Republic of Zambia

Ministry of Health

Scale-up Plan for HIV Care and Antiretroviral Therapy Services

2006 - 2008

Ndeke House

Lusaka

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Foreword

With over one million people living with HIV/AIDS and 20% of these eligible for ART, expanding access to treatment is one of the most pressing challenges in Zambia. Provision of treatment is essential to alleviate suffering and to mitigate the devastating impact of the epidemic. It also presents unprecedented opportunities for a more effective response by involving people living with HIV/AIDS, their families and communities in providing care and strengthening of HIV prevention through increased awareness. Increased awareness creates a demand for counselling and testing and reducing stigma and discrimination.

The challenges are great and multiple. Sustainable financing is essential. Drug procurement, storage, distribution and regulatory mechanisms must equally be strengthened. Health care workers must be trained, infrastructure improved, communities educated and diverse stakeholders mobilized to play their part.

This implementation plan provides details of how the nation will provide quality HIV care and ART services. The plan also addresses the collaboration needs among the key stakeholders including the government, civil society, private organizations and others providing antiretroviral treatment and care to people with HIV/AIDS.

The success of providing HIV/AIDS services to as many Zambians as possible lies in this well articulated implementation plan developed under a consultative process.

Dr. S. K. Miti
Permanent Secretary
Ministry of Health

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal
ARI	Acute Respiratory Infections
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
AZT	Zidovudine
BHCP	Basic Health Care Package
CARE	Cooperative for Assistance and Relief Everywhere
CBOH	Central Board of Health
CBOs	Community Based Organizations
CCZ	Christian Council of Zambia
CDC	U.S. Centers for Disease Control and Prevention
CD4	Cluster of Differentiation 4 (cell count)
CHAZ	Churches Health Association of Zambia
CHEP	Copperbelt Health Education Project
CIDRZ	Centre for Infectious Disease Research in Zambia
CRS	Catholic Relief Services
CSO	Central Statistical Office
CTC	Counselling Testing and Care
DATF	District AIDS Task Force
DFID	Department for International Development
DHMT	District Health Management Team
DOTS	Directly Observed Treatment Strategy
EFZ	Evangelical Fellowship of Zambia
FBO	Faith Based Organisations
GDP	Gross Domestic Product
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GRZ	Government of the Republic of Zambia
HAART	Highly Active Anti-Retroviral Therapy
HIPC	Highly Indebted Poor Country Initiative
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Services and Systems Program
IEC	Information, Education and Communication
JHPIEGO	Johns Hopkins Program for Information and Education on Gynaecology and Obstetrics
JICA	Japan International Cooperation Agency
JSI/Deliver	John Snow Inc. /Deliver
KAP	Knowledge, Attitudes and Practices
KCM	Konkola Copper Mines
LDCs	Less Developed Countries
LMS	Logistics Management Systems
MAP	World Bank Multi-Country HIV/AIDS Program for Africa

MCZ	Medical Council of Zambia
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSF	Medecin sans Frontier
MTCT	Mother-to-Child Transmission of HIV
NAC	National Aids Council
NGOs	Non-Governmental Organizations
NHCs	Neighbourhood Health Committees
NARFs	National Aids Council Reporting Forms
NZP+	Network of Zambian People living with HIV
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PATF	Provincial AIDS Task Force
PEP	Post Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPPs	Public Private Partnerships
PRSP	Poverty Reduction Strategy Paper
PWAS	Public Welfare Assistance Scheme
SBS	Sexual Behaviour Survey
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
VAT	Value Added Tax
VCT	Voluntary Counseling and Testing
YWCA	Young Women Christian Association
ZAMSIF	Zambia Social Investment Fund
ZBCA	Zambia Business Coalition on AIDS
ZDHS	Zambia Demographic Health Survey
ZNAN	Zambia National Aids Network
ZPCT	Zambia HIV/AIDS Prevention, Care and Treatment (ZPCT) Partnership

Executive Summary

Scaling-up of HIV care and Antiretroviral Therapy (ART) services in Zambia for the period 2006-2008 will be based on the National HIV/AIDS/STI/TB Strategic Framework for 2006-2010. The previous 2004/5 plan contributed to comprehensive care and treatment of 51,764 people living with HIV/AIDS by December 2005. The current broad objective will aim to increase comprehensive care and treatment to 130,000 (37%) people in need of ART by December 2008. The goal of the National HIV/AIDS/STI/TB Strategic Framework for 2006-2010 is to prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2010. The ART scale-up programme will be implemented along nine main intervention strategies constituting eight previous ones and an added ninth pertaining to quality assurance of ART services. The evaluation undertaken for the implementation of the 2004/5 ART Implementation Plan guided the selection of both strategies and activities.

The plan will ensure widespread and timely distribution of policies and guidelines. MOH will develop and widely circulate guidelines on routine diagnostic testing and counselling as part of comprehensive HIV/AIDS care. While great strides have been made in the scale-up of ART in Zambia, the majority of children infected with HIV still do not have access to comprehensive HIV/AIDS care. This implementation plan will strengthen the capacity of health staff in Paediatric HIV/AIDS management and provision of affordable diagnostic facilities. The plan will focus on provision of technical support, training, transport and information materials to the community groups and greater involvement of PLWHA. It will guide community volunteers to provide outreach services for adherence support and treatment counselling.

The Logistics Management System (LMS) for all levels of care will be strengthened to meet the demands of HIV and ART services. Efforts will be made to improve the HIV and ART monitoring and evaluation system by instituting a national monitoring and evaluation system; national ARV drug resistance surveillance and pharmacovigilance systems as well as carrying out operations research to address specific ART scale-up issues. The MOH and the Medical Council of Zambia has taken initiatives to develop and establish an accreditation system for ART sites. The assessment will cover the public, NGO, FBO and private sectors. The MOH will also review existing Performance Assessment and Technical Support Supervisory tools for health facilities to include HIV/AIDS services.

1.0 Background

Globally, the HIV prevalence rate is believed to have peaked in the late 1990s and stabilized subsequently, notwithstanding increasing prevalence in a number of countries. Sub-Saharan Africa remains the worst affected region in the world. Across the region, rates of new HIV infections peaked in the late 1990s, and a few of its epidemics show recent declines, notably in Kenya, Zimbabwe and in urban areas of Burkina Faso. The prevalence in this region appears to be leveling off, albeit at exceptionally high levels in Southern Africa. Such apparent 'stabilization' of the epidemic reflects situations where the numbers of people being newly infected with HIV roughly match the numbers of people dying of AIDS-related illnesses. A little more than one-tenth of the world's population lives in sub-Saharan Africa, which is home to almost 64% of all people living with HIV (24.5 million) with two million of them being children under 15 years. The 2 million children infected with HIV in Sub-Saharan Africa represent 90% of world-wide infection of children under 15 years. An estimated 2.7 million people in the region became newly infected, while 2.0 million adults and children died of AIDS. There were some 12 million orphans living in sub-Saharan Africa in 2005[1].

Zambia is one of the most heavily affected countries in the region with unprecedented suffering and adverse effects on the population. A recent demographic and health survey reports that 16% of adults aged 15 to 49 years are HIV infected. In addition, the survey also shows that the HIV/AIDS prevalence varies across the country. 25-35% of the urban population and 8 – 16% of the rural population age 15 to 49 years respectively being HIV infected. It is estimated that close to one million Zambians are living with HIV/AIDS with approximately 200,000 PLWHA needing immediate ART[2].

1.1 Current status of HIV/AIDS care and treatment

The Zambian Government is highly committed to addressing the HIV/AIDS epidemic. It has put in place a number of national support structures, including a high level Cabinet Committee on HIV/AIDS, to provide policy direction and regularly report to Cabinet on HIV/AIDS issues. The National HIV/AIDS/STI/TB Council (NAC), established by an Act of Parliament in December 2002, coordinates the national multi-sectoral response. The Ministry of Health is responsible for the health sector response and among other things sets health policy related to HIV/AIDS. NAC has established National Technical Working Groups (TWGs). The Care and Treatment TWG composed of care and treatment technical experts from different stakeholders including the public, NGO, FBO and private sector provides technical guidance on care and treatment. The Ministry of Health, through the ART Committee works with the NAC TWG to strengthen ART policies and services.

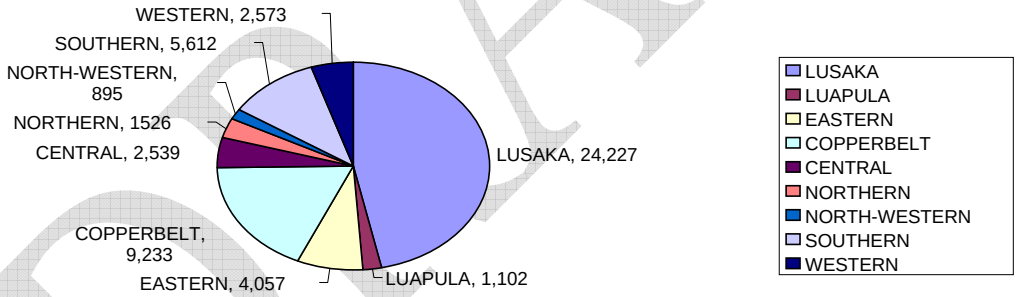
[1] *UNAIDS Report, 2006*
[2] *ZDHS 2001/2*

Through a number of initiatives (i.e. the Poverty reduction strategy program; Zambia Social Investment Fund; the Zambia National Response to AIDS) funded through the World Bank MAP Program, and the Global Fund, the country has been scaling up the health sector response to HIV/AIDS. The private sector introduced ART in 1995 and has till 2002 been the main provider of ART in Zambia. The ART programme has rolled out to 90% of the 72 districts in the country with 107 health facilities currently providing ARVs around the country.

In order to establish a national M&E system, the NAC activity reporting forms (NARFs) were developed and operationalized to capture HIV and AIDS programme data from provincial and district levels. These health information systems are functional in most districts.

With over one million people living with HIV/AIDS and 20% of these eligible for ART, expanding access to treatment is one of the most pressing challenges in Zambia. Provision of treatment is essential to alleviate suffering and to mitigate the devastating impact of the epidemic.

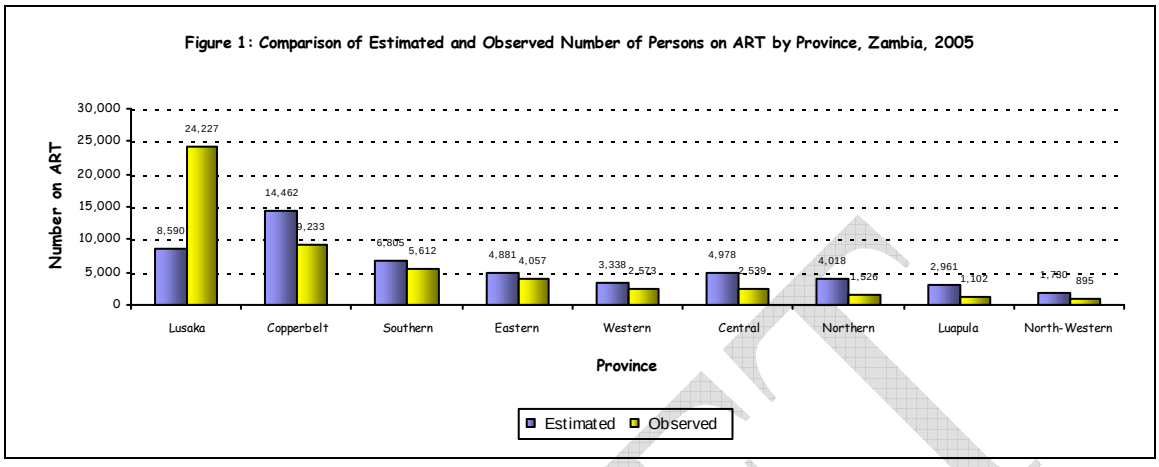
The total number of patients receiving ARVs around the country is 51,764 as at the end of December 2005[3].



The graph shows that Lusaka had more people on ART (24,227) than was estimated (8,590). However, the rest of the provinces were unable to meet their projected targets. Some of the possible reasons for this observation could be: Higher numbers of facilities offering HIV/AIDS services in Lusaka; higher prevalence of HIV, and the phased ART roll out meant that some districts initiated ART services later. For instance, by September 2005, of the seven districts in North-Western Province, three districts (Chavuma, Mufumbwe, and Zambezi) had not started offering ARVs because they had not yet received ARVs. The situation could be similar in other provinces. This also

[3] *MoH ART Report; May 2006*

means that, a lot of people could have traveled from other provinces to Lusaka in search of ART services.



1.2 Evaluation of the first National ART Implementation Plan

The first National ART plan (2004-2005) was developed in order to implement the 3 by 5 country program whose main objective was to contribute to comprehensive care and treatment of 100,000 people living with HIV/AIDS by December 2005. The plan was implemented along eight main intervention strategies namely:

- Develop a enabling environment for rapid ART scale-up.
- Expand the provision of ART services in all sectors in Zambia.
- Develop the national human resource capacity to deliver ART.
- Strengthen the infrastructure and laboratory capacity to support scaling up of ART.
- Strengthen the role of the community in the provision of ART services.
- Strengthen the procurement, storage and distribution of drugs, medical supplies and logistics for ART scale-up.
- Strengthen ART program monitoring, evaluation and research.
- Strengthen ART program management and coordination.

