Resource tracking mechanisms should be enhanced and well coordinated.

Monitoring and Evaluation

The goal of the national HIV and AIDS M&E framework is to guide data collection, analysis, use, and dissemination of information that enables the tracking of progress made in response to the National AIDS Strategic Framework (NASF). This enhances informed decision-making, advocacy, policy direction and better utilisation of resources and planning. There is also need to get accurate and complete data from the private sector on what they are doing which can be better integrated into the monitoring and evaluation system. The M&E directorate of NAC is charged with the task of co-ordinating all HIV and AIDS M&E initiatives in the country. The M & E for this strategy

will therefore be part of the already existing national M&E framework. In addition, documentation and dissemination of best practices has to be made an integral part of the monitoring system.

Gender-responsive monitoring and evaluation should also be enhanced. Traditionally, the monitoring mechanisms have been gender-blind. Progress towards policy, programme and project objectiveness for men and women can only be understood if monitoring mechanisms are gender-sensitive. Therefore, NAC should monitor policies, programmes and projects designed to implement interventions that address gender inequalities and promote equal outcomes for men and women from a gender perspective. Gender-responsive monitoring and evaluation should include gender-specific indicators to ensure that they measure the progress towards programme/project objectives to benefit men and women, and to check that gender disparities are not being made worse by the intervention but rather progress should be made towards gender equality. At the end, gender-responsive evaluation should be undertaken, to ensure that the policy intervention, programme or project has achieved its objectives by measuring the impact of the initiatives.

The measurable objectives to be monitored are:

1. Percent increase of young people (aged 15-24, male and females) with correct information on the prevention of sexual transmission of HIV and who reject major myths and misconceptions, from 35% in 2007 to 68.4% in 2010.
2. Percent increase of HIV+ pregnant women on ART prophylaxis to reduce MTCT from 29.7% in 2006 to 80% in 2010.
3. Percent increase among women and men (aged 15-49) who receive and HIV test in the last 12 months and know their results from 154.% in 2007 to 20% in 2010.
4. Basic HIV prevention package for health care settings integrated in 80% of the 265 urban health centres and 70% of the 1029 rural health centres by 2010 (to be reviewed).

CONCLUSION

This strategy document has identified a number of key factors that are driving the pandemic in the country, especially: multiple and concurrent sexual partnerships with low condom use, low rates of male circumcision; alcohol and drug abuse; harmful cultural beliefs and practices; stigma and discrimination; gender-based and sexual violence; low risk perceptions; high population mobility; high sexually-transmitted infections; and poverty.

A number of gaps and challenges in scaling-up HIV prevention interventions have been identified, analysed and considered in this strategy. Key priority areas for the next five years have also been stipulated. It is, therefore, incumbent upon government to provide effective leadership, strong commitment and political will to ensure that all stakeholders take ownership and buy into this strategy.

APPENDIX 1: STRATEGY DEVELOPMENT PROCESS

This HIV Prevention Strategy is a collaborative effort of stakeholders in the multi-sectoral response to HIV and AIDS. In 2007, NAC, with the support of co-operating partners, held stakeholders' meetings in Southern, Northern and Central provinces to find out the drivers of the HIV epidemic in those parts of the country. These provincial meetings were followed by a national consultative meeting in Lusaka, which also looked at the drivers of the epidemic, as well as the gaps in prevention interventions. Key informants and direct observations provided insights to the document.

Between 2007 and 2008, international and local consultants were engaged to conduct a literature review of the data in Zambia and the SADC region on prevention to inform the development of the HIV prevention Strategy. In April 2008, provincial consultative meetings were held and field visits conducted in Eastern, Western, Copperbelt, Luapula and North-western provinces to validate the existing evidence and to find out the drivers of the epidemic in those provinces. Service delivery areas like rural health centres and hospitals were also visited to identify the challenges in delivery of prevention services. Different stakeholders were also consulted in Lusaka province to determine the same. Those consulted included traditional and religious leaders, the Drug Enforcement Commission, the Prisons AIDS Advisory Group, the Non-Governmental Organisations Coordinating Committee (NGOCC) and International and Local NGOs.

The literature review that was conducted, during and after the consultations, included the National HIV and AIDS Strategic Framework (NASF) 2006 – 2010, the National HIV/AIDS/STI/TB Monitoring and Evaluation Plan and the draft SADC Strategic Action Plan for the Universal Access to HIV prevention. Others were the Rapid Consultancy Report on HIV epidemic drivers in Zambia, the report on the SADC Expert Think Tank meeting on HIV prevention in high prevalence countries in Southern Africa, Zambia Sexual Behaviour Surveys: 1998, 2000, 2003 and 2005, the 2001/2 and 2007 Zambia Demographic Health Survey, The Mid-Term Review report of the NASF, the Modes of Transmission report, draft report on the epidemiological synthesis study and the Interim Report for Girls forum for four provinces in Zambia.

The international and local consultants, working closely with the NAC Prevention Theme Group, drafted the Strategy. The draft Strategy was circulated to all stakeholders in the country for comments and input. In addition, the revised Strategy went through a two-day consensus building meeting with stakeholders from all provinces to further refine and consolidate it.

APPENDIX 2: PREVENTION STRATEGY LOGICAL FRAMEWORK

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	% of adults aged 15-49 who are HIV infected	Prevent sexual transmission of HIV	% of 15-19 years olds who report being sexually active median age at first sex	Behaviour change communication (bcc) mass media	12 million	5 million	7 million	# HIV and aids IEC materials broadcasted or distributed (radio & TV programmes/new spaper	Behaviour change communication , Condom promotion, and life-skills education. .	unit cost of mass media @ $489,565 per campaign running for 3 months (research & development =$150,000 promotion and dissemination=$120,000 production cost/25 min episode prime time=$30,000 transportation and delivery costs= $190,000)
	% of married partner 15-49 who are HIV infected		% of married respondents who report at least 2 sexual non regular partners in the past 12 months	address multiple and concurrent sexual partners (MCP) work-place-based education and services				# HIV and aids IEC materials broadcasted or distributed (radio & TV programmes/new spaper	Behaviour change communication	
	% of pregnant women aged 15-19 who are HIV infected		% of health facilities providing PMTCT services.	Strengthen programme management co-ordination of PMTCT services at health community levels. increase demand and uptake for PMTCT increase male involvement	30,000	10.000	2.4 million	# of professional providers trained in the provision of PMTCT services and number of community providers trained to provide PMTCT services	Training on PMTCT services.	

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	% of 15-24 year olds who are HIV positive	Prevent sexual transmission of HIV	% school children aged 10-18 who report receiving life-skills education in school	Scale-up evidence based prevention for young people. Strengthen and scale-up activities on prevention and management of STIs. Make affordable quality male and female condoms available and accessible to youth	3 million	900,000	2.1 million	# of young people reached by life-skills based HIV and aids education in schools	Life-skill education programmes and school based interventions	Cost per youth in school $35
	% of 15-24 year olds who are HIV positive		% of 15-24 years olds who both correctly identify ways of preventing sexual transmission of HIV reject major misconceptions of HIV transmission	Scale-up evidence based prevention for young people. Strengthen and scale-up activities on prevention and management of STIs				# of young people reached by life-skills based HIV and aids education in schools	Life- skill education programmes and school based interventions and condom use	
	% of 15-49 year olds who are HIV positive		% of 15-49 years olds using condoms during the last sexual act with non regular sexual partner	Make affordable quality male and female condoms available and accessible to people	200 million	40 million	160 million	# of male and female condoms available for sale through the private sector	Behaviour change communication and condom promotion	Cost distributed freely is $0.55. Cost for social marketing is @ $0.6 per condom.
				Condoms-female	2 million	300,000	1.7 million	# of male and female condoms available for distribution free of charge		

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	% of facilities with observed STI treatment protocol	Prevent sexual transmission of HIV	% of women and men with STIs health care facilities who are appropriately diagnosed, treated and counselled according to national guidance	Strengthen and scale-up activities on prevention and management of sexually-transmitted infections	2 million	200,000	1.8 million	600,000 clients of patients with STIs receive treatment according to national guidelines	Strengthen and scale-up of STI services in public and private health facilities; Develop BCC and SCC strategies; Integrate HIV & STI services	cost of drugs
	% of facilities with observed STI treatment protocol		% of facilities with observed STI treatment protocols	Strengthen and scale-up activities on prevention and management of sexually-transmitted infections	2 million	200,000	1.8 mil	health facilities that offer STI diagnosis, treatment and counselling in line with national guidance	Provide diagnosis and treatment of STIs	cost per CSW targeted is $15.83
	% of facilities supporting services to vulnerable groups		% of facilities offering services to vulnerable groups	Expand coverage of a core package of comprehensive prevention interventions for vulnerable groups (prisoners, persons living with disability and other vulnerable groups).	1 million	300,000	700,000	# of most at risk populations reached (labour migrants, IDU, MSM and sex workers)	Outreach activities integrate appropriate skills, messages and communication channels	refugee care for a year is $650

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	number of facilities offering mc services	Prevent sexual transmission of HIV	number of people undergone mc services	Strengthen and scale-up male circumcision (mc) services as part of the national comprehensive prevention package and in the context of comprehensive male reproductive health services				•strengthen health services to increase safe access •full adherence to medical ethics & human rights	Develop and implement MC policy and guidelines. develop and distribute IEC materials provide mc services	
	Number of people counselled for alcohol abuse		number of health providers trained to provide counsel on alcohol abuse	Address the role of alcohol and substance abuse in HIV transmission through a comprehensive response that combines individual, community and environmental approaches				Number of persons counselled on alcohol and other substance abuse	Develop BCC campaign expand and strengthen existing support services for alcoholics and substance abusers.	
	Number of HIV positive people counselled to prevent infection		Number of health providers trained to provide counsel on the prevention of positives	Integrate prevention interventions with other HIV and health care services, with special attention to prevention with positives.				Number of HIV positive people provided with counselling services	Incorporate prevention counselling for HIV infected persons into counselling and testing services scale-up standardised minimum prevention package	

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	% of infants born to HIV infected mothers who become infected	prevent mother to child transmission	% of HIV positive pregnant women receiving complete course of ARV prophylaxis to reduce MTCT	Strengthen programme management and co-ordination of PMTCT services at health facility and community levels				Pregnant women who were tested for HIV and know their result	Strengthen human resources capacity at all levels of implementation by providing training and technical support services	
			Number of HIV+ pregnant women receiving complete course of ARV prophylaxis	Expand integration of PMTCT with antenatal, family planning and other MCH related activities	1 million for FP services	600,000 for FP services	400,000	Pregnant women who were tested for HIV and know their result	Strengthen health facilities to provide quality PMTCT services	strengthening delivery services to undertake regimen for woman testing + is $13.70. cost per case is $54.93 .
			number of facilities offering PMTCT services	Strengthen provision of comprehensive prevention of mother-to-child transmission and paediatric HIV prevention services, including strengthening referral networks for care, support and treatment at all levels of the health care system	500,000 screened 100,000 HIV+	40,000	460,000	HIV infected pregnant women who received ARVs to reduce the risk of MTC	Expand integration of PMTCT with other health services	
	% of HIV positive pregnant women receiving complete course of ARVs	Scale-up access to and use of PMTCT services	Number of HIV exposed infants seen in the first one month life for check up					infants born to HIV infected women who received an HIV test within 12 months	Increase the number of prevention of PMTCT sites in the country	

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
	% of HIV positive pregnant women receiving complete course of ARVs	Scale-up access to and use of PMTCT services	Number of HIV exposed infants receiving co-trimoxazole prophylaxis	social protection of children		40,000	460,000	Infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth	Promote community mobilisation involvement in PMTCT services.	cost per woman of six months of formula milk @$50.
				Increase male involvement in PMTCT services		40,000	460,000	HIV+ pregnant women with their couples receiving HIV services and support		
Reduce HIV incidence by 50% from baseline by 2014	% of health facilities providing post exposure prophesies	prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment	% of health facilities that apply national guidelines for blood screening, storage, distribution & transfusion	1.3 prevent HIV transmission through blood and blood product	100,000 blood units per year	70,000 units	30,000 units	Donated blood units screened for HIV in quality assured manner	Train health care providers to control general infectious materials . improve infrastructure to enhance prevention of medical transmission of HIV	cost per safe unit collected is between 14$ and $18.22 . we use 16$. cost of blood safety equipment=$306,000
	% of transfused blood units screed for HIV		% of transfused blood units screen for HIV	Promote provision of safe blood and blood products				Number of individuals trained in blood safety. number of services outlets carrying out blood safety activities	Expand coverage of screening of blood and blood products	

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014	% of health facilities providing HIV prevention services	integrate prevention of all aspects of care at all health care settings	% of health care providers trained in HIV prevention	Institutional and human capacity development for HIV prevention in the health care setting. recruit and train more health care workers to minimize HIV transmission in the health care setting	1 million	600,000	400,000	Individuals trained in injection safety	Train health care providers to control of HIV infection. improve infrastructure to enhance prevention of medical transmission	cost of training for 12 days is $2,033 per person (urban) $1,500 per person (rural) cost of pep kit for 28 days
				provide pep for health care workers and victims of sexual abuse				# of health facilities with PEP available		
	% of individuals counselled for HIV	scale-up access to and use of CT services	% of adult population (15-49 yrs) counselled and tested for HIV and received their test results	Build institutional and human resources capacity to provide routine quality ct services	6 million	800,000	5.2 mil	Women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Improve infrastructure for provision of routine ct services	cost per person counselled and tested is $4-$6=average $5
	% of HIV positive individuals counselled		% of facilities offering VCT services	Improve the national logistic management system for procurement and distribution of HIV test kits and other commodities				Number facilities providing VCT services	Strengthening the national logistic management system for HIV testing	psychosocial support is $3 per person
	% public and private facilities providing VCT services		% of population counselled and tested for HIV and received their test results	Conduct targeted BCC/IEC interventions to increase the demand for ct				Number of professional providers trained to provide VCT services	Train and retrain counsellors and peer educators	unit cost of training a psychosocial counsellor is $2,033

Goal	Impact Indicator	Strategic Objective	Outcome Indicators	Core Strategy	Annual need	Current Coverage	Annual Gap	Targets or Output Indicators	Key Interventions	Unit Costs
Reduce HIV incidence by 50% from baseline by 2014.	% of HIV positive people stigmatised against	mitigate stigma and discriminatio n against HIV	% of people living with HIV reporting to be stigmatised	Empowerment of people living with HIV (i.e. active involvement of PLHA in the project design				% of adult population reached with messages of stigma and discrimination against PLHA	Foster interaction between PLHIV and key audiences (i.e. contact strategies, part. education)	unit cost of awareness creation and general public sensitization through on reduction of stigma and discrimination against PLHA is $0.45
				A combination of social mobilisation, human rights and legal activism (turns "victims" into empowered groups engaged in self-determination and social change)					Updated education about HIV (i.e. how HIV is and isn't transmitted)	
	% of individuals provided with gender awareness	gender issues and human rights	% of individuals receiving gender awareness	Standard HIV and AIDS interventions				Number of individuals sensitised on gender awareness	Gender sensitive training	
	number of facilities providing capacity on gender issues		Number of facilities receiving capacity building on gender issues	Health systems strengthening				Number of health institutions providing training on gender awareness	Training on gender awareness	
	% of facilities providing support services		Number of individuals provided with support services	Creating a supportive environment				Number of institutions provided with support services	Provision of support services	
	% of institutions providing human rights awareness		Number of individuals trained on gender and human rights	Human rights				Number of human rights training sessions provided	Training on human rights	