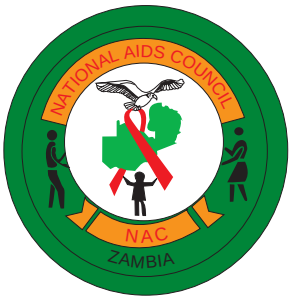

Republic of Zambia **National HIV/AIDS Council**

NATIONAL HIV AND AIDS STRATEGIC FRAMEWORK

2006-2010

May 2006

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FOREWORD

This National HIV and AIDS Strategic Framework (NASF 2006-2010) is the second in the series of the strategic plans implemented.

It is my considered view that, with appropriate levels of commitment and support from the Government, Cooperating Partners, workers and other key stakeholders, this plan would significantly improve the health status of Zambians and significantly contribute to national development. I therefore, urge all the people involved in the implementation of this plan to fully dedicate themselves to this important national assignment. NAC will remain committed to ensuring the successful implementation of this plan.

Dr B. Chirwa
Director General
National AIDS Council

ACKNOWLEDGEMENTS

The strategic framework has been developed through a participative and consultative process involving significant contributions and support from various individuals and institutions.

I wish to thank the consultants who assisted in the initial collection of data and development of the zero draft of the plan.

Finally, I wish to thank the Cooperating Partners, all the members of staff of the National AIDS Council, Provincial AIDS Task Forces, District AIDS Task Forces representatives of statutory boards, line ministries, and NGOs, for their participation, contributions and support to the process of formulating this strategic framework.

Dr. A. Simwanza
Director Programmes

ABBREVIATIONS

ABCs	Abstinence, Be Faithful, use Condoms
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
AM	Afya Mzuri
ART	Anti Retroviral Therapy
ARV	Anti Retro Virals
BCC	Behaviour Change Communication
CBOH	Central Board of Health
CCM	Country Coordinating Mechanism
CCT	Confidential Counselling and Testing
CHAMP	Comprehensive HIV and AIDS Management Programme
CHAZ	Churches Health Association of Zambia
CHEP	Copperbelt Health Education Project
CIDA	Canadian International Development Agency
CPs	Cooperating Partners
CRAIDS	Community Response to AIDS
CRS	Catholic Relief Services
CSO	Central Statistics Office
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DAPP	Development Aid from People to People
DATF	District AIDS Task Force
DDCC	District Development Coordinating Committee
DFID	Department For International Development
DHMT	District Health Management Team
DHS	Demographic and Health Survey
ETWG	Expanded Technical Working Group
FYOZ	Forum of Youth Organisations Zambia
GDP	Gross Domestic Product
GHE	Gross Health Expenditure
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater and meaningful Involvement of People living with HIV and AIDS
GIS	Geographic Information System
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HFS	Health Facilities Survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDU	Injecting Drug User
IEC	Information, Education and Communication
IT	Information Technology
JAPR	Joint Annual Programme Review
JFA	Joint Financing Agreement
KCTT	Kara Counselling and Training Trust
LCMS	Living Conditions Monitoring Survey
LM	Line Ministries
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MIS	Management Information System
MOE	Ministry of Education
MOFNP	Ministry of Finance and National Planning
MOH	Ministry of Health
MTCT	Mother to Child Transmission (of HIV)
MTEF	Mid Term Expenditure Framework
NAC	National AIDS Council
NAISP	National AIDS Intervention Strategic Plan
NARF	NAC Activity Reporting Form
NASF	National AIDS Strategic Framework
NDP	National Development Plan
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development
NZP+	Network of Zambian People Living with AIDS
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PATF	Provincial AIDS Task Force
PAU	Programme Administration Unit
PDCC	Provincial Development Coordinating Committee
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (USG)
PLHA	Person Living with HIV and/or AIDS
PMTCT	Prevention of Mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
PS	Private Sector
SBS	Sexual Behaviour Survey
SHARe	Strengthening the HIV and AIDS Response (a USAID-funded project)
SIDA	Swedish International Development Agency
STARZ	Strengthening the AIDS Response, Zambia
STI	Sexually Transmitted Infection
TA	Technical Assistance
TALC	Treatment Advocacy and Literacy Campaign
TB	Tuberculosis
THPAZ	Traditional Health Practitioners Association of Zambia
TOR	Terms Of Reference
TWG	Technical Working Group
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session on HIV and AIDS
UNICEF	United Nations International Children's Emergency Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
UTH	University Teaching Hospital
VCT	Voluntary Counselling and Testing
YSC	Youth Steering Committee

ZAMSIF	Zambia Social Investment Fund
ZANARA	Zambia National AIDS Response (a World Bank-funded project)
ZBCA	Zambia Business Coalition on AIDS
ZHABS	Zambia HIV and AIDS Business Sector Project
ZHECT	Zambia Health Education and Communication Trust
ZINGO	Zambia Interfaith Networking Group
ZNAN	Zambia National AIDS Network
ZWAP	Zambia Workplace AIDS Partnership

1.0. INTRODUCTION

1.1. Status of the HIV and AIDS Epidemic

Zambia is one of the Sub Saharan African countries worst affected by the HIV and AIDS pandemic. Estimates put the prevalence rate at about 16 percent among the 15-49 years age group and about 1 million Zambians infected with HIV, of which over 200,000 are in need of antiretroviral therapy.

The epidemic is characterised as follows:

- Feminisation of the epidemic with women 1.4 times more likely to be HIV-infected than men, and infection rates among young women aged 15-24 years are 4 times higher than those for young men in the same age group.
- HIV rates vary considerably among and within Provinces ranging from 8% in Northern Province to 22% in Lusaka Province and higher prevalence in urban areas with 23% of urban residents HIV infected as compared with 11% in rural areas
- Nearly 80% of HIV transmission in Zambia is through heterosexual contact exacerbated by the high-risk sexual practices, gender inequity, high levels of poverty, stigma and discriminatory practices and high prevalence of sexually transmitted infections and tuberculosis. The remaining 20% is predominantly due to mother-to-child transmission during pregnancy, at birth or while breastfeeding.
- 7.7% of young people 15-24 years are estimated to be HIV infected

1.2. The Status of the Response

1.2.1. Prevention Programmes

Mainly as a result of the ABCs prevention programme, the mean age of sex debut has increased to 18.5 years and the percentage of young people 15-24 years reporting sexual relations with a non-regular partner has decreased to 29% for males and 16% for females. On the other hand, vulnerability to HIV among youth remains high. Only 34% of young people can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission. Condom utilisation with a non-cohabiting partner is low among youth, at 38.4% for males and 26.1% for females.

Access to Voluntary Counselling and Testing (VCT) and Prevention of Mother to Child Transmission (PMTCT) services has continued to increase with 400 and 270 sites respectively currently offering these services. However, only 25% of HIV positive mothers are receiving a complete course of ARV prevention. 100% of transfused blood units are routinely screened for HIV.

1.2.2. Universal Access to Treatment

In 2003, the Government launched its national policy of providing free and universal access to Antiretroviral Treatment (ART), which was expanded in 2005 to include all ART related services. By the end of 2005, an estimated 40,000 people living with HIV and AIDS (PLHA), out of an estimated 200,000 persons requiring treatment, were on ART.

Only 10% of persons with Sexually Transmitted Infections (STIs) are estimated to be appropriately diagnosed, treated and counselled and tuberculosis is the leading cause of mortality for HIV infected patients. Care and Support Programmes have been strengthened and expanded to include home based care, nutritional support, palliative care including pain management and support for caregivers.

1.2.3. Socio-economic Impact Management and Mitigation

As much as poverty makes people vulnerable to risky behaviours for HIV, the loss of the main income earner or earners in the prime of their lives due to HIV and AIDS is pushing many families into poverty – and the cycle repeats itself. The HIV and AIDS epidemic is as much a development concern as it is a health concern. The increase in morbidity and mortality rates due to HIV and AIDS is limiting overall productivity in both the productive and services sectors as well as altering the Zambian population structure, decreasing life expectancy from 50 to an estimated 37 years and heavily impacting the supply of human resources[1].

Consequently, the nation has continued to witness a breakdown in social service delivery, reduction in household incomes and a less than optimal national economic growth rate necessary for overall national development.

A stark example of a group made more vulnerable are orphans whose parents died from HIV and AIDS. Estimates of number of orphans range from 750,000 to 1.2 million, of which 75% are HIV orphans[2]. Throughout Zambia, there are growing initiatives in support of orphans and vulnerable children being implemented by government, international donors, NGOs, and several other groups. These are successful programs that keep children in the community rather than in orphanages, increase incomes to vulnerable households and provide psychosocial and physical help to families and caregivers who are often the elderly. Increasing access to formal education is a key consideration for this group of children as this in turn will mitigate the impact on the quality of the future labour force as well as possible impacts on national security. The increase in community schools and the provision of bursaries for poor children have contributed to increasing orphan access to basic education. In 2004 total orphan enrolment in schools, according to the Ministry of Education, was 536,672.

1.3. Policy and Institutional Responses

1.3.1. The Government response

Government has put in place a number of national support structures:

- a high level Cabinet Committee of Ministers on HIV and AIDS
- the National AIDS Council and Secretariat (NAC), established in 2002 as a broad-based corporate body with government, private sector and civil society representation
- the National HIV/AIDS/STI/TB Policy of 2005 provides the directive and mandate for the national response
- At decentralised levels, Provincial and District HIV and AIDS Task Forces (PATF and DATF) have been established to operate as sub-committees of the decentralised development coordinating structures

[1] Ministry of Finance and National Planning, Poverty Reduction Strategy Paper, 2002-2004.
[2] Central Statistics Office, Epidemiological Projections, 2005

As the employer of nearly 40% of the formal workforce and, therefore, severely affected by the HIV and AIDS epidemic, the Government has also begun to establish workplace policies and programmes aimed at the protection of public sector employees.

1.3.2. The Civil Society Response

Broadly, civil society for HIV and AIDS is considered to include Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs) and Faith-Based Organisations (FBOs) as well as the media, trade unions, traditional healers and youth structures or groups. In Zambia, civil society is considered to play a significant role in strengthening the multi-sectoral response to HIV and AIDS, TB and STIs. Civil society organisations (CSOs) are frequently key role-players in developing and implementing services which are innovative and culturally-sensitive and that include elements of mainstreaming, decentralisation, outreach and community participation.

1.3.3. The Private Sector Response

The Private Sector accounts for an estimated 58.5% of the formally employed workforce in Zambia, that is an estimated 243,645 employees. The design and implementation of workplace programmes in companies and businesses have been largely supported by a private sector NGO network known as ZWAP (Zambia Workplace AIDS Partnership). There are a growing number of Zambian companies undertaking innovative practices in the workplace across prevention, treatment care and support and beginning to extend access to these services to families and communities in which they are located.

1.4. The Challenges Ahead for 2006-10

The commitment to tackling HIV and AIDS is unprecedented. It is estimated that about US$273 million annually have been mobilised from Government and Cooperating Partners to finance the multi-sectoral response for the period up to 2008. In addition, the expanded response from communities, civil society and private sector is also contributing significant amounts of their own resources to the scale up of action. Critical issues of improving coordination, monitoring and demonstrating value for money for these resources need to be strengthened to ensure continued support for the Response.

It is essential for Zambia in this next planning period, as access to ART is expanded, that a renewed and intensified prevention programme be also implemented. Despite some of the success that has been demonstrated with HIV prevention efforts with small populations, like sex workers, many of these lessons have not been taken to scale for the general population to have an impact on overall incidence. The epidemic can only be reversed by intensifying effective HIV prevention in scale and scope, so as to control the rate of new infections as the critical step to reducing the prevalence rate as the mortality rate falls and people with HIV survive. In addition, the number of new infections must be dramatically reduced in the next few years, to ensure that ART scale up remains economically and socially sustainable.

This means that there must be a strong additional emphasis on reaching the youth of Zambia, and even more of a case to reach the younger children to reduce stigma and discrimination for the growing number of persons who will live with HIV. The combined impact of intensified HIV prevention **and** expanded access to treatment, care and support will have a multiplier effect for the communities in the longer term.

1.5. The National HIV and AIDS Strategic Framework 2006-2010

The Zambian Government, Cooperating Partners and programme implementers agree that HIV and AIDS is more than a health problem and requires a broad-based multi-sectoral approach to address the many facets of the epidemic. There is a strong realisation that HIV and AIDS is very much inter-linked with poverty, social and economic inequities between men and women and long-standing cultural behaviours and beliefs.

The National HIV and AIDS Strategic Framework 2006-2010 (NASF) has been built on the process of joint annual reviews of the progress with the current 2002-2005 Strategic Intervention Plan and a broad consultative process with the Partners. The management intent of the NASF 2006-10 is not to replace the need for Partners to have their own plans, but rather to:

- Support coordinated, prioritised and knowledge-based scale up of the response
- Facilitate broad ownership of the response by all partners and practical partnerships for the implementation of the response
- Represent joint strategic direction of all Partners
- Enable the involvement of key sectors and decentralised levels in all stages of the process
- Guide resource management at the strategic level

The 6 Themes of the new NASF represent the partners' priority action areas for 2006-10 and include:

I. Intensifying Prevention of HIV
II. Expanding Treatment, Care and Support for people affected by HIV and AIDS
III. Mitigating the Socio-economic impact of HIV and AIDS
IV. Strengthening the Decentralised Response and Mainstreaming HIV and AIDS
V. Improving the Monitoring of the Multi-Sectoral Response
VI. Integrating Advocacy and Coordination of the Multi-Sectoral Response

The following matrix summarises the main objectives of the NASF 2006-10.

SUMMARY OF THE OBJECTIVES OF THE MULTI-SECTORAL RESPONSE TO HIV AND AIDS

Our Vision
A proud Zambia free from the threat of HIV and AIDS

Our Mission
The National Multi-Sectoral Response, coordinated by the NAC, is committed to controlling HIV and AIDS by integrating HIV and AIDS into the work of every partner and our development agenda.
We will scale up prioritised actions which are rapid and responsive to the needs of the local communities to be served.

Our Goal
Prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2010

Our Guiding Principles[3]

- **Adoption of a human rights approach** which requires that the rights of the people of Zambia, to equality before the law and freedom from discrimination, are respected, protected and fulfilled. This in turn means that programmes and interventions are **people centred** and **culturally sensitive** supporting and empowering communities, families and individuals to develop their own competencies and to learn from the experience of others. This approach further call for strong **political leadership, commitment and engagement** so as to promote **good governance, transparency and accountability** at all levels and in all sectors.
- The **greater and meaningful involvement of PLHA (GIPA)** at all levels of the response
- **Gender equity and HIV** issues are interconnected
- HIV and AIDS interventions should be **pro-poor, with HIV and AIDS mainstreamed** in the national development agenda, sector policies, plans and budgets of the Country in order to ensure **sustainability**. These are to include the Poverty Reduction Strategy (PRSP), National Development Plan (NDP), the Medium Term Expenditure Framework (MTEF) and other national development instruments
- Controlling HIV and AIDS needs the involvement of all sectors of society **through the multi-sectoral response and partnership** in the design, implementation, review, monitoring and evaluation of the National AIDS Strategic Framework (NASF) in order to ensure success and effectiveness of the response. This is in keeping with the nationally and internationally supported "**Three Ones" approach:** one national coordinating authority, one strategic framework, and one monitoring and evaluation framework
- Implementation shall be in line with the National **Decentralisation** Policy to ensure maximum participation by communities and to strengthen the leadership by the District Development Coordination Committees
- It is essential that the national response to HIV and AIDS be guided by ethically sound, current **scientific and evidence based research** bringing out **best practices** and using a **public health approach** to guide prioritization and selection of the most cost effective interventions

[3] National HIV/AIDS/STI/TB Policy, June 2005

THEMES

I. Intensifying Prevention	II. Expanding Treatment, Care and Support	III. Mitigating the Socio-economic impact	IV. Strengthening the Decentralised Response and Mainstreaming HIV and AIDS	V. Improving the Monitoring of the Response	VI. Integrating Advocacy and Coordination of the Multi-Sectoral Response
STRATEGIC OBJECTIVES					
1. Prevent Sexual Transmission of HIV with a special emphasis on youth, women and high risk behaviours 2. Prevent Mother to Child Transmission 3. Prevent HIV transmission through blood and blood products 4. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment 5. Improve access to and use of confidential counselling and testing 6. Mitigate stigma and discrimination against HIV 7. Prevent HIV transmission through intravenous drug use 8. Support development and participation in HIV vaccine clinical trials	9. Provide Universal Access to ART including access to CCT at all Treatment Centres 10. Expand treatment for Tuberculosis, sexually transmitted infections (STIs) and other opportunistic infections (OIs) 11. Strengthen home/community- based care and support including access to comprehensive palliative care and pain management 12. Support the utilisation of alternative and/or traditional medicines which have scientifically demonstrated efficacy 13. Promote appropriate nutrition and positive living for PLHAs	14. Protect and provide support for orphans and vulnerable children 15. Provide social protection for people made vulnerable from the affects of HIV and AIDS 16. Promote programmes of food security and income/ livelihood generation for PLHA and their caregivers/ families	17. Mainstream HIV and AIDS into district level development policies, strategies, plans and budgets 18. Improve capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination 19. Mainstream HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets 20. Develop and implement comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support 21. Support the development of workforce development strategies which prioritise the key sectors critical to the response to HIV and AIDS	22. Strengthen mechanisms and systems for monitoring and evaluation of the multi-sectoral response 23. Improve capacity of implementing partners for monitoring and evaluation of the situation and the response 24. Strengthen operational and behavioural research and access to information on best practice and cost effective interventions	25. Strengthen the institutional and legal framework 26. Improve coordination and resolve areas of duplication and gaps in the multi-sectoral response to HIV and AIDS to include resource management 27. Advocate for mainstreaming, effective policy implementation and fighting stigma and discrimination 28. Promote effective leadership for the multi-sectoral response for HIV and AIDS

2.0. INTRODUCTION

2.1. Background

The human toll of HIV and AIDS is a tragic reality being experienced by families, communities and the nation at large. There is no aspect of life that has not directly or indirectly been negatively influenced by the epidemic. AIDS has become the major cause of illness and death among the young and middle aged Zambians, depriving households and society of a critical human resource base and thereby reversing the social and economic gains Zambia is striving to attain. The feminisation of the disease means that our young women are at 5 times greater risk of contracting HIV than our young men.

In effect, HIV and AIDS are limiting the realization of economic development and have the potential to continue diminishing the chances of alleviating poverty and hunger, of achieving universal primary education, of promoting gender equality and of reducing child and maternal mortality. HIV and AIDS, therefore, seriously undermine our commitment to achieving the Millennium Development Goals (MDGs).

The HIV and AIDS epidemic is as much a development concern as it is a health concern. The increase in morbidity and mortality rates due to AIDS is altering the Zambian population structure and the functioning of the productive sectors by limiting both productivity and the supply of services. Simultaneously HIV and AIDS increase the demand for adequate and quality health and other social services. Consequently, the nation has continued to witness a breakdown in social service delivery, a reduction in household incomes and a less than optimal economic growth rate necessary for overall national development.

It is not possible to understand the magnitude of the challenges to be addressed without taking a holistic view of the situation. The Zambian Government, Cooperating Partners and programme implementers now agree that HIV and AIDS is more than a health problem and requires a broad-based multi-sectoral approach to address the many facets of the epidemic. There is a strong realisation that HIV and AIDS are very much inter-linked with poverty, social and economic inequities between men and women and long-standing cultural behaviours and beliefs.

While there have been major advancements in HIV prevention, and AIDS treatment and care in Zambia, efforts to significantly scale up responses to HIV and AIDS have been inadequate and insufficient. A more systematic approach is needed to build local capacity to manage and sustain a comprehensive response to the epidemic. Through efforts to create a more enabling environment for community based and local government initiatives, foundations can be built to support the scaling up of responses to HIV and AIDS.

As we implement our National HIV/AIDS/STI/TB Policy which commits us to providing treatment for AIDS and improved care and support for those affected by AIDS, it is as crucially important that we commit to a renewed emphasis on behavioural change to control the rate of new infections.

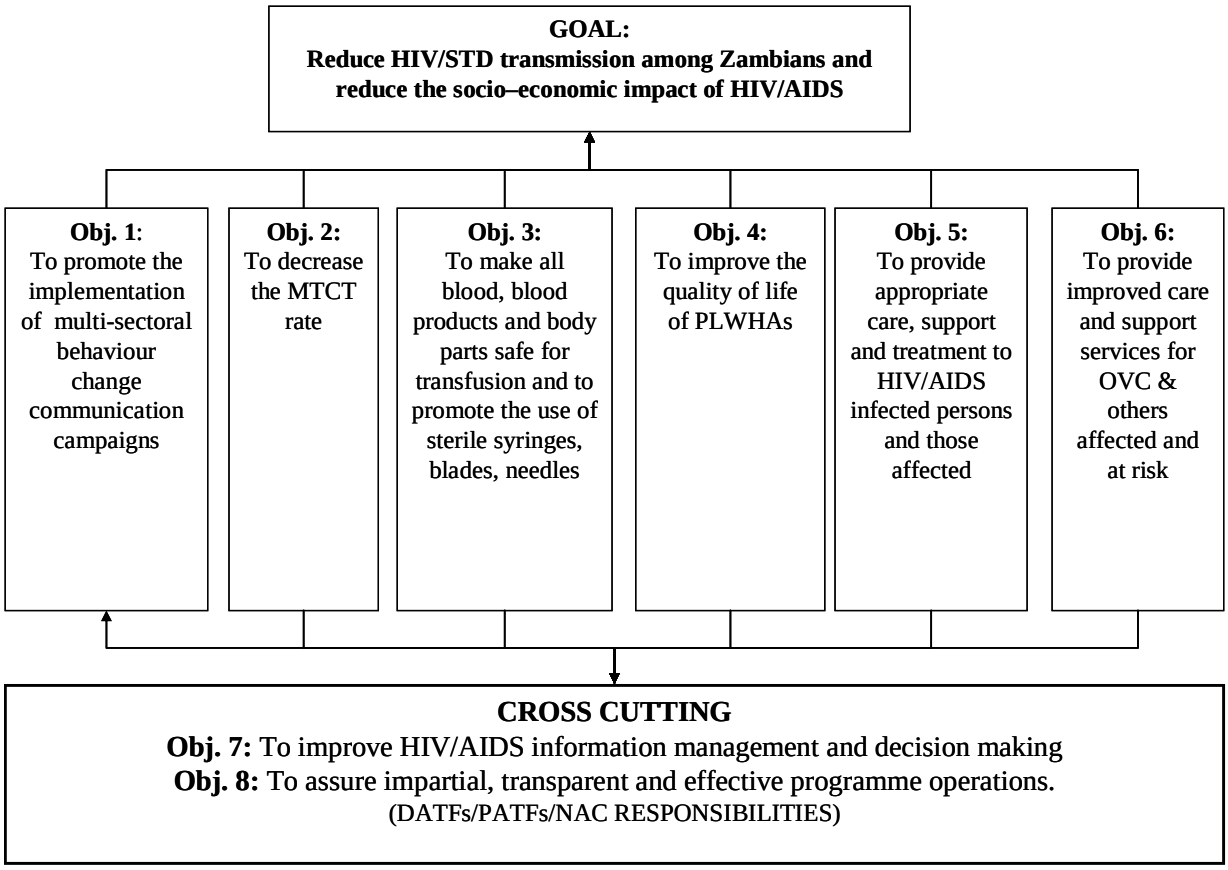
The National HIV and AIDS Strategic Framework 2006-10 has been mainstreamed into the National Development Plan 2006-2010. This provides an opportunity to further the process of putting in place appropriate measures and strategies to control this crisis. To address all the dilemmas associated with HIV and AIDS, activation of development planning institutional structures at all levels must be facilitated to sustainably support the process of forecasting and planning for the future trends and galvanising action to mitigate the impacts of the epidemic.

3.0. REVIEW OF PAST PERFORMANCE OF HIV and AIDS RESPONSE

3.1. The Objectives of the National HIV/AIDS Intervention Strategic Plan (NAISP) 2002-5

The goal of the National AIDS Intervention Strategic Plan (NAISP) 2002-5 was to **reduce HIV/STD transmission among Zambians and reduce the socio-economic impact of HIV/AIDS**. The Plan was comprised of eight strategic objectives, the first six principally focused on different strategic interventions to reduce transmission and provide treatment, care and support to people living with HIV and AIDS while the last two objectives re cross cutting with a focus on improving the enabling environment for a coordinated and sustainable response. Figure 1 provides a summary of these strategic objectives.

Figure 1: Summary of the Strategic Objectives of the NAISP 2002-5



3.2. Progress with the NAISP 2002-5

3.2.1. Indicators at a Glance

Figure 2 illustrates the outcome and impact level indicator set which were used to monitor progress of the objectives of the NAISP 2002-5 and *Table 1* provides the status of these indicators.

Figure 2: Summary of the Strategic Objectives of the NAISP 2002-5

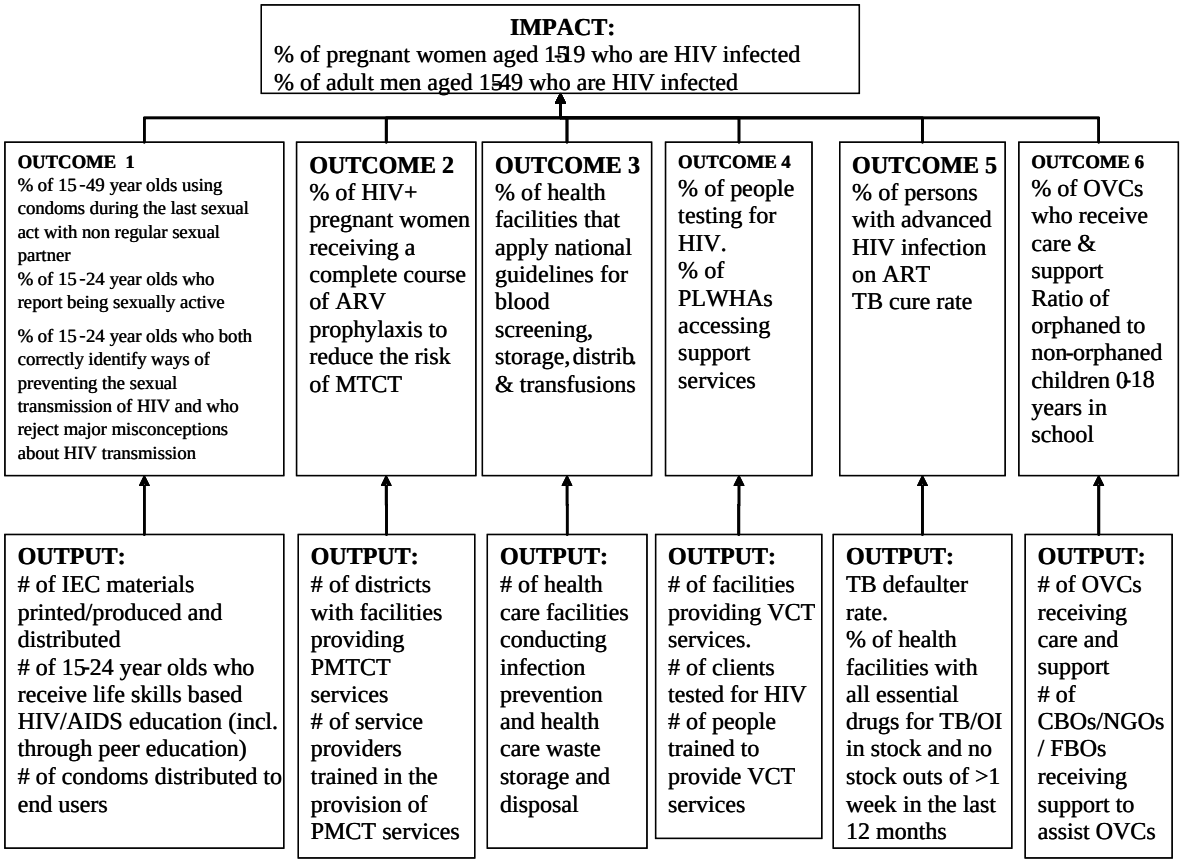


Table 1: Indicators at a glance 2005[4]

LEVEL, AREA, AND OBJECTIVE	CORE INDICATORS	DATA SOURCE	2005 Status	Trend from Baseline
	IMPACT LEVEL			
Reduce HIV/AIDS transmission among Zambians and the socio economic impact	*1. Percent of infants born to HIV infected mothers who become infected*	COHORT STUDY	Not available	39%
	2. Percent of pregnant women aged 15-19 who are HIV infected	SENTINEL SURVEILLANCE	11.7 % (2004)	14.1% (1994)
	3. Percent of adults aged 15-49 who are HIV infected	DEMOGRAPHIC AND HEALTH SURVEY	16% (2002)	First data point in 2002
	4. Percent of 15-24 year olds who are HIV positive		7.7% (2002)	First data point in 2002
STRATEGIC	***OUTCOME INDICATORS***			
Prevention of Mother to Child Transmission	*5. Percent of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT*	HEALTH MANAGEMENT INFORMATION SYSTEM	25% (2005)	
TB Treatment (TB)	*6. Tuberculosis cure rate*		72.5% (2003)	50% (2001)
Promotion of Safer Sex Practices (ABCs)	*7. Percent of schools with teachers who have been trained in life skills education and taught it during the last academic year*	EDUCATION CENSUS	60% (2005)	
	8. Median age at first sexual debut	ZAMBIA SEXUAL BEHAVIOUR SURVEY (ZSBS)	18.5 years (2005)	16.5 years (1998)
	9. Percent of 15-24 year olds who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		43.5% (2005)	28% (2000)
	10. Percent of 15-49 year olds using condoms during the last sexual act with non regular sexual partner		38.4% (M) 26.1% (F) (2005)	38.9(M) 33.0(F) (2000)
Voluntary Counseling and Testing (VCT)	*11. Percent of the general population aged 15-49 years receiving HIV test results and know their results*		8% (2005)	5% (2000)
Support for Orphans and Vulnerable Children (OVC)	*12. Percent of OVCs to whom community support is provided*		13.4% (2005)	First data point in 2005
	13. Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years		1.03 (2005)	
STI Treatment (STI)	*14. Percent of clients with STIs who report having been diagnosed, treated and counselled according to national guidelines*	HEALTH FACILITY SURVEY	n/a	10% (2000)
Traditional Healers	*15. Percent of traditional healers who store and use sharp instruments according to national safety guidelines*		n/a	
Anti-retroviral Therapy (ART)	*16. Percent of persons with advanced HIV infection receiving ARV therapy[5]*		25% of target (2005)	6% (2004) (12,000 people on treatment)
Sectoral Mainstreaming	*17. Percent of workplaces with HIV/AIDS policies and programmes*	WORKPLACE-BASED SURVEY	80%	increasing

[4] Zambia UNGASS 2005 Report, NAC and UNAIDS

[5] 51,764 reported on ART by Dec. 2005. The private sector information has not yet been integrated into the public sector HMIS

3.2.2. Status of the HIV and AIDS Epidemic

Zambia, with a population of over 10.3 million and an annual growth rate of 2.9 percent (Census 2000), is one of the Sub Saharan African countries worst affected by the HIV and AIDS pandemic. Estimates put the prevalence rate of about 16 percent among the 15-49 years age group and about 1 million Zambians infected with HIV, of which over 200,000 are in need of antiretroviral therapy. 7.7 % of young people aged 15-24 years and 40% of infants born to HIV infected parents are HIV infected[6]. More than 50 per cent of the population is less than 20 years of age and constitutes the most vulnerable group to new HIV infection.

Overall Stabilisation of HIV Prevalence

Recent trend analysis for the period 1994 to 2004 indicate a stabilisation of HIV prevalence, with national adult prevalence at 16% in 2002. However, the analysis based on sentinel surveillance, indicates that the national situation contains many smaller epidemics with their own dynamics in different geographical, sectoral, and other population groups. Programming must take these into account with sound analysis and understanding of the driving forces for the epidemic in different population groups, between genders and in different age cohorts.

Higher prevalence among women

The prevalence is significantly higher among women compared to men especially for those below the age of 35. Overall, women are 1.4 times more likely to be HIV-infected than men, with prevalence rates of 17.8% for women and 12.6% for men with infection rates among young women aged 15-24 years 4 times higher than those for young men in the same age group. Cross-generational sex and transactional sex makes younger girls more vulnerable to HIV infection than males their own age. Prevalence among women is highest between the ages of 30 to 34 and is thought to be as a result of high levels of social and economic vulnerability, inadequate access to life skills and information, low levels of negotiation skills, and unequal protection under statutory and customary laws and traditions.

Higher prevalence in urban areas and within provinces

According to the ZDHS 2001-2, 23% of urban residents were HIV positive compared to 11% of rural residents. Urban residents are more than twice as likely to be infected as rural residents: The HIV prevalence rates vary significantly by and within Provinces, with a range of 8% in Northern Province to a high of 22 percent in Lusaka province.

Vulnerability among youth

The age at first sexual debut among young people 15-24 year old, has continued to show a steady increase from the average of from 16 years (1998) to 17 years (2003) to 18.5 years in 2005[7]. This implies that young people are delaying sexual activity thereby reducing early risky sexual behaviour. Also, the percentage of young people

[6] University Teaching Hospital Study, 1999
[7] Zambia Sexual Behaviour Survey, 2005

reporting having sex with a non-regular partner has decreased to 18.6. However, only 43.5% of young people demonstrate comprehensive knowledge of HIV and AIDS and only 26.1% of young women 15-24 years reported using a condom at last sex with non regular partner. The Antenatal Sentinel Surveillance indicates that young girls who are pregnant have very high rates of HIV. This indicates that young sexually active girls are at very high risk of HIV.

Other Risk Factors

The most at risk individual in Zambia is the sero-negative partner of a HIV discordant couple. It is estimated that 21-26% of all couples are discordant[8]. A recent secondary analysis of the Zambia DHS 2001-2 indicates that culture and regional social norms may be the most significant factor contributing to men engaging in extramarital sex and being exposed to HIV transmission.

Summary

In summary, Zambia has not achieved the overall decrease in prevalence HIV as hoped in our goal for 2005. However, caution is needed in using prevalence rates to monitor the progress of the epidemic. The effect of the National Policy of providing free ART, initiated in 2004, for those persons deemed in need of treatment will have significant positive implications for the epidemiology of HIV and AIDS. The prevalence of HIV is influenced by the rate of new infections and the mortality rate of those already infected. Availability of ART will decrease the mortality rate and, therefore, in the short to medium term prevalence could in fact increase as ART becomes more readily available. The determining factor for decreasing overall prevalence in the longer term will be the control of the rate of new infections.

It is important, therefore, that in order to maintain this apparent progress that the variations observed by age, gender, geographic region, and by other risk and vulnerability factors need to be seriously taken into account.

Still, even in the midst of such an epidemic, it is important to remember that 84% of people aged 15-49 remain uninfected with HIV, and have the opportunity to take measures to protect themselves and help stop the spread of the virus. This is why a strong response to the epidemic from all sectors of Zambian society is critically important[9].

In the new planning horizon of 2006-2010, there is an urgent need to address the smaller epidemics within the generalized epidemic, in order to reach those people most in need of treatment, care and support and aggressively prevent the next wave of new infections. The Strategic Framework has the potential to do that by focusing new and available resources in a more harmonized way and to institutionalize the response in the evolving coordination structures and mechanisms.

[8] Modeled by CDC/Zambia
[9] HIV and AIDS Communication Strategy, NAC May 2005

3.3. Patterns of Transmission of HIV[10]

Nearly 80% of HIV transmission in Zambia is through heterosexual contact. This mode of transmission is exacerbated by the high-risk sexual practices, poor socio-economic status of women and high prevalence of STIs. The remaining 20% is predominantly due to mother-to-child transmission during pregnancy, at birth or while breastfeeding. It is estimated that less than 1% is through contaminated blood and blood products, use of needles and sharp instruments and sex between men.

3.4. The Environment

The main factors that could impact on the performance of Zambia during the implementation of this strategic plan include political and legal, economic, social and cultural, and technological factors, as summarized below.

3.4.1. Political and Legal Factors

The political climate in Zambia is generally peaceful, stable and conducive for smooth delivery of services throughout the country. However, there are some major political and legal developments that could impact on the implementation of this plan.

National Decentralisation Policy of 2003

In 2003, the Government launched the National Decentralisation Policy, which will be implemented over a period of 10 years, starting from 2003. This development has brought in another dimension to the future organization and management of services in Zambia, with major implications on planning, resource allocation, human resource management and accountability, as the overall decentralization policy calls for channeling and control of resources through the Local Authorities at district level.

While the National Decentralisation Policy aims at devolving responsibilities to the district level, the provincial level management will provide the necessary intermediate level of programme management, coordination and supervision of district authorities.

3.4.2. Economic Factors

Macroeconomic Overview

Since 1992, the Government has continued to pursue stringent fiscal policy measures aimed at stabilizing the macroeconomic environment and achieving sustainable economic growth. During the period from 2000 to 2004, the Zambian economy registered positive real growth at an average rate of 4.6% per year, which is higher than the average rate of 4.4% projected for the period from 2001 to 2005 (MoFNP: TNDP/2002-05). Despite the improvement in GDP growth rate, it is still inadequate to have significant changes on the standard of living and health status of Zambians. It is estimated that the economy must consistently grow at 7-8% per annum for at least 10 years, in order to achieve the desired people-level impact.

[10] The HIV/AIDS Epidemic in Zambia, NAC September 2004

Table 2 presents selected key macroeconomic indicators for the period from 2000 to 2004.

Table 2: Selected Key Macroeconomic Indicators, 2000-2004

Indicator	Unit	2000	2001	2002	2003	2004
Real GDP Growth	%	3.6	4.9	3.3	5.1	5.0
GDP	US$ 'Mil.	3,239	3,640	3,776	4,318	5,409
Inflation Rate (Year-end)	%	30.1	18.7	26.7	17.2	17.5
Domestic Fiscal Deficit	% GDP	-	-	3.3	5.1	1.9
Exchange Rate	K/US$	3,111	3,608	4,307	4,743	4,772
% GHE to GDP	%	-	7	6	6	6

Source: Ministry of Finance and National Planning: Macroeconomic Indicators and Economic Reports

Specific social and work-based groups

High mobility of specific social and work based groups puts them at risk because they are away from the security and stability of home and tend to engage in high risk sexual behaviour, at times for monetary and material favours. These include refugees, long distance truckers, migrant workers, cross-border traders, fish mongers and uniformed security personnel.

Drug and alcohol abuse

Drug and alcohol abuse enhances the risk of HIV infections either directly or indirectly by lowering inhibitions which lead to risky behaviours. In particular, drug in-take through syringes (or intravenous drug use) which involves sharing of needles has been shown to be an extremely high risk behaviour among this group, though less common, in Zambia, than the risks associated with alcohol use.

3.4.3. Social/Cultural Factors

Demography

In 2000, the Zambian population was estimated at 9.9 million (CSO 2000), with an average growth rate of 2.5%. The population for 2005 is estimated at 11.3 million. Out of the total population, approximately 50% are males and 50% females. Zambia is one of the countries with the highest dependency ratios in the world, with 47% of the total population being children under the age of 15 years. It is one of the most urbanized countries in Sub-Saharan Africa, with approximately 38% of the population living in urban areas. Unemployment is high and presents a serious social problem. According to the Living Conditions Monitoring Survey (LCMS III) for 2002/2003 (CSO-LCMS III 2003), out of the estimated labour force of 4,055,169, 13.3% were unemployed, 14.7% were employed in the formal sector and the balance in the informal sector. A combination of a high dependency ratio and high unemployment presents a significant challenge for HIV and AIDS.

Poverty and HIV and AIDS

Poverty levels in Zambia have remained high. In 2002, the overall poverty incidence was estimated at 67%. The link between HIV and AIDS and poverty has been well established.

High levels of poverty directly or indirectly promote behaviours which create vulnerability to HIV and AIDS. In turn, the consequences of HIV and AIDS can lead to poverty resulting in a complex and mutually re-enforcing inter-relationship between HIV and AIDS and poverty; where the majority of the poor are women.

As a result of poverty, preventable and treatable diseases have taken an enormous toll on the poorest people in Zambia who do not have access to professional care, health information, education, and secure employment. Further, evidence from research in Zambia has shown that although the poorest people suffer disproportionately from preventable diseases, they tend to make less use of health services. Table 3 presents statistics on the poverty situation in Zambia.

Table 3: Poverty Situation in Zambia, 1996-2002

Indicator	Indicator	1996	1998	2002*
National Incidence	%	78.0	73.0	67.0
Incidence of Extreme Poverty	%	66.0	58.0	46.0
Rural Poverty (% of Rural Population)	%	89.0	83.0	72.0
Urban Poor (% of Urban Population)	%	60.0	56.0	28.0
Income Distribution (Gini Coefficients)	-	0.61	0.66	0.57

Source: Ministry of Finance and National Planning – Economic Report 2004
*** The methodology used in 2002 was different from the other years**

Literacy Levels and inadequate and inappropriate communication

The average national literacy rate in 2001-02 was estimated at 65.1% (ZDHS 2001-02). In all the age groups, literacy levels for men were higher than for women. The total literacy level for men was 81.6%, against 60.6% for women. Literacy levels were also higher in urban areas (79% for women and 91% for men) than in rural areas (48% for women and 76% for men). Literacy levels for the 15-24 years age group stood at 59% for females and 71% for males. Poor literacy levels, especially among the females and rural dwellers, has adverse implications on service delivery as it presents difficulties in communicating HIV and AIDS related messages and programmes.

Communication is often inadequate and inappropriate due to the fact that, in many cases, information disseminated is not audience-specific, not based on evidence, incomplete due to cultural and religious beliefs and not geared to changing risky behaviours. Discussions of sexual matters between children and their parents and other authority figures such as teachers are, in most cases, still regarded as taboo.

Gender and HIV and AIDS

Gender issues that perpetuate the dominance of male interests and lack of self-assertiveness on the part of women in sexual relations put both men and women at risk. Women are taught to never refuse their husbands sex regardless of the number of extra-marital partners he may have or his non-willingness to use condoms. This is often the case even when he is suspected of having HIV or other STIs.

Socio-cultural beliefs and practices

Socio-cultural beliefs and practices such as having concurrent and multiple-sexual partners, cross-generation sex, transactional sex, dry sex, the traditional practice of sexual cleansing and some practices during initiation ceremonies facilitate the transmission of HIV.

Stigma and discrimination

Stigma leads to discrimination, silence, shame, denial and blaming others with the result that there are unnecessarily delays in diagnosis and/or treatment are. As ART becomes more widely accessible and acceptable, fear of the diagnosis of HIV will be less of the issue and feelings borne of shame and denial will place an increasingly important role.

Prison confinement

Prison confinement can increase vulnerability to HIV due to frequent unprotected sex in the form of rape, non-availability and non-use of condoms as well as a high prevalence of STIs.

Since the most important determinants of inequalities may reside in the broader social economic environment, the major challenge for the HIV and AIDS programme will be to improve the targeting of resources to disadvantaged districts and populations with higher gender inequities and poverty.

3.4.4. Technological Factors

Significant advances in the world of science and technology present major challenges and opportunities for the health sector in Zambia. Currently, there are a number of methodologies and technologies on the market, which could be used in resolving major healthcare problems in a more efficient, effective and economical manner. These include:

- Anti-Retroviral Therapy (ART) which presents an opportunity for the management of AIDS cases. ART has the ability to extend the lives of HIV-infected individuals;

- Lower costs of computers, improved connectivity, the internet and more user-friendly software packages that could improve the abilities of service providers

to communicate and share data and contribute to improvements in efficiencies and cost-effectiveness;

Whilst it is acknowledged that there are significant advances in the fields of science and technology, the need to carefully assess and only access the most appropriate, ethical, affordable and sustainable new sciences and technologies is of critical importance. Zambia will need to develop appropriate policies and approaches for accessing the new developments in science and technology in a planned, coordinated and cost-effective manner. Of critical importance will be the global partnerships and functional links with the private sector.

3.5. Social and economic impact of HIV and AIDS

The pandemic is taking place within a development framework burdened with high levels of poverty. Zambia ranks 163 out of 175 countries according to the 2003 Human Development Report index meaning the country is among the poorest in the world. In 1998, 80 percent of Zambians lived below the poverty datum line. The Government of Zambia has declared HIV and AIDS a disaster and an emergency. The impact of HIV and AIDS on the country has been enormous both in the social and economic spheres, with reversals in many of the human development indicators.

Human Resource Supply implications

At the social level, the impact has been on the individual, household, community and national levels. HIV and AIDS have tended to affect mostly the income earners. At national level, the impact has been felt in high mortality and morbidity rates among workers, both in public and private employment and in the informal sector reaching as far as the peasant farmers. Our education, health and security sectors are those known to be most affected. At the economic level, productivity in sectors such as agriculture, mining and manufacturing as well as tourism have also been adversely affected.

Increasing numbers of orphans and vulnerable children affected by HIV and AIDS

HIV and AIDS has left an estimated 750,000-1,200,000 orphans, many of whom will have no hope of obtaining formal education if no pragmatic steps are taken. This will affect the quality of the future labour force in Zambia, as well as having possible impacts on national security. It has been estimated that 6% of these children are in the streets. Less than 1% lives in orphanages.

3.6. Institutionalising the Government Response

To achieve these objectives, Government has put in place a number of national support structures:

- a high level Cabinet Committee of Ministers on HIV and AIDS, which provides policy direction, supervises and monitors the implementation of HIV and AIDS programmes.
- the National AIDS Council and Secretariat (NAC), established through an Act of Parliament in 2002, is a broad-based corporate body with government, private sector and civil society representation. The NAC is the national mechanism to coordinate and support the development, monitoring and evaluation of a multi-sectoral national response to HIV and AIDS whose overall mission is the prevention and combating of the spread of HIV and AIDS and reduce the personal, social and economic impacts of the HIV and AIDS epidemic.
- the National HIV/AIDS/STI/TB Policy of 2005 provides the directive and mandate for the national response.

At decentralised levels, NAC has established Provincial and District HIV and AIDS Task Forces (PATF and DATF). These are intended to operate as sub-committees of the decentralised development coordinating structures, the Provincial Development Coordinating Committees (PDCCs) and the District Development Coordinating Committees (DDCCs) respectively. Local level planning to support development of more strategic planning for HIV and AIDS at decentralised Districts level has been initiated. Districts have also been provided guidelines for mainstreaming of HIV