An evaluation[4] was carried out at the end of implementation by the MOH and its cooperating partners to provide sufficient information for developing the successor ART plan for the period 2006/8. Some of the key areas reviewed included ART data collection and reporting for monitoring and the reliability and validity of the current ART data reported; routine counseling and testing; procedures for referrals within the facility as well as to other service points outside of the facility; number and capacity of staff in post; and the infrastructure, space, logistics and commodities available. The evaluation covered all nine provinces, 49 districts (68% of the 72 districts in the country), and 92 facilities in

[4] *ART Program Evaluation Report, 2006*

all. Of the 92 facilities, 17 (18%) constituted the PHOs and DHMTs who were mainly concerned with coordination. Seventy-five facilities (82%) constituted ART service delivery facilities and included the central hospitals, general hospitals, district hospitals, health centres and special health facilities. The 75 sites represented 71% of the all ART sites in the country.

Table 1: Summary of Sample in the ART Program Evaluation 2005

Institution Classification	Coordination		1st Referral Level		2nd Referral Level	3rd Referral Level		
Institution Type	District Health Management Team (DHMT)	Provincial Health Office (PHO)	Health Centre (HC)	District Hospital (DH)	General Hospital (GH)	Central Hospital (CH)	Special Hospital (SH)	All institutions
No of Sample Sites	12	5	16	40	14	3	2	92
% of total sample sites	13%	5%	17%	43%	15%	3%	2%	100%

Notes:

Total no. of provinces visited was all 9 (or 100%)

Total no. of districts visited was 49 (68%) of 72 total districts

The sample comprised of: 18% coordination institutions and 82% ART service delivery sites
No. of ART service delivery site in the sample was 75 (or 72% of all 104 ART sites nation-wide, at time of evaluation)

The observations state that although the National ART Plan was well disseminated at central level, 84% of institutions visited and 97 % if individuals interviewed had not seen the plan. 99 % of interviewees had not seen the HIV/AIDS Policy. More than 97% of individuals interviewed had not seen the National ART Implementation plan 2004-2005. The feedback from some sites also reported a partial implementation of the free ARV policy due to difficulties encountered due to loss of revenue for sustaining activities. Previously, the cost sharing arrangements had been the source of the revenue.

Table 2: Summary of Observations on Policy and Planning.

Question in ART Evaluation (paraphrased)	Responses	No. of Responses	% Responses
Have a copy of the National ART Implementation Plan 2004-5?	Yes	14	16%
	No	74	84%
Know about the HIV/AIDS policy?	Yes	45	50%
	No	45	50%
Know about the Free ARV policy?	Yes	84	93%
	No	6	7%

According to the findings of the report only 12 % of the sample sites reported to have regular discussions from the national level and 20 % reported to have been engaged in coordinating the HIV/AIDS programmes at their jurisdiction level. 45 % of the facilities reported not having a forum/mechanism for sharing information on HIV and ART work with other partners. This is despite the fact that 58 % of the sites reviewed knew there was a coordinating body at the different implementation.

Table 3: Summary of Observations on Coordination

Question in ART Evaluation (paraphrased)	Responses	No. of Responses	% Responses
Regular discussions with the National level ART coordinating bodies?	Yes	10	12%
	No	73	88%
Coordinating the work of the various organizations working on HIV/ART?	Yes	16	20%
	No	64	80%
Forum/ mechanism for sharing information on HIV/ART work with other partners?	Yes	46	55%
	No	37	45%
Know is there is a coordinating body at the different levels of HIV/ART implementation?	Yes	41	58%
	No	30	42%
Know of policy for linking the private sector component of ART to the public sector?	Yes	10	12%
	No	74	88%

The evaluation also observed a gap between the private/ public health care institutions in the implementation of ART. 90 % of the respondents were not aware of the policy direction for collaboration between the private and public sector for ART services. A considerable number of institutions were not aware if policies, guidelines or manuals existed for linking up the private sector ART to the public sector, for setting up workplace programs, and referrals or linking ART to other health programs.

In relation to scaling up access to treatment the findings of the evaluation reported on gaps in the several key aspects of ART services. One of the observations of the review highlighted the need to set realistic targets based on the regional situation and needs specific for a particular region. This emerged from discussions in the consultative meeting with stakeholders. Although HIV testing should be part of the standard package of care that patients presenting in health facilities and admitted in hospitals receive, however, only 33 % of the sample sites were reported to practice routine counselling and testing. A common definition and guidelines for routine counselling were also not provided. The evaluation mission report states that the most significant constraint in ART service delivery was severe shortage and high turnover of trained staff. The main reason being inadequate number of staff recruitment, insufficient re-training of the few staff in position and inadequate monetary and non monetary retention incentives, long working hours in ART sites, increased workload due to rapid increase in numbers of enrolments due to the free ARV policy. Only 30 % of respondent sites reported having staff retention schemes in place and 47 % of sites reported that training was inadequate given the high attrition of staff.

Table 4: Summary of Service Delivery, HR and Infrastructure

Question in ART Evaluation (paraphrased)	Responses	No. of Responses	% Responses
Routine testing in practice in the ART site?	Yes	29	33%
	No	58	67%
Been trained in HIV/ART service delivery?	Yes	76	94%
	No	5	6%
Staff retention measures in place to mitigate the attrition of trained staff?	Yes	25	30%
	No	59	70%
Provided with the minimal standards for infrastructure, laboratory, pharmacy and imaging facilities for delivering ART?	Yes	49	58%
	No	35	42%
Adequate space for providing ART services (testing and counselling, clinical care, pharmacy and laboratory services, etc)?	Yes	28	33%
	No	57	67%
Adequately equipped in terms of providing ART services including lab, pharmacy etc?	Yes	32	37%
	No	54	63%

According to the evaluation report, 58 % of the facilities participating in the review reported having minimum standards for infrastructure, laboratory, pharmacy and imaging. 38 % reported having adequate space for providing ART services while 37 % reported being inadequately equipped to provide laboratory and pharmacy services for ART. The main concern expressed by the respondents was the lack of a CD 4 count machine. MoH and other cooperating partners have made substantial contributions towards strengthening diagnostic support service facilities in selected ART sites. A laboratory capacity assessment covering space, equipment and reagent availability, human resource capacity, transport availability and road networks was conducted in ZPCT existing and planned ART sites. Based on assessment findings, laboratory refurbishment, staff training and mapping of equipment were completed. A specimen referral strategy was designed, and haematology, chemistry and CD4 machines were procured and placed strategically throughout the districts to allow for access to all ART sites. Motorcycles and Cooler boxes were also procured to transport specimens between facilities. Outlying facilities providing ART and PMTCT services have specific clinic days to draw blood for essential laboratory tests, and specimens are transported via motorcycles to hospitals with the laboratory equipment. The test results are sent back to the centres for patient management.

Sixty-five percent (65%) of the sampled ART sites reported having experienced stock outs in the previous year. Forty-two percent (42%) of these were imminent and the coping mechanism was to delay putting more people on ART at these sites. Moreover, facilities were required to travel to the national level to collect their supplies of drugs and commodities. This was time consuming and meant compromising service delivery. There was also no guarantee as to the amount of time they would need to spend to get the drugs supplies. Some of the stock out problems included drugs for Opportunistic Infections, Paediatric ARV formulations. Seventy-three percent (73%) of the ART sites reported stock out of commodities such as test kits and laboratory reagents. Staff from 92% of the facilities had been trained in commodity management but only 67% of the sites had well

established and functioning logistics management systems. Other constraints in drugs supplies include human resources shortage, lack of information technology equipment and training, lack of stationery and lack of storage space

Table 5: Summary of Supply Chain and Logistics Management System

Question in ART Evaluation (paraphrased)	Responses	No. of Responses	% Responses
Experienced stock outs of ARV drugs in the previous year?	Yes	55	65%
	No	30	35%
Experienced imminent stock outs which required you to delay provision of ARV drugs to eligible individuals?	Yes	29	42%
	No	40	58%
Experienced stock outs of medical commodities such as test kits and laboratory reagents in the previous year?	Yes	62	73%
	No	23	27%
Staff responsible for dispensing ARV drugs been trained in HIV/ART?	Yes	77	92%
	No	7	8%
Well established and functioning logistics management system that enables tracking the stock situation and forecasting drug & commodity requirements?	Yes	57	67%
	No	28	33%
Have support groups/NGOs/CBOs/FBOs working in partnerships in HIV/ART?	Yes	72	84%
	No	14	16%

The evaluation findings confirm the working partnerships already established between the facility staff and the community support groups in 84 % of the sampled ART sites. Hundreds of FBOs (e.g. Catholic Relief Services, YWCA, Christian Council of Zambia, and Evangelical Fellowship of Zambia) are in the frontline fighting HIV and AIDS, and other infectious diseases.

Numerous FBOs provide home-based and hospices care for the chronically ill with AIDS. The 2004 OVC Situation Analysis identified 538 FBOs/CBOs/NGOs providing care and support to OVCs. Faith-based health care facilities are almost exclusively in rural areas and make up 30% of the health care delivery system. Almost all FBO-administered facilities are co-ordinated by Churches Health Association of Zambia (CHAZ), and largely function in the same manner as public health facilities. Government provides CHAZ–administered facilities with a grant to enable them to serve hard-to-reach areas of the country.

2.0 SWOT Analysis for ART implementation

Strengths

- Availability of free ART Policy.
- Availability of Health Care providers trained in ART in the private sector
- ART targets (national and district) developed and disseminated.
- Ethical guidelines for prescribing ARVs by non-medical doctors finalized by MCZ and in use.
- Harmonization of ART information management systems among stakeholders
- Improved and increased sensitization on ART.
- Active participation of CBOS/NGOs and support groups of PLWHAs.
- Strong and efficient partnership created with local and international stakeholders.
- Increased coordination of ART partners by NAC and MOH.
- Increased linkages between health facilities and HBC.

Weaknesses

- Declaration of free ART services.
- Lack of health insurance cover for ART.
- Inadequate laboratory facilities/equipment including CD4 machines.
- Referral guidelines for community ART not finalized.
- Accreditation system for ART not developed.
- Inadequate physical infrastructure to support ART services.
- HR crisis, high staff attrition, and lack of ART trained health care providers.
- Delayed integration of ART information system into the HMIS.
- Weak logistic/procurement management system.
- Insufficient monetary incentives (such as overtime and hardship allowances) and non-monetary incentives (accommodation and transport).
- Insufficient guidance to ART implementation from central level.
- Weak community participation in the ART program.
- Insufficient guidelines for management of Paediatric ART.
- Insufficient manpower at the centre to implement ART.

Opportunities

- Availability of Rapid HIV testing by non-lab personnel
- Presence of Monitoring and Evaluation system – Following the 3 ones approach
- TB/HIV/STI services integrated in the health facilities
- Availability of additional funding – GFATM, PEPFAR, UN Agencies and other partners
- Implementation of HIV/AIDS workplace programmes.

Threats

- Shortage of human resources in the health sector.
- Programme “verticalism” (VCT, PMTCT, ART and TB).
- Segmented Logistics systems.
- Weak public/private sector partnership.
- Inadequate funding for sustaining & increasing access to ART.
- Inadequate logistic systems for ARVs and Test kits.
- Free ART policy might lead to a Demand/Supply mismatch if not well handled.
- Workload burden may lead to heath care worker burnout.
- Multiple partner reporting systems and formats.
- Stigma on HIV/AIDS among the general population and health workers.
- Inadequate infrastructure to house consultation, counselling rooms, laboratories, pharmacies.
- Roles and responsibilities of the DHMTs and DATFs (and perhaps the PATF and PHO) not clearly defined.
- Sustainability of the ART program not clearly documented.
- HIV/AIDS service delivery coordination weak.
- ART implementation is donor dependant.

3.0 Guiding Principles

The provision of ART in Zambia will be guided by the National HIV/AIDS/STI/TB Strategic Framework for 2006-2010, whose goal is to prevent, halt and begin to reverse the spread and impact of HIV/AIDS by 2010. All stakeholders will contribute to ensure that there is universal access (at least 80%) to antiretroviral treatment and preventive services. As outlined by the National HIV/AIDS/STI/TB strategic framework, ART will be part of the wider response to HIV/AIDS and will complement and build on the existing programmes. ART will particularly impact on the following areas:

1. It will reinforce prevention efforts through increased rates of counseling and testing for HIV.
2. The ART program will support the Prevention of Mother-To-Child-Transmission of HIV (PMTCT) through the concept of PMTCT plus.
3. The program will provide prophylaxis to people with accidental exposure to HIV.
4. By improving the quality and length of lives of the sub-population infected with HIV, the program will help in mitigating the socio-economic impact of HIV/AIDS.

In addition to the provisions of the HIV/AIDS/STI/TB strategic framework, the ART program will be implemented within the conceptual framework of Primary Health Care, with the following emphasis areas:

- The program will put great emphasis on **prevention** of HIV/AIDS through Information, Communication and Education (IEC) strategies, prompt treatment of opportunistic infections, including STIs, strengthening PMTCT and development of community support services, including counseling, adherence support groups, etc.

- The program will need to be effective in limiting the spread of HIV/AIDS, and in **mitigation** of its short, medium and long-term effects on the affected sub-population.

- The program will observe and promote **equity** in accessing of ART services. Every client will be offered a package of essential health services on the basis of nothing else, but need.

- The program will recognize the synergy inherent in a **multi-disciplinary** approach, and will therefore elaborate an overarching approach to include public-public and public-private partnerships.

- The program will encourage and support **community participation**.

- The program will be structured in such a way that it wins **universal acceptability** among users

- The program will borrow from the constitutional imperatives on the bill of rights that, every citizen has a right to good health and a legal duty of right of access to healthcare.

- To promote **sustainability**, the program will not constitute one off events, but will have continuous processes, a dedicated budget and adequately trained staff.

4.0 Goal, Objectives and Strategies of the ART program

The aim of the Zambia ART scale-up program is to reduce HIV-related morbidity and mortality through universal access to antiretroviral therapy for people living with advanced HIV infection so as to reduce the socio-economic impact of HIV/AIDS. The program's broad objective is to develop and implement a national ART program capable of providing services to 130,000 people living with HIV/AIDS by December 2008 that contributes to comprehensive care and treatment for people living with HIV/AIDS[5].

4.1 Strategic Goal

Prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2015

4.2 General Objective

To expand access to HIV prevention, care and support for 80% of people living with HIV and their families and/or caregivers by the end of 2008

4.3 Specific Objectives

- Provide HIV care to at least 1 million PLWHIV with their families (80% of people in need of such services) by the end of 2008
- Provide Opportunistic Infection (OI) prevention and treatment services to at least 240,000 PLWHIV (80% of people in need of such services) by the end of 2008
- Provide ART to at least 130,000 PLWHIV in need if ART (37% of people in need of ART) by the end 2008
- Provide improved prevention of HIV transmission in health care setting, confidential counseling and testing access to post exposure prophylaxis.

In line with theme No. 2 of the National HIV/AIDS/STI/TB Zambia AIDS Strategic Framework 2006- 2010, the ART scale-up programme will be implemented along nine main intervention strategies. The objectives constitute eight previous ones and an added ninth strategic objective pertaining to quality assurance of ART services:

1. Create an enabling legal/policy environment for rapid ART scale up nationwide

[5] *District targets for the ART programme in Zambia (2005-2006)*

2. Increase access to HIV care and ART services for eligible persons nationwide
3. Develop and implement strategies to strengthen human resource development and management in order to increase the number and capacity of health workers required to effectively deliver HIV care and ART services
4. Strengthen the health infrastructure, laboratory pharmacy and imaging capacity for accelerating HIV care and ART services
5. Strengthen the community partnerships and participation in HIV care and ART services
6. Strengthen the systems for procurement storage, distribution and logistics for HIV care and ART Services
7. Strengthen monitoring and evaluation systems including surveillance and operations research for HIV care and ART services
8. Strengthen program management and coordination for Health Sector HIV/AIDS prevention, care, treatment and support activities at all levels
9. Develop and strengthen national quality evaluation and accreditation systems for HIV care and ART services

4.4 Activity description by Strategic Objective

For each strategic objective main activities have been identified and finalized through the consultative meeting. The evaluation undertaken for the implementation of the previous ART Implementation Plan for 2004-2005 guided the selection of the activities.

4.4.1 Strategic Objective 1: Create an enabling legal/policy environment for rapid ART scale up.

The plan will support the MOH to develop and widely circulate guidelines on routine diagnostic testing and counselling as part of comprehensive HIV/AIDS care. The plan will support realistic target setting through provision of guidelines based on health care capacity, population size and disease burden. The plan will ensure widespread and timely distribution of policies and guidelines through:

- Dissemination of the policy and implementation guidelines.
- Development of partnerships with civil society Organizations and private sector.
- Sensitization of policy makers at all levels of implementation.

The plan will also put in place mechanisms for monitoring implementation of the polices with a particular focus on the free ART policy.

4.4.2 Strategic Objective 2: Increase access to ART services for eligible persons nationwide.

There is an urgent need to provide equitable HIV/ART services to the populations in need, with particular emphasis on children, women, minority groups and the indigent. The plan will support the MOH to develop and widely circulate guidelines on routine diagnostic testing and counselling as part of comprehensive HIV/AIDS care.

Reaching out to more infected people requires quick and efficient means of testing. The current shortage of trained laboratory technicians has been a major constraint in getting more people to be tested. The component will support the training of non-laboratory personnel and community members in using rapid HIV testing. Short courses on counselling and issues related to informed consent will also be organized for providers. The plan will also support capacity building of health staff as well as the community volunteers to provide outreach services for adherence support and treatment counselling.

There are several approaches to counselling and testing available in Zambia. An approach to be supported is the mobile outreach ART services. During these clinics, nurses and clinical officers are mentored to provide follow up of patients. ARVs dispensed are either transported from the hospitals or stored in the health centre depending on available infrastructure.

While great strides have been made in the scale-up of ART in Zambia, the majority of children infected with HIV still do not have access to comprehensive HIV/AIDS care. Significant obstacles to scaling up Paediatric care remain, including limited screening for HIV, lack of affordable simple diagnostic testing technologies, lack of human capacity, insufficient advocacy and understanding that ART is efficacious in children, limited experience with simplified standardized treatment guidelines, limited adherence support mechanisms and a lack of affordable practicable Paediatric antiretroviral (ARV) formulations. The implementation plan will strengthen the training of staff in Paediatric HIV/AIDS management and provision of affordable diagnostic facilities.

4.4.3 Strategic Objective 3: Develop and implement strategies to strengthen human resource development and management in order to increase the number and capacity of health workers required to effectively deliver HIV care and ART Service

Availability of adequate numbers of competent health workers to provide antiretroviral treatment is an essential factor to the successful implementation and scaling up of the programme to improve equity of access. ART services like other health services face enormous human resource challenges such as high attrition rates and absenteeism particularly due to HIV/AIDS among health workers and their families. The plan will focus on the following activities:

- Provision of guidance on the Human Resources Strategic plan to meet ART targets.
- Production of newly trained health professionals with competencies to deliver ART.
- Provision of all practicing health professionals with competencies in ART delivery.

- Recruitment, motivation and retention of health professionals.
- PEP for providers and other workplace based services.
- Training of non-healthcare providers (adherence supporters, peer educators, ART support groups and community leaders) to support ART delivery.
- Motivation and retention of non-health ART providers. One of the community strategies to be promoted in this plan is the provision of funds to setup self sustaining income generating activities (IGA) that will support the activities of community volunteers.

4.4.4 Strategic Objective 4: Strengthen the health infrastructure, laboratory, pharmacy and imaging capacity for accelerating HIV care and ART Services

In view of meeting diagnostic support needs for HIV and ART, attempts have been made to refurbish infrastructure, laboratory, pharmacy and imaging facilities in some health facilities in Zambia. The urgent requirement is to have a well defined national minimum standard for laboratory and other diagnostic services finalized and disseminated to Health facilities. This plan will ensure availability of guidelines to

- enable the Ministry of Health and Cooperating Partners adhere to national standards in carrying out the necessary refurbishment and strengthening of the pharmacy, imaging and laboratory facilities;
- assist provincial, districts and health facilities in planning and budgeting and setting priorities;
- specify the role of Cooperating partners to work within the minimum standards set by MOH.

The scale up of ART to Health Centres demands that laboratory services have to be provided at the same level or provision put in place to ensure testing is feasible at the earliest possible time at the next higher level. A reliable and dependable laboratory network for easy of specimen transfer is therefore necessary. It is not possible to equip every laboratory due to the high costs of equipment and reagents, therefore strategies must be developed to ensure equitable access to laboratory services (e.g. zoning of centres to one with improved facilities or resources, promoting mobile specimen delivery services, etc.

4.4.5 Strategic Objective 5: Strengthen the community partnerships and participation in HIV care and ART Service

Innovative partnerships between communities and health staff at the facility level are still informal and weak and, are not sustainable without proper support. It will be important to sustain and further strengthen this source of support for effectively scaling up ART services to the community level. The current ART Implementation Plan will focus on the following activities: provision of technical support, training, transport and information materials to the community groups and greater involvement with PLWHA. The Plan will also directly support the communities through monetary and non monetary incentives for their voluntary services. Documentation of successful models will be reviewed and scaled

up in areas where community participation is weak. Main interventions to be supported include:

- Strengthening of the national communications strategy based on the information needs of the community
- Provision of support to the media to adequately address ART issues
- Provision of tools to districts for capacity building of community support groups in ART
- Strengthening of community support to HIV services

Community groups are effective information agents within their own communities. However, it will be important to conduct a rapid assessment of the level of treatment awareness and ART information needs. Inevitably, the level of awareness and type of information required will vary across communities and geographical regions. Once the baseline for this is established necessary information will be made widely available through appropriate communication strategies and through local media such as community radio programmes. In this regard, the ART Plan will support the capacity of local media through trainings and provision of resource materials on HIV and ART.

Training tools and guidelines will be developed for various HIV activities such as VCT, condom distribution, HBC support and ART. ART site staff will be orientated and trained in the application of these tools, which will be widely disseminated to all facilities. In addition, the facilities will be supported to provide support supervision to community support groups in their outreach ART work.

4.4.6 Strategic Objective 6: Strengthen the systems for procurement, storage, distribution, and logistics for HIV care and ART Services

The Logistics Management System (LMS) for all levels of care will be strengthened to meet the demands of HIV and ART services. The plan will address the following:

- Strengthening of the pharmaceutical and laboratory management systems to ensure availability of drugs, commodities and other medical supplies for ART
- Ensuring availability and quality of drugs, nutrition supplements and other medical supplies
- Ensuring rational management of drugs and medical supplies

4.4.7 Strategic Objective 7: Strengthen Monitoring and Evaluation systems including surveillance and operations research for HIV care and ART Service

The Ministry of Health has a comprehensive monitoring and evaluation framework and plan that include a Health Management Information System (HMIS), programmatic systems (PMTCT, ART, VCT, TB, and Malaria), Financial and Administrative Management System (FAMS), and a newly developed Logistics Management

Information System (LMIS). Going forward, every effort will be made to ensure all patients (HIV and non-IV) have an electronic health record using the recently identified national patient-level tracking system. Patient-level data can be analyzed to satisfy nearly every indicator required for transfer to the HMIS. The plan will support national efforts to improve the HIV and ART monitoring and evaluation component of the national monitoring and evaluation system by:

- Instituting a national monitoring and evaluation system as a component of the National HIV/AIDS M&E system
- Putting in place national ARV drug resistance surveillance and pharmacovigilance systems
- Carrying out operations research to address specific ART scale-up issues

From 2006 to 2008, the MOH will engage all partners active in the provision of ART in a joint evaluation exercise. Data will be shared quarterly to share lessons learned and to develop solutions to gaps in quality identified. Special studies will be conducted on areas in need of in-depth investigation. Towards the end of the implementation period of the 2006/08 plan, the Ministry of Health in collaboration with the Cooperating Partners will conduct an evaluation of the ART program.

4.4.8 Strategic Objective 9: Develop and strengthen national quality evaluation and accreditation systems for HIV care and ART services

Rapid scaling up of ART programmes under the pressure for achieving quantitative targets is likely to compromise the quality of service. The MOH and the Medical Council of Zambia has taken initiatives to put in place quality control measures in collaboration with cooperating partners. The initiatives include the development and establishment of an accreditation system for ART sites, pharmacovigilance and HIV drug Resistance monitoring systems. The assessment will cover the public, NGO, FBO and private sectors. The MOH is also reviewing existing Performance Assessment and Technical Support and Supervisory tools for health facilities to include HIV/AIDS services. This plan will focus on the following interventions:

- Putting in place an efficient quality assurance system.
- Ensuring use of routine health information and patient-level data analyses.
- Accrediting public, NGO, FBO, and private-for-profit health facilities to provide ART.
- Certifying health care providers providing ART.
- Ensuring availability and quality of drugs, nutrition supplements, reagents and other medical supplies.
- Ensuring rational use of ART medicines and medical supplies.
- Putting in place national ARV drug resistance surveillance and pharmacovigilance systems.

4.4.9 Strategic Objective 8: Strengthen program management and coordination for Health Sector HIV/AIDS prevention, care, treatment and support activities at all levels

Management and Coordination of activities at all levels of implementation is crucial for the achievement of programme goals and outputs within the means of available resources. The plan will support this key component through:

- Building of the ART coordination teams (central, provincial and district)
- Strengthening the coordination and supervision of national ART programme
- Coordinating multilateral and bilateral technical assistance for ART scale up
- Mobilizing adequate local and international resources for ART service delivery

4.5 Costing, financing and resource mobilization

The Government of Zambia, the cooperating partners, the private and business communities will significantly meet the cost of implementing this plan. Implementation of this programme is going to cost approximately **US$ 348.8 million**. With the continuing decline in the price of ARV drugs and diagnostics it is expected that the unit cost of treatment will reduce over the period of time.

5.0 Institution arrangements for implementation of HIV care ART services

The Government of the Republic of Zambia (GRZ) through the National AIDS Council (NAC) has the overall responsibilities for coordinating all national HIV/AIDS/TB/STI activities as stipulated in the NAC act. NAC will undertake resource mobilisation as well as monitoring and evaluation of the programme. The MOH will be responsible for providing national leadership, implementation of policies, forging partnerships with key players, and coordination at national level. The MOH will also work closely with the National AIDS Council, Churches Health Association, Faculty of General Practitioners and Private Sector, Network of Zambian People Living with HIV/AIDS, Zambia National AIDS Network (ZNAN) and the different Cooperating Partners. The success of the implementation plan rests on these stakeholders recognising their role and embracing collaborative approaches. The Directorate of Clinical Care and Diagnostic Services of MOH through the National ART Programme Coordinator will provide the leadership through the implementation of effective systems and cooperation amongst stakeholders.

The Coordination at provincial level will be provided by the Provincial Health Office (PHO) whereas the District Health Management Team (DHMT) will coordinate activities at district level. The district level institutions include the hospitals, health centres, Faith Based Organisations (FBO), NGOs, and the private sector. The private sector will include private clinics and hospitals, private pharmacies and companies which provide health services to their employees requiring ART.

The Medical Council of Zambia (MCZ) will be responsible for accreditation of ART facilities as well as certification of health care providers of ART services.

Annex i: Logical Framework for the HIV Care and ART Services Plan 2006-2008

Strategic Goal

Prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2015

General Objective

To expand access to HIV prevention, care, treatment and support for 80% of People living with HIV (PLWHIV) and their families and/or caregivers by the end of 2008

Specific Objectives

Provide HIV care to at least 1 million PLWHIV together with their families (80% of people in need of such services) by the end of 2008

Provide OI prevention and treatment services to at least 240,000 PLWHIV (80% of people in need of such services) by the end of 2008

Provide ART to at least 110,000 PLWHIV in need of ART (37% of people in need of ART) by the end of 2008

Provide improved prevention of HIV transmission in health care setting, confidential counseling and testing, access to post exposure prophylaxis

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4												
Strategic Objective 1: Create an enabling legal/policy environment for HIV/AIDS care and ART services scale up nationwide																						
1.1	**Widely disseminate policy and implementation guidelines to public and private sector implementers and other stakeholders**	1.1.1	Disseminate the national comprehensive HIV/AIDS/STI/TB policy through appropriate means such as sensitization materials and orientation meetings at all levels										NAC and MOH	NAC	Approved HIV/AIDS policy disseminated to all provinces	Central level only	9 provinces by end of Q1: 2007	NAC	Budgeted in ZASF (2006-10)			0	185,728
		1.1.2	Advocate for policies that encourage local production of ARVs, in the context of the national HIV/AIDS/STI/TB policy										MOH and NAC	Pharmacy and Poisons Borad, GRZ, MCTI	# of advocacy meetings held	0	Quarterly HSC meetings (ongoing)		68,572	51,429	51,429	171,430	
		1.1.3	Conduct an evaluation of the impact of the free ARV policy										MOH	MOH and CPs	Evaluation of free ART service delivery done	0	1 study by end of Q2: 2007						
		1.1.4	Disseminate the national policy promoting the 4 models of HIV counseling and testing (Voluntary Counseling and Testing, Routine offer of HIV Testing, Diagnostic Counseling and Testing and Mandatory HIV screening)										MOH	MOH and CPs	National policy on 4 models disseminated	Central level only	9 provinces by end of Q1: 2007						
		1.1.5	Disseminate the HIV/AIDS Care and ART Services Implementation Plan										MOH	MOH and CPs	{Same indicator as in 1.1.1}	0	by end of Q4 2006		12,868	1,430	0	14,298	
		1.1.6	Develop and diserminate policy on rapid HIV testing by non-laboratory health staff										MOH	MOH and CPs	{Same indicator as in 1.1.1}	0	9 provinces by end of Q1: 2007		Cost covered in 1.1.2			0	
1.2	**Develop the public-private partnership to facilitate delivery of ART services by the public, NGO, FBO and private sectors**	1.2.1	Develop and implement operational guidelines for expanding government provision of subsidized ARVs to the for-profit private sector and NGOs										MOH	MOH and CPs	Operational guidelines for subsidizing ARVs disseminated	0	9 provinces by end of Q1: 2007		120,000	120,000	120,000	360,000	360,000
		1.2.2	Expand coverage of HIV/AIDS care and treatment through the various forms of health insurance and social security schemes										MOH		% of health insurance schemes covering HIV/AIDS care including ART	0	9 provinces by end of Q1: 2007						

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4												
Strategic Objective 2: Increase access to HIV care and ART services for eligible persons nationwide																						
2.1	**Expand the identification and recruitment of HIV infected people equitably for prevention, treatment, care and support services**	2.1.1	Institute appropriate routine and opt-out models of HIV counseling and testing in all in-patient and out-patient health facilities with each client point of contact and linked across health services (including ART, PMTCT, ANC, FP, MCH, TB, OPD, in-patient)											# of HIV testing done annually		50% by Dec 2006		44,384	11,096	11,096	66,576	66,576
		2.1.2	Expand use of rapid HIV testing by non-laboratory health staff and community at Provincial, District and Health Center level for the diagnosis of HIV infection												10%	30% increase annually		Costs covered under the various entry point programs			0	
2.2	**Increase number of service delivery centers to provide HIV prevention, treatment, care and support services**	2.2.1	identify and certify potential centres to deliver HIV prevention, treatment, care and support services including infrastructure, human resources, pharmacy and equipment capacity.											# of potential (pulbic, private, NGO, FBO, etc) centres identified	107	174 by end of Q4: 2008		10,865	10,865	10,865	32,596	80,596
		2.2.2	Set up HIV care and ART service delivery guidelines based on a mobile clinic approach to cover remote populations.											Guidelines formulated and circulated	5	20 every year		16,000	16,000	16,000	48,000	
2.3	**Build the capacity of ART centres to deliver quality prevention, treatment, care and support services**	2.3.1	Strengthen referral system (Hospital, health centres, community) for HIV care and ART services											# of ART centres with adequate referral systems according to set national guidelines; and % of patients referred who bring feedback to the refering facility	107	174 by end of Q4: 2008		Budgeted in NHSP 2006-2010			0	355,542
		2.3.2	Disseminate protocols and guidelines to facilitate the delivery of adult and paediatirc HIV care and ART services (including PMTCTplus and PEP) by health providers											% of ART centres providing adult ART services in line with national gudielines; % of ART centres providing paediatric ART services in line with national gudielines	107	by Dec 2006		48,000	0	0	48,000	
		2.3.3	Develop, disseminate and train health workers in the use of paediatric ART management guidelines and protocols											# of health workers trained in use of paediatric ART	0	25 every quarter		102,514	102,514	102,514	307,542	

Main Activities			Tasks and Subactivites	Timeframe								Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
				2006				2007				2008										
				Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4							2006	2007	2008	Budget by Activity	Budget by Strategy
Strategic Objective 3: Develop and implement strategies to strengthen human resource development and management in order to increase the number and capacity of health workers required to effectively deliver HIV care and ART Services																						
3.1	**Produce newly trained health professionals with competencies to deliver ART**	3.1.1	Integration, periodic review and update of HIV curricula for training institutions for use by students, lecturers and medical libraries									MOH and CPs	Training institutions, CPs	# of updated HIV curricula for training institutions	0	3 curricula by Dec 08	Training Institution curricula	120,000	0	0	120,000	8,731,140
		3.1.2	Conduct in-service training in HIV/AIDS for newly recruited health professionals prior to certification (in accordance with National certification guidelines)									MOH, training institutions, health facilities	Training institutions, health facilities	# of newly recruited health professionals undergone in-service training	700	1680 by Dec 2008	HRIS	2,870,380	2,870,380	2,870,380	8,611,140	
3.2	**Provide all practicing health professionals with competencies in ART delivery**	3.2.1	Periodically update the national ART training materials for health and non health ART providers in line with global guidelines and recommended procedures for ART delivery									MOH	MOH, Training Institutions, CPs			Annual update	MOH Training Unit	90,000	0	0	90,000	90,000
		3.2.2	Conduct institutionalized in-service training of ART health providers (doctors, clinical officers, nurses, lab scientists, pharmacists, pharmacy technicians and dispensers and other cadres)									MOH, CPs	MOH, Training Institutions, CPs	# of health providers trained	1700	2500 by 2008	HRIS					
3.3	**Recruit, motivate and retain health professionals**	3.3.1	Increase the number of health profesionals critical to the delivery of HIV/AIDS services in C and D districts (emergency recruitment)									MOH, CPs	MOH	# of health providers recruited	0	850	HRIS	Cost Borne in HRH plan (MOH 2005)			0	1,997,440
		3.3.2	Retain health profesionals critical to the delivery of HIV/AIDS services in C and D districts									MOH, CPs	MOH	% of health providers retained	48% (80)	78% (140)	HRIS	532,651	665,813	798,976	1,997,440	
3.4	**Train non-healthcare providers (adherence supporters, peer educators, ART support groups, community leaders) to support ART delivery**	3.4.1	Build TOT teams for training non-health ART providers in each district									PHOs	DHMTs	# of districts with capacity to train non-health workers	9 in Dec 05	72 by Dec 08		337,333	440,000	146,667	924,000	924,000
		3.4.2	Coordinate institutionalized training of non-health ART providers at district level									DHMTs	DHMTs and partners					Budgeted in 3.5.1			0	
3.5	**Motivate and retain non-health ART providers**	3.5.1	Provide performance-related honoraria (monetary and non-monetary) to non-health ART providers.									DHMTs	DHMTs and partners	% of ART service delivery centres providing performance-related support to non-health workers	0	41% by Dec 06, 56% by Dec 07	District Accounting System	818,950	1,118,565	1,118,565	3,056,080	3,056,080
		3.5.2	Support and supervise non-health ART providers									DHMTs and CPs	DHMTs and partners					Budegted in 8.2.4			0	

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4												
Strategic Objective 4: Strengthen the health infrastructure, laboratory, pharmacy and imaging capacity for accelerating HIV care and ART Services																						
4.1	**Build up the infrastructure, laboratory, pharmacy and imaging capacity of health facilities deliver HIV care and ART Services**	4.1.1	Finalize and disseminate the national minimum standards for infrastructure, laboratory, pharmacy and imaging facilities for the delivery of ART										MOH	MOH and CPs	Minimum Standards Guidelines received by all stakeholders	0	Dec 06		60,000	0	0	60,000	16,288,500
		4.1.2	Equip laboratories providing support to ART centres in line with set national minimum standards										MOH	MOH, CPs and ART facilities	# of ART service delivery centres with capacity to provide ART services in line with national minimum standars	60 (approx.) in Dec 05	by July 2007		1,566,000	2,610,000	1,044,000	5,220,000	
		4.1.3	Equip pharmacies of ART centers in line with set national minimal standards										MOH				by July 2007		645,750	1,076,250	430,500	2,152,500	
		4.1.4	Equip ART centres with X-Ray and ultrasound imaging facilities in line with set national minimum standards										MOH				100% by 2008		2,952,000	2,952,000	2,952,000	8,856,000	
Strategic Objective 5: Strengthen the community partnerships and participation in HIV care and ART Services																						
5.1	**Strengthen the national communications strategy based on the information needs of the community**	5.1.1	Finalize and disseminate the national community ART communications package										NAC, MOH	CPs, DHMTs, PHOs	% of adults aware of ART services		80% adults aware of ART services	ZDHS	60,000	0	0	60,000	2,100,000
		5.1.2	Conduct community anti-stigma campaigns										MOH	CPs, DHMTs, PHOs					40,000	40,000	40,000	120,000	
		5.1.3	Develop treatment awareness materials to include PMTCTplus and PEP and emphasis on Adherence										MOH	MOH, CPs, DHMTs and PHOs					120,000	0	0	120,000	
		5.1.4	Conduct treatment awareness education in the community										MOH						600,000	600,000	600,000	1,800,000	
5.2	**Provide support to the media to adequately address ART issues**	5.2.1	Foster media programming (national and community) that allows for formal and informal dialogue and debate on ART issues										MOH						120,000	120,000	120,000	360,000	360,000
5.3	**Provide tools to districts for capacity building of community support groups in ART**	5.3.1	Develop and disseminate frameworks/guidelines for districts to identify and strengthen ART support groups										MOH		Ratio of support groups to ART sites in a district	3:5	1:1	based on ART Program Evaluation (2006) data	120,000	0	0	120,000	383,784
		5.3.2	Increase number of support groups and home-based care organizations linked to ART services												# of support groups and HBC organizations supported in catchment areas of ART centres	At least 1 per ART centre (for 84% of centres)	3 per ART centre by 2008		87,928	87,928	87,928	263,784	
5.4	**Strengthen community support to HIV services**	5.4.1	Scale up community based HIV counseling and testing										MOH		# of sites with links to community based HIV counselling and testing	5.6%	50% of all ART sites	based on HMIS data	41,007	41,007	41,007	123,022	123,022
		5.4.2	Strengthen the education on male and female condoms												Condom utilisation with	38.4% for males; 26.1% for females	75% by 2008	ZDHS	Budgeted for in ZASF (2006-2010)			0	

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4												
Strategic Objective 6: Strengthen the systems for procurement, storage, distribution, and logistics for HIV care and ART Services																						
6.1	**Strengthen the pharmaceutical and laboratory management systems to ensure availability of drugs, commodities and other medical supplies for ART**	6.1.1	Strengthen an ARV, test kit, and laboratory logistics system to provide consumption data										MOH	MSL, CPs	% of districts providing consumption data	0	30% by Dec 06	LMIS	48,000	0	0	48,000	7,281,284
		6.1.2	Train appropriate staff in the strenthened LMIS										MOH	MSL, CPs	# of appropriate staff trained	108 at end-2005	3,686 by 2008	HRIS	481,814	578,177	867,265	1,927,256	
		6.1.3	Improve the storage capacity for those health facilities and hospitals for ARV drugs.										MOH	MSL, CPs	# of ART centres with logistical system to support ART service delivery in line with national minimum standars	60 (approx.) in Dec 05	114 by Dec 2006; 237 by Dec 08	HMIS	Budgeted under 4.1.4			0	
		6.1.4	Improve capacity for commodity distribution from the districts to health centres										MOH	MSL, CPs				HMIS	1,626,269	1,783,650	1,836,110	5,246,028	
		6.1.5	Establish timely registration of AIDS medicines and diagnostics										MOH	PRA		92 in Dec	123 by Dec 2006	PRA annual reports	60,000	0	0	60,000	
6.2	**Ensure procurement and distribution of food to patients in need for the first 6 months when they start ARV treatment**	6.2.1	Coordinating and facilitating provision of nutritional supplements to patients on ART (Operations research)										MOH	MSL, CPs	% of PLWHA on ART provided with nutritional supplements	0	10% by Dec 07	Operations Research report	Budegted under 6.3.3			0	0
6.3	**Ensure availability and quality of drugs, nutrition supplements and other medical supplies**	6.3.1	Procure ARVs										MOH	MSL, CPs	# of days in a month during which there are	0	Zero by Dec 06	LMIS	64,260,000	78,540,000	92,820,000	235,620,000	295,369,462
		6.3.2	Procure drugs for treating Opportunistic Infections										MOH	MSL, CPs	# of days in a month during which there are stockouts of tracer Ois drugs in MSL	0	Zero by Dec 06	LMIS	5,054,054	10,866,217	16,678,379	32,598,650	
		6.3.3	Procure nutritional supplements (iron, vitamins etc) for AIDS patients on ART										MOH	MSL, CPs	% of PLWHA on ART in need provided with food/nutritional supplements	0	57% by Dec 06	LMIS	4,315,330	8,900,368	13,755,114	26,970,812	
		6.3.4	Carry out national multi-year quantification of HIV and AIDS drugs and laboratory commodities										MOH	MSL, CPs	# of Quantification meetings annually	1	1 annually	LMS				0	
		6.3.5	Conducting quality control tests on samples of drugs and commodities at point of import										MOH	PRA	% of post-batch tested samples that are of adequate quality according to set criteria	0	100%	PRA annual reports	60,000	60,000	60,000	180,000	
6.4	**Ensure Rational Use of ART medicines and medical supplies**	6.4.1	Assessment of utilisation of AIDS medicines, diagnostics and other supplies										MOH	MSL, CPs, DHMT, PHO	Assessment done and findings diseminated	1	Annual assessment report	LMS	120,000	0	0	120,000	5,366,130
		6.4.2	Conduct training and refresher courses in rational drug use for prescribers.										MOH	DHMT, PHO, CPs	# of prescribers trained and sesnsitized in rational drug use	4,080 at end-2005	14,315 by 2008	HRIS	1,311,533	1,573,839	2,360,759	5,246,130	
		6.4.3	Sensitize and train staff on the use of rational drug use guidelines.										MOH	DHMT, PHO, CPs				HRIS					

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4												
Strategic Objective 7: Strengthen Monitoring and Evaluation systems including surveillance and operations research for HIV care and ART Services																						
7.1	**Institute a national monitoring and evaluation system as a componet of the Nationa HIV/AIDS M&E system**	7.1.1	Finalize the national ART monitoring and evaluation system with a minimum set of indicators									MOH	CPs, DHMTs, PHOs	% of districts submitting ART data through HMIS reports	0	72 by Dec 06	HMIS	40,000	40,000	40,000	120,000	1,020,000
		7.1.2	Disseminate and implement mechanisms that ensure the participation of all partners in the implementation of the agreed national ART M&E framework.									MOH	CPs, DHMTs, PHOs									
		7.1.3	Orient all providers in the monitoring and evaluation of ART program.									MOH	CPs, DHMTs, PHOs					462,000	198,000	0	660,000	
		7.1.4	Disseminate the monitoring and evaluation data from all partners nationally through reports and meetings to promote information use by all									MOH	CPs, DHMTs, PHOs					80,000	80,000	80,000	240,000	
7.3	**Carry out operations research to address specific ART scale-up issues**	7.3.1	Update the national research agenda to ensure ART implementation issues are addressed.									MOH	National Research Advisory Committee	National ART research agenda developed and disseminated to all partners	0	Mar 07	National Research Advisory Committee reports		75,000	75,000	150,000	150,000
		7.3.2	Develop mechanisms for review and development of operations research activities in line with the national ART research agenda									MOH	National Research Advisory Committee									
		7.3.3	Conduct relevant operations research to address priority ART scale-up issues as per the national research agenda and regularly disseminate findings to all partners									MOH	Directorat of Public Health & Research, Research and Health Institutions	# of Operations research studies on ART issues carried out and disseminated	0	2 major areas annually	Directorate reports					
Strategic Objective 8: Strengthen program management and coordination for Health Sector HIV/AIDS prevention, care, treatment and support activities at all levels																						
8.1	**Build the ART coordination team of MOH (center, provincial and district)**	8.1.1	Create new position in ARV unit at the central levels									MOH	MOH HQ	# of new ART posts at central levels	1	4 new posts by Dec 2008		69,806.00	139,612.00	279,224	488,642	488,642
8.2	**Strengthen the coordination and supervision of national ARV program**	8.2.1	Hold national quarterly meetings involving all stake-holders to share experiences and good practices in the implementation of HIV services									MOH	MOH HQ	# of stakeholder meetings held on experiences and good practicies in HIV services implementation	0	4 annually		132,000	132,000	132,000	396,000	1,956,000
		8.2.2	Coordinate all ART stakeholders at provincial and district levels									MOH	PHO, DHMT	% of ART sites in different sectors supported and supervised within set schedule	86%	100% by Mar 2007		240,000	240,000	240,000	720,000	
		8.2.3	Support and supervise providers in public, NGO, FBO and private-for-profit sectors in ART delivery									MOH	PHO, DHMT			100% by Mar 2007		280,000	280,000	280,000	840,000	
		8.2.4	Integrating ART into Health System (planning, performance assessment-PA, Technical Support Supervision- TSS tools) at all levels									MOH	PHO, DHMT	Planning, PA and TSS tools revised to intergrate ART services	planning tools revised	All tools revised by Dec 2007		Budgeted in NHSP 2006-2010			0	
8.3	**Utilise technical assistance from multilateral and development partners in ART scale up**	8.3.1	Maintain database of partners according to their mandate and technical specialization									MOH	MOH HQ	Database of partners in place	0	by Dec 06		Budgeted in ZASF 2006-2010			0	0
		8.3.2	Access technical assistance from multilateral and development partners in the scale up of HIV services									MOH	MOH HQ									
8.4	**Mobilize adequate local and international resources for ART service delivery**	8.4.1	Determine the true costs of ART service delivery at all levels									NAC, MOH	MOH, NAC				NAC resource tracking report(s)	30,000	0	0	30,000	294,000
		8.4.2	Tracking the mobilization and utilization of ART resources									NAC, MOH	MOH, NAC					0	0	0	0	
		8.4.3	Conduct advocacy meeting for resource mobilisation for HIV care and ART Services									NAC, MOH	MOH, NAC					88,000	88,000	88,000	264,000	

Main Activities		Tasks and Subactivites	Timeframe									Responsible Authority	Implementers & Support partners	Indicators	Baseline (2005 unless indicated)	Targets	Data Source / Method of verification	Budgeting				
			2006				2007				2008							2006	2007	2008	Budget by Activity	Budget by Strategy
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4												
Strategic Objective 9: Develop and strengthen national quality evaluation and accreditation systems for HIV care and ART services																						
9.1	**Accredite public, NGO, FBO, and private-for-profit health facilities to provide ART**	9.1.1	Develop and disseminate guidelines for accreditation process for all ART centers in the public, FBO, NGO and private sectors									MOH, MCZ	MCZ	% of potential (pulbic, private, NGO, FBO, etc) centres accredited to deliver ART	0%	100% by Dec 07		150,000	0	0	150,000	150,000
		9.1.2	Accredit centres meeting national criteria to deliver ART									MOH, MCZ	MCZ					Budgeted in 2.2.1			0	
		9.1.4	Accredit ART training institutions/facilities									MOH, MCZ	MCZ					Budegted in 3.3.2			0	
9.2	**Certify health care providers providing ART**	9.2.1	Certify trained ART providers and review certification on a regular basis depending on participation in continuous education in ART									MCZ	MCZ					Budegted in 3.2.2			0	0
9.3	**Ensure availability and quality of drugs, nutrition supplements, reagents and other medical supplies**	9.3.1	Establish and operationalise the national drug quality control system (including the setting up of a national quality control laboratory)									MOH	PRA					200,000	0	0	200,000	200,000
9.4	**Ensure Rational Use of ART medicines and medical supplies**	9.4.1	Strengthen adverse drug reaction reporting system (Pharmacovigilance System) including for ARVs									MOH	PRA, CPs, DHMTs, PHOs	Annual bulletins on Pharcovigilance	0	by Dec 07		45,000	45000	0	90,000	90,000
9.5	**Put in place a national ARV drug restistance surveillance system that encompasses all sectors**	9.5.1	Finalise protocols for the setting up of a national ARV drug resistance surveillance system									MOH	PRA, UTH, CPs, DHMTs, PHOs	Quartely reports on ART resistance trends in Zambia	0	Quarterly reports by Dec 07	HIV Drug Resistance Surveillance System reports	48,000	0	0	48,000	1,352,864
		9.5.2	Identify and select nationally representative sentinel surveillance sites from all sectors to participate in the national ARV drug resistance monitoring									MOH						42,000	0	0	42,000	
		9.5.3	Set up a national drug resistance surveillance system that involves the public, NGO, FBO and private sector, including developing capacity									MOH						24,000	24,000		48,000	
		9.5.4	Identify and set up a nationally representative dynamic cohort to monitor ARV resistance									MOH						24,000	24,000		48,000	
		9.5.5	Conduct ARV drug resistance monitoring and provide regular reports to all stakeholders									MOH						233,373	466,746	466,746	1,166,864	

Annex ii: Policy and Operational Guidelines for scaling up

1 INTRODUCTION

The Zambian Adult HIV prevalence of is currently at 16%. About 1,100,000 Zambians are currently living with HIV/AIDS, of these about 1,000,000 are adults (15 years and over) and 130,000 are children. Of these about 280,000 people will need antiretroviral treatment in 2006. The deaths due to AIDS currently stand at 98,000 every year.

HIV and AIDS Estimates	Average	range
Number of people living with HIV	1,100,000	1,1,00,000-1,200,000
Adults aged 15 to 49 HIV prevalence rate	16%	15.9-18.1
Adults aged 15 and over living with HIV	1,000,000	950,000-1,100,000
Women aged 15 and over living with HIV	570,000	540,000-610,000
Deaths due to AIDS	98,000	77,000-120,000
Children aged 0 to 14 living with HIV	130,000	53,000-250,000
Orphans aged 0 to 17 due to AIDS	710,000	630,000-830,000

The country continues to experience an increase in illness and deaths due to HIV/AIDS with effects on individuals, families, households and entire communities. HIV/AIDS has resulted in a breakdown of family and community cohesion, increased numbers of orphans, reduced economic output and weakened health systems. This has also adversely affected the labour force in all social and economic areas. The increasing number of patients is overwhelming the health care services. In major hospitals for example, HIV/AIDS patients now occupy more than 50% of all hospital beds.

Zambia is committed to controlling the HIV/AIDS epidemic by intensifying prevention, strengthening care and support, expanding treatment and instituting impact mitigation. Zambia has so far actively responded to the HIV/AIDS epidemic on nearly all of these fronts.

Declining costs of ARV drugs and diagnostics, simplified procedures for delivering treatment availability of external funding and experiences in implementing the Antiretrovirals programme

in Zambia over the last three years; all offer a window of opportunity for wide scale use of antiretroviral treatment (ART) in response to HIV/AIDS in Zambia.

Antiretroviral treatment involves a person with HIV/AIDS taking a combination of antiretroviral drugs (ARVs), in addition to other support services, for life. Evidence and treatment outcomes from the national programme show that ART leads to a significant improvement in the quality of life of people with HIV/AIDS. ART does not cure HIV/AIDS but significantly delays progression of disease allowing people with HIV/AIDS to live longer, healthier and more productive lives than would be the case without it. ARV drugs can also be used to prevent mother to child transmission of HIV (PMTCT) and for post-exposure prophylaxis (PEP) to prevent HIV infection after accidental exposure (such as in medical care) or other forms of injury (such as sexual assault).

Building on the national commitment to respond positively to the HIV/AIDS epidemic Zamibia will in the 2006 -2010 ART plan, focus on implementing activities in the key HIV prevention, treatment, care and support interventions as outlined in the Zambia AIDS Strategic Framework.
HIV/AIDS has continued to decimate the most productive and reproductive age group with high morbidity and mortality rates affecting the vital sectors such as health, education, agriculture, government and business workforce. Eighty four percent of Zambia's are HIV negative. There is, therefore, a strong case for strengthening provision of combined preventive and treatment strategies.
Some of the reasons for a wide scale ART programme are as follows:

1.1 **Zambia is experiencing a mature HIV/AIDS epidemic** which is characterised by high prevalence of HIV infection, high HIV/AIDS-related morbidity and mortality and increasing social and economic consequences of the epidemic. The risk of HIV transmission is high if preventive and treatment strategies are not synergistic.

1.2 **Benefits of antiretroviral treatment have been well documented.** The benefits include improved survival and quality of life for people with HIV/AIDS, reduced occurrence of opportunistic infections, reduced hospitalization for HIV/AIDS-related illnesses and reduction in number of children who become orphans due to HIV/AIDS. These outcomes contribute to improved economic output poverty reduction. ART has also led to increased uptake of some preventive services such as counselling and testing.

1.3 **Antiretroviral treatment coverage and high demand for ART.** At the end of 2005, about 51,764 were receiving ART. This number accounts for less than 25% of the number of people who are in need of treatment.

1.4 **Lessons from previous phases of implementation of ART scale up.** Zambia has demonstrated that ART can be provided effectively in the tertiary, provincial, district and urban health centre levels. Lessons leant indicate that with appropriate strategies ART with integrated preventive strategies can also be well implemented in the Zambian setting.

1.5 **A number of opportunities currently exist** for scaling up antiretroviral treatment. Cost of drugs and diagnostics have been drastically reduced over the past few years. Systems for logistics management are being strengthened. There has also been significant increase in funding for HIV/AIDS programmes in the country through the existence of facilities such as the Global Fund, the US Emergency Fund for AIDS Relief and the other multilateral and bilateral support initiatives.

2 IMPLEMENTATION GUIDELINES

The administration of ART is complex and requires adequate facilities and competence in order to achieve expected outcomes. ART is a life-long treatment. A break in the treatment can result in unsatisfactory treatment outcomes. The following guidelines provide a basis for the orderly implementation of ART to ensure wide access, quality and sustainability.

3 KEY ELEMENTS IN SUCCESSFUL IMPLEMENTATION OF ART

The following key elements need to be in place if successful implementation of antiretroviral therapy is to be realized:

- Consistent political leadership and support at all levels
- Reliable drug procurement, storage and distribution systems coupled with effective system for drug monitoring, security and use at all levels.
- Effective laboratory services with capacity to provide basic tests to support the minimum package,
- Clear national treatment protocols and clinical guidelines
- Adequately trained and motivated health and other support personnel
- Community based initiatives that promote treatment literacy and adherence to treatment

4 RECOMMENDATIONS FOR USE OF ANTIRETROVIRAL DRUGS

ARV drugs are recommended to be used for the treatment of HIV/AIDS patients and the prevention of HIV infection as follows:

4.1 Treatment of people with HIV/AIDS who meet clinical eligibility criteria

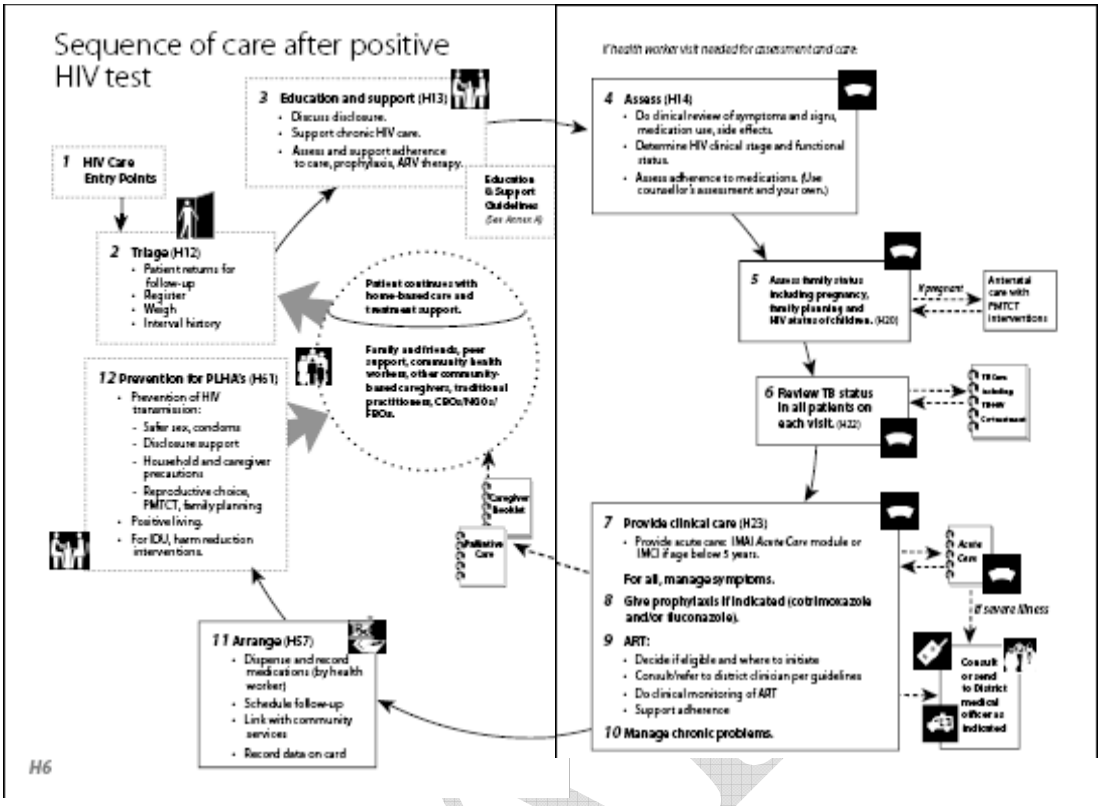
4.2 Post-exposure prophylaxis (PEP) in the case of accidental exposure for health workers and victims of sexual assault.

4.3 For the prevention of mother-to-child transmission (PMTCT)

The following steps are recommended during the course of delivering ART:

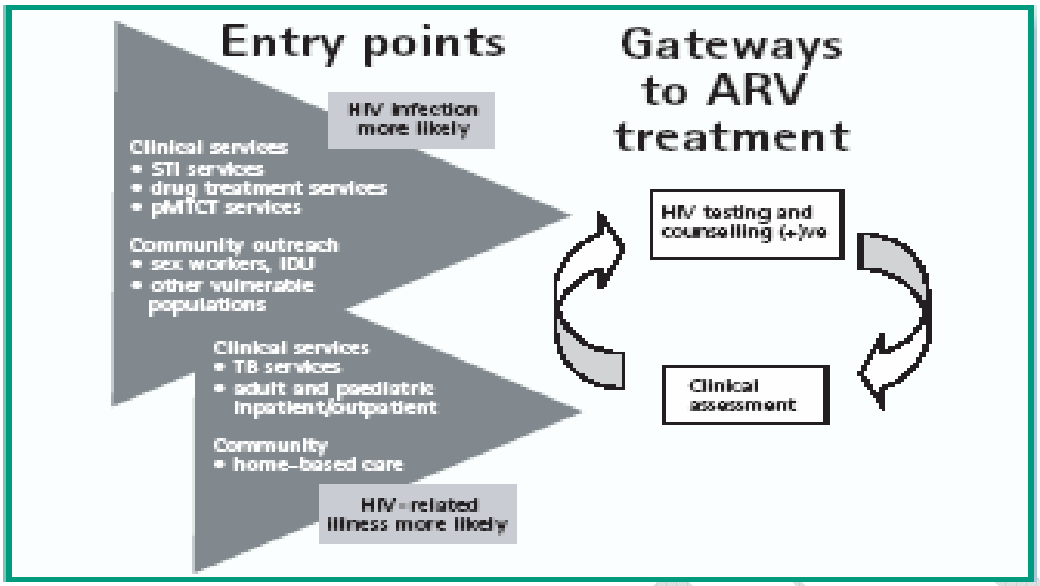
- Individual candidates should be tested to determine their HIV status

- Additional testing and/or clinical assessment to determine whether the candidate is at the stage of infection where ART is required (staging and eligibility assessment)
- For those candidates not eligible for ART, counselling on prevention, management (including prophylaxis) of opportunistic infections, must be provided
- For candidates that are eligible for ART, further counselling should be provided to inform the client /patient (and family members or community support personnel, with the permission of the patient) about what is involved in ART and to assess the likelihood of adherence to treatment
- Treatment of opportunistic infections and especially TB, where patient has an active disease
- Prescription of ARV drugs according to recommended national treatment guidelines
- Daily taking of ARV drugs for the rest of the patient's life
- Consistent and timely re-supply of ARV drugs, accompanied by assessment of response to treatment, counselling on managing side effects and reinforcing the importance of adherence
- Timely treatment of emerging opportunistic infections
- Scheduled clinical and laboratory review to assess response to treatment
- Change of ARV drugs for those not responding to or not compatible with the recommended first line regimens.



5 ENTRY POINTS

To maximize utilization and effectiveness of ART services it is necessary to exploit existing opportunities, as entry points, to identify people who can benefit from treatment. Entry points are clinical and community situations where people with high probability of HIV infection or where people who might be seeking treatment, are likely to pass through. These include TB services, general medical services, STI services, MTCT services and home based care. The entry points must be linked to HIV counselling and testing which is the gateway to treatment services.



5.1 Tuberculosis services

The association between TB and HIV/AIDS is very close. TB is the leading cause of morbidity and mortality in patients with HIV/AIDS while HIV fuels the TB epidemic. In Zambia about 70% of TB patients are co-infected with HIV. TB control services need to have facilities for HIV testing and counselling and be able to refer for antiretroviral treatment patients with HIV infection. TB services also provide models for promoting long-term treatment and adherence.

5.2 General medical services (inpatients and outpatients)

There are usually a high proportion of people with HIV infection among those attending medical clinics and in hospital wards. Currently in Zambia, over 50% of hospital beds are occupied by people with HIV-related conditions. Medical and paediatric facilities are an important entry point to ART and need to be reinforced with adequate HIV testing and counselling services.

5.3 MCH and MTCT services

Many MCH services are now offering prevention of MTCT as well as counselling and treatment services for mothers and children affected by HIV/AIDS. While aiming at prevention of HIV infection in infants, HIV/AIDS treatment and care should also be extended to mothers and other family members.

5.4 STI services

Sexually transmitted infections facilitate transmission of HIV and serve as a marker for infection. Services providing STI care should routinely offer testing and counselling to ensure that patients have an opportunity to know their HIV status and utilize ART services where necessary.

5.5 Home base care

Home based care services are provided through out the country mainly by nongovernmental, community-based and faith-based organizations. The home based care services generally look after people with HIV/AIDS and other chronic illnesses. People on home based care are therefore very likely to require ART. Counselling and effective referrals between home based care and health facilities must be enhanced to ensure that people requiring treatment are effectively treated and followed up.

5.6 Services for vulnerable groups

Sometimes people who need the services the most are not able to access them because of certain barriers such as financial, physical accessibility and discrimination. Population groups such as the very poor, women, children, sex workers, young people, migrants and prisoners. Programmes that are designed to work with these and other population groups in HIV prevention and care are also important entry points to treatment. They require access to testing and counselling services and ART services.

6 TESTING AND COUNSELLING

The goal of counselling and testing is to firstly, facilitate behavioural change and hence preventing acquisition and transmission of HIV and secondly serve as an entry point to HIV/AIDS care, treatment and support services. Access to testing and counselling services is therefore an essential component of the process of implementing ART. Testing and counselling services must be widely available at entry points and in the community.

All clients must be helped to understand the importance of HIV testing so that they can make an informed decision. It is essential that confidentiality is maintained when conducting HIV testing of any kind. Clients' records must be kept securely with limited access. Test results must only be disclosed to the client. Results and other information may only be shared with others on the request and with permission from the client (this is known as "shared confidentiality"). The minimum age of consent for requesting HIV testing is 16 years. When testing children the primary concern should be the child's welfare.

7.1 Models of Counselling and Testing

There are several approaches to counselling and testing are available in Zambia:

1. Voluntary counselling and testing
   - Client initiated HIV testing, stand alone or mobile
2. Routine offer of HIV testing by health care providers
   - Provider initiated at **high risk entry points** such as STI clinics, Antenatal Clinics, and also in clinical and community settings where HIV is prevalent and antiretroviral treatment is available (injecting drug use treatment services, hospital emergencies, etc) but **clients are asymptomatic**
3. Diagnostic counselling and testing in a clinical setting
   - Offered in the clinical setting where patients come to the clinic for other illnesses such as TB or other opportunistic infections.

4. Mandatory HIV screening
    - Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts such as in blood transfusion, artificial insemination, corneal grafts and organ transplants.

Routine offer and Diagnostic HIV counselling and testing are based on the opt-out approach in which the HIV test is recommended and **provided** to each patient (as opposed to just being **offered in opt in**) and the patient retains the right to refuse testing.

7 PROVIDING ART

7.1 When To Start Treatment

Persons who are tested and found to be HIV positive may present themselves or be referred for additional testing or assessment for determining clinical eligibility for ART. ART may be initiated in those found to be clinically eligible after appropriate counselling.

The following are the Zambian Recommendations for initiating antiretroviral therapy in adults and adolescents with documented HIV infection:

Clinical Stage	CD4 Available	CD4 not available
I	CD4 guided	Do not treat
II	CD4 guided	Total lymphocyte count <1200mm3
III	Consider CD4	Treat
IV	Treat	Treat

CD4 criteria for initiation of ART

CD4 (cell/mm)	Actions
<200	Treat irrespective of clinical stage
200-350	Consider treatment*; initiate before drop below 200
>350	Defer treatment in asymptomatic persons
*Treat if there is more than one sign or repeated Stage III problem	

7.2 ART for children

HIV positive children are treated similarly to adults, with some exceptions. When a child is tested for HIV infection the caregiver (mother, family member or guardian) should be provided with counselling. HIV positive children who are to receive ART should then be assessed for clinical eligibility. Caregivers of those children found not to be eligible should be counselled on prevention and how the children will become eligible. Prophylaxis for common opportunistic infections should be provided

The caregivers of children found to be eligible for ART must be counselled on the need for and the likely effects of ART on the children and on adherence.

7.3 Prescription of ARV drugs

Health care providers (doctors, clinical officers and nurses/midwives) who have been **trained in ART and certified** by the Medical Council of Zambia and the Ministry of Health can prescribe ARV drugs **within an approved setting** for provision of ART services.

Patients who agree to receive ART after being clinically assessed are prescribed ARV drugs according to the recommendations outlined in the treatment guidelines.

The recommendations include a combination of three ARV drugs (triple therapy) and sometimes four, from among the recommended list of ARV drugs. The combination seeks to offer therapeutic efficacy and cost effectiveness. The clinical guidelines recommend alternative combinations in case of unsatisfactory treatment outcome from the first line combination or conditions which do not allow use of the primary first line ARVs.

7.4 Follow-up and monitoring of treatment

Once treatment has been started, it must be continued for the rest of the patient's life. The patient needs to return regularly to the health facility for re-supply of drugs, additional counselling and periodically, clinical assessment and testing to determine responsiveness to treatment. The patient's tolerance to the drugs, detection of side effects and verification of compliance should be established at this time.

Recommended follow up schedule and tests for ART monitoring are outlined in the National treatment guidelines

7.5 Treatment adherence

In order to achieve the intended treatment results all medication must be taken as directed. Adherence is therefore a very important component of treatment. Poor adherence is likely to result in treatment failures and emergence of drug resistance. Patients must be trained on ARV use and ensure their commitment to adherence before ART is initiated. Most

treatment adherence support is done in the community by community health workers or treatment supporters.

ARVs will be supplied as fixed dose combinations or in blister packs whenever possible, or use of pill organisers (pill boxes) for dispensing which helps patients with adherence. At each visit to the health facility for patients continuing on ART, self-reported adherence and pill counts must be recorded as part of adherence assessment and support.

8 MANAGEMENT OF OPPORTUNISTIC INFECTIONS AND OTHER HIV-RELATED CONDITIONS

Patients receiving effective ART suffer fewer opportunistic infections than those who are at a similar stage of HIV infection but not receiving ART. However, they continue to be more susceptible to opportunistic infections than persons who are not HIV positive. Facilities offering ART should always be able to manage opportunistic infections and other HIV-related conditions according to recommended treatment guidelines or be able to refer to the next level of care.

9 POST-EXPOSURE PROPHYLAXIS

Administering antiretroviral drugs to uninfected persons soon after exposure to HIV can prevent infection. Post-exposure prophylaxis (PEP) is usually administered after accidental exposure such as in health care settings or after assault (such as rape or child sexual abuse). All facilities that provide ART must also be able to offer post exposure prophylaxis.

Persons to be offered post exposure prophylaxis must undergo counselling and testing. To that end, health care workers must be encouraged to undergo regular HIV testing to avoid delays in administering post exposure prophylaxis. Each health facility should be provided with PEP kits.

10 ACCREDITATION OF HEALTH FACILITIES

All health facilities that provide ART are expected to meet certain minimum standards to ensure that the quality of care patients received is of the required standard. A system for accrediting health facilities to deliver ART has been developed by the Medical Council of Zambia in collaboration with Ministry of Health.

Facilities that provide ART must have the following:

- Health personnel who have been trained to deliver ART
- Facilities to provide the required clinical services for ART and opportunistic infections
- Access to laboratory facilities capable of performing tests necessary to deliver ART and diagnosis of opportunistic infections
- Adequate drugs for ART, treatment and prophylaxis of opportunistic infections
- Dispensing and drug storage facilities

- Counselling and support services
- Facilities for record-keeping and monitoring treatment outcomes

11 QUALITY ASSURANCE

Quality assurance is a more comprehensive approach to quality. Currently there are a number of mechanisms for monitoring quality of care. These mechanisms need to be structured in a system that can be applied to the new HIV care services. Quality assurance is a process with the objective of improving the outcome of all health care in terms of functional ability and the well-being and satisfaction of health care users. In order to improve these, a number of systems need to be supported:

- The Quality Assurance system,
- Health Facility Accreditation system,
- A system of certifying providers,
- National level coordination and use of quality-related data,
- Quality assurance of commodities,
- Rational use of medicines,
- Pharmacovigilance, and;
- HIV Drug Resistance Surveillance System.

These will ensure that Quality standards are strengthened for the services that make up the package of ART. The services include counselling, testing, clinical assessment, prescription, management of opportunistic infections, monitoring treatment and providing support to patients.

12 REFERRAL SYSTEM

A functional referral system between different levels of health services is essential for a treatment programme. Referrals might occur for the following reasons:

12.1 **To manage complications, deal with treatment failure, when diagnosis is in doubt**. In this case one site will refer to another that is at a higher level (e.g. health centre to hospital) or has facilities to address the problem in question.

12.2 **For follow-up in the community**. In this case a hospital might refer a patient who is already on treatment to a health centre or home based care that is closer to the community in which the patient lives, for regular follow-up and adherence promotion.

12.3 **When patients relocate**. When patients relocate from one area or district to another it may necessary for them to be referred for continued treatment to health facilities that are closer to their new place of residence.

12.4 **Individual choice**. Sometimes people might chose to move from one treatment site to another for various personal reasons including perceptions of quality and confidentiality.

12.5 **Virtual referrals**. Patients need not always be referred physically to the next level of care should they need higher level consultations. This will apply to courier services for test samples such as the dry blood spots (DBS) for PCR in infant HIV diagnostics and consultations through telemedicine. Patients will not be expected to move to the next level physically thus saving on patients' out of pocket expenses.

The referral system must ensure that patients or records or samples that move between different facilities and levels of the health system do not experience unnecessary delays and complications in the continuation of treatment.

13 PAYING FOR TREATMENT

Ideally antiretroviral treatment should be offered free of charge to all people who need it. This is because treatment is both costly and lifelong. About 87.4% of Zambians live on less than US$2. Antiretroviral Therapy is comprehensive care for an HIV-infected patient that includes treatment with drugs (ARVs) that specifically attack the HIV virus. ART will thus include prevention, treatment of opportunistic infections, support and care and provision of ARVs amongst other activities. The major costs of ART are mainly ARVs, laboratory reagents and nutritional supplements. Most Zambian's can not afford the full cost of ART. The free ARVs Policy is intended to assist many of the socio-economically disadvantaged Zambians and will try to ensure that no one is denied treatment due to inability to pay for the full cost of ART. The policy will allow for the major costs of treatment to be borne by the Government. Costs of drugs and laboratory investigations will be free in public health facilities and cost of drugs in government supported private-public mix schemes. Patients will have to bear the cost of nutrition, transport costs to the clinics (in most situations) and other costs that may be applicable but not supported by government programmes.

13.1 Public health care system

Provision of antiretroviral therapy shall be provided free of charge in public health care institutions. Post exposure prophylaxis (for accidental exposure and rape or child molestation) will be provided free of charge to all persons that test HIV negative. Patients shall only bear the in-direct costs of treatment that are not provided free of charge by the public health facilities.

13.1.1 Registration fee

All patients accessing the ART will pay a registration fee using the current system of determining fees by the Districts. This user fee will also be regulated by the user fees regulations being applied by the districts.

13.1.2 Individual payments

All Zambians are not required to pay anything toward the cost of drugs or the basic laboratory services and tests. Refugees living in Zambia will not be required to pay for ARVs.

Foreign nationals, excluding refugees and health care workers, shall be required to pay the full cost of the ARVs (estimated at K200, 000 per month per patient).

13.1.3 Payment by employers

For employers that wish to support their employees access ART from public facilities or subsidised ARVs in private facilities they will be required to make a contribution to the cost of the ARVs. It is therefore recommended that for those in employment, their employers contribute 25% of the total cost of ARVs, which translates into K50, 000 per employee per month.

13.2 Private health services

The private sector will often require full payment of the cost of treatment, including the cost of drugs and diagnostics. Mechanisms for payment in the private sector will include the following:

13.2.1 Direct individual payments

The person seeking treatment will pay a fee for service that will be determined by the health provider.

13.2.2 Workplace based schemes

Some employers already have arrangements with private health providers in which the employer pays the selected health provider for the cost of treating employees.

13.2.3 Insurance and medical aid schemes

There is need to also encourage individuals to contribute towards a Medical insurance scheme in order to offset the need for them to pay from their pockets when they are unwell. Ways in which insurance and medical aid schemes can be effective in contributing towards payment for antiretroviral treatment while offering financial protection to the patient and family needs.

13.3 Non-governmental and community based services

Non-governmental health services might target particular population groups (such as orphans, victims of sexual assault or victims of domestic violence) or particular geographical areas (such as rural people or underserved urban populations). Depending on the type of target population, non-governmental services might be offered free of charged, at very subsidized rates or might follow similar schemes as the public health care system.

13.4 Subsidised ARVs and Free services within the public-private mix

Government will collaborate with the private sector, non-governmental health services and faith based health services to target particular population groups and/or or particular geographical areas. To provide HIV care to these populations and areas commodities and services will be provided to the public free of charge or at subsidised cost through the public-private initiatives.

14 HUMAN RESOURCES

Availability in adequate numbers of personnel who are competent to provide antiretroviral treatment is an essential factor to successful implementation of HIV care services on a wide scale. Some of the skills required for ART include counselling, clinical assessment and prescribing, laboratory testing, dispensing of drugs, data capture and recording and management.

Health services currently face numerous staffing challenges. These include fiscal constraints which have led to public sector limits for recruitments, migration of qualified staff from public to private or other sectors within the county or abroad, increased levels of absenteeism due to HIV/AIDS affecting staff and their families and burnout among existing staff.

A number of measures need to be taken to address the human resource challenges in delivering ART. They include the following:

14.1 Addressing the staffing shortfall

14.1.1 Authorizing other trained health workers, such as nurses and clinical officers, to initiate first line standard regimens in patients who do not have complications under the supervision of physicians.

14.1.2 Authorizing trained and certified community health workers to provide HIV counselling and testing services

14.1.3 Developing and re-examining workforce policies (limits on spending, hiring of health care staff), including addressing issues of externally imposed fiscal constraints to recruitment.

14.1.4 Defining a framework and identifying resources to ensure that volunteers can be given appropriate support and supervision to promote on-going commitment

14.1.5 Offering post-retirement contracts and recruitment drives to bring inactive workers back into service

14.1.6 Strengthening and developing national mechanism for dialogue with unions, professional and civil service organizations, to address recruitment.

14.1.7 Training people living with HIV/AIDS and other community members to address issues such as adherence and supportive counselling. Contracting PLWA groups and community-based organizations to support treatment literacy and preparedness.

14.2 Support and motivation of existing staff

14.2.1 Engaging community leaders and community-based organizations to support community health workers, health workers and service delivery centres

14.2.2 Improving working environment by providing information, training, incentives, equipment and support mechanisms for healthcare workers to play an active role.

14.2.3 Actively engaging staff in decision-making on service delivery issues.

14.2.4 Ensuring free access to post exposure prophylaxis and ART to health workers.

14.2.5 Regularly reviewing and monitoring staffing ratios for impact on quality of care and staff burn-out

14.2.6 Minimizing delays in payment of salaries and other benefits.

14.2.7 Exploring the possibility of supplementing salaries of staff through provisions such as project grants.

14.2.8 Developing effective supervision and feedback mechanisms.

14.2.9 Providing incentives/remuneration, career path development, better living conditions, equipments.

14.3 Training and skills development

14.3.1 Identifying and training key managers to improve their skills and competencies for rapid scale-up of ART - give special consideration to monitoring and evaluation, supply chain management, and general management skills

14.3.2 Using and strengthening existing pre-service institutions to identify and use other appropriate training providers to provide training of ART and care for in- and pre-service training.

14.3.3 Defining minimum standards of training for different service providers and for the certification of trainers.

14.3.4 Ensuring rapid procurement and distribution of teaching and learning materials (in relevant and appropriate languages).

14.3.5 Establishing mechanisms for mentorship at all levels.

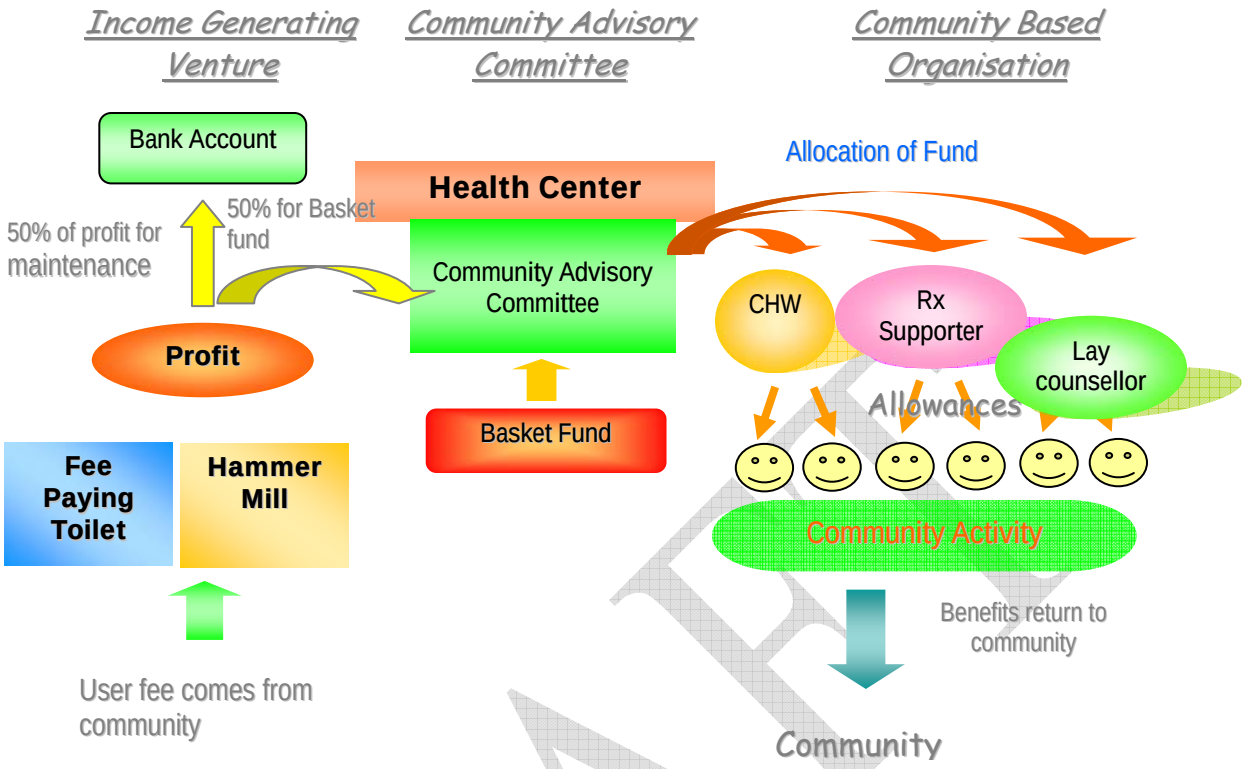
14.3.6 Seeking opportunities and invest in the expansion of information technology access to training institutions.

14.3.7 Introducing the accreditation of appropriate training courses and programs.

15 COMMUNITY INVOLVEMENT IN ART

The Community plays an important role in HIV prevention and supporting patients on treatment. Although involvement of the community is generally accepted as essential the exact roles and contributions are not well articulated in most strategies and polices. This leads to the community component not being well funded. Community support mechanisms once mobilized and organized need to be capacitated to be able to meet local demand for services in a manner that is comprehensive and relevant. Community activities need to be closely linked to the local service delivery structures for technical support and integration.
One of the community strategies to be promoted in this plan is the provision of funds to setup self sustaining income generating activities (IGA) that will support the activities of community volunteers. The volunteers are expected to provide patient education, adherence support and community mobilisation.

Health centres will setup a community advisory committee (CAC) which will be made up of community volunteers and health workers. The committee will then be given initial funds to setup a community basket fund that will be used to run an IGA. The funds raised from this IGA will be used to sustain the activity and to support volunteers. Fifty percent of the raised funds will be applied to sustaining the fund and the other fifty% can be applied to activities such as community outreach programmes or paying allowances for the volunteers or any activity the CAC deems beneficial for patients on ART.



16 DRUGS AND SUPPLIES MANAGEMENT

A wide range of commodities is required for ART and needs to be available at all time in facilities providing ART. The essential commodities include ARV drugs, HIV tests, supplies for management of opportunistic infections and other HIV-related illnesses, palliative care (including morphine), laboratory reagents and condoms.

Drugs and other commodities for ART require careful management because:

- ARV drugs, laboratory equipment and other materials used during ART are very costly. Wastage should be avoided
- Interruption in the supply of ARV drugs is undesirable as it may promote treatment failures and emergence of drug resistance. Stock outs of ARV's should therefore be avoided at all costs.
- Most of the products used in ART are imported and the effect of lead times between ordering and local availability can be significant. Forward looking procurement plans should be developed.
- Key considerations in the management of drugs and supplies include cost, quality, accurate quantification and reliability of supplies.

16.1 Selection, forecasting and quantification

Drugs to be procured must be either on the Essential Drug List or recommended in the national treatment guidelines. It is advisable to limit the number of different formulation/items available through standardization of treatment regimens and diagnostics. Drugs in fixed dose combinations are easier to administer and should be preferred, whenever possible. However, some single dose drugs should also be available for use in cases of intolerance or adverse reactions to fixed dose combinations. Only drugs not requiring refrigeration must be selected for first line treatment, unless a cold-chain can be guaranteed.

Quantification of drug requirements must be based on accurate estimates of patient numbers, based on eligibility criteria, availability of HIV testing, size of existing patient population already in follow-up and HIV prevalence estimates, to define total demand for commodities. Morbidity and consumption figures from districts must be used to forecast and quantify future supply needs. Forecasting on a quarterly basis will facilitate timely replenishment of supplies and indeed adjustment of orders for commodities that may be surplus to requirements.

16.2 Procurement and supply chain management

16.2.1 There are a variety of drug procurement systems currently existing in the country. For the public sector quantification and sourcing for drugs and supplies is the responsibility of the Ministry of Health and conforms to the requirements of government tendering procedures, including international or local competitive bidding. Storage and distribution of drugs and supplies is the responsibility of Medical Stores Limited (MSL).

16.2.2 Private for-profit providers procure drugs and supplies directly from local and international suppliers. Non-governmental providers also make direct purchases from local and international suppliers in addition to what they get through the public system. Not for-profit providers also receive significant amounts of drugs and supplies as donations.

16.2.3 Commodities used for ART will be managed within the context of existing systems while at the same time ensuring that disruptions in the supply chain are avoided. In this regard, a national logistics system has been developed by MOH with support from other stakeholders, and is in the roll-out phase. National ARV and Test Kit quantification, up to 2008 has also been done, including development of a national procurement plan to coordinate procurement across all stakeholders. Price should be only one of and not the over-riding factor for selection of suppliers of drugs and other commodities used for ART. Product quality and reliability of supply are equally important factors.

16.2.4 Where possible and desirable the public and private sector providers may cooperate to procure drugs and supplies for ART in order to benefit from economies of scale and from concessionary prices or subsidies that might be offered to the public sector.

16.2.5 Timely and accurate information regarding inventories, rates of consumption, delivery times and product shelf life will assist in developing the necessary mechanisms for improving delivery of supplies

16.2.6 Local manufacturing of ARV drugs might be considered where this would lead to further reduction in drugs costs and ensure reliability of supplies, quality and conformity with international trade regulations (such as TRIPS).

16.3 Regulation and quality control

The Pharmaceutical Regulatory Authority is the body responsible for the registration of pharmaceutical products. All products used for ART must be registered for use in Zambia. The process of product registration ordinarily takes quite a long time. However, a provision for "fast tracking" has been employed when considering applications for products used for ART.

Most drugs used in ART are protected by patent and may also be available as generic equivalents. Generally the prices of generic drugs are lower than branded drugs. Both branded and generic drugs will be procured where quality is assured and price is favourable.

Quality of supplies will be assured by ensuring existence of reliable national drugs regulatory authority in the country of origin of the drugs. Regular sampling of batches of imported drugs will be conducted. Samples will be sent to competent laboratories outside the county for testing of potency.

16.4 Rational use

The rational use of drugs for ART means that patients receive medicines appropriate for their clinical needs, in recommended doses, continuously, and at the lowest cost to them and their community. To ensure rational use of drugs and supplies the following need to be done:

- Monitor and analyse data from all levels to ensure patient numbers and commodity usage match each other.
- Train patients and treatment supporter (family members, community health workers or others) on ARV use and ensure their commitment to adherence before ART is initiated.
- Design and provide patient information leaflets for all levels of health care, in appropriate language and content.
- Develop programmes for continuing education of prescribers.
- Expand and strengthen the pharmaco-vigilance system for monitoring drug effects on the population.
- Avoid perverse financial incentives to prescribers and dispensers.

17 MONITORING AND EVALUATION

There is need to monitor and evaluate the programme in order to ensure that the desired goals are achieved. A system for monitoring and evaluating the implementation of ART, monitoring

patients will be integrated into the existing national health management information system (HMIS) and will involve information collection from all sites providing ART, including public, private, non-governmental organisations (NGO), and workplace service provision. Paper and computerised systems will be used depending on resources and expertise available.

In addition to improvement and expansion of routine health information systems, an appropriate forum will be organized by the MOH to share and use information. During the plan period, MOH will convene partners to jointly share data, lessons learned, and evaluate key questions of concern on quality, community mobilization, and other systemic issues related to ART. This approach will promote standardized approaches to quality improvement, identify gaps in the continuum of care, and allow for coordination of service coverage.

The HIV drug resistance surveillance system will be set up to monitor HIV resistance country wide. Operations research will also be encouraged in all areas of service delivery.

18 INSTITUTIONAL ARRANGEMENTS IN DELIVERING ART

Delivery of antiretroviral treatment is being integrated into the existing national health care system. ART will be part of the essential health care package with components that will be delivered at all levels of the health system. The various levels, stakeholders and institutions involved in the delivery of ART include the following:

18.1 District Health System

District Health System provides primary health services have been reorganized as follows;

- The District Health Boards have been set up with a mandate to provide health services at that level, preventive and promotive services and clinical services. The operational wing is the District Health Management Teams.

- The following levels of health care provision are at district level, the District Hospital (Level I hospital), Health Centre, and Health Post. At the community level NGOs, CBOs, the Church, CHWs, CBDs and TBAs supplement health delivery.

18.2 The Private Sector

The private sector plays a significant role in providing of medical services. Private-for-profit health services are mainly concentrated in urban areas. The private sector includes private clinics and hospitals, private pharmacies and companies which provide health services, to a greater or lesser extent, to their employees who require ART. The private sector has been treating patients with ARV drugs for a long time. The private sector will be encouraged to continue providing services as before and support will be provided to ensure that they meet the required standards and follow the guidelines provided. The government may facilitate access, by the private sector, to preferentially-priced ARV drugs, where this is feasible.

18.3 Hospital Management Boards.

Hospital management Boards provide health services through large public (and NGO) hospitals that are outside the District Health System. Included here are second level and third level hospitals.

18.3.1 Second level hospitals

Under the authority of the Hospital Management Boards, the second level hospitals provide clinical services in paediatrics, internal medicine, obstetrics & gynaecology and general surgery as well as advanced diagnostic services. This level receives referrals from and provides technical support to the district level. Conduct training for health workers.

18.3.2 Third level hospitals

Under the authority of the Hospital Management Boards, five hospitals have been identified to provide tertiary services. These hospitals provide specialized services in clinical disciplines including paediatrics, internal medicine, obstetrics & gynaecology, general surgery, radiology, specialized laboratory as well as other specialized diagnostic services.

18.4 Ministry of Health (MoH)

The Ministry of Health provides the majority of all the health services in Zambia. The MoH will:

- Interpretation and implementation of health policies
- Development of guidelines, including treatment and preventive protocols,
- Monitoring performance of health facilities through Provincial Health Offices
- Ensuring steady flow of drugs, medical and non medical supplies

The MoH will also retain the functions of resource mobilization, policy formulation, strategic planning and bilateral and multilateral international coordination

18.5 National HIV/AIDS/STD/TB Council (NAC)

The Council is responsible for:

- Policy interpretation and implementation
- Coordination of HIV/AIDS/STD/TB activities
- Donor and stake holders coordination
- Resource mobilization and disbursement
- Monitoring and evaluation of HIV/AIDS/STD/TB programmes and activities

18.6 Medical Council of Zambia

The Medical Council of Zambia will be responsible for overall quality of medical practice in the country including quality of medical facilities. This will also include health facility accreditation to ensure all facilities that are providing ART provide the services within the minimum required standards. The MCZ will also certify health care providers of HIV care and ART services.

18.7 National Food and Nutrition Commission

The National Food and Nutrition Commission will be responsible for providing nutritional support guidelines and implementation of nutrition bases interventions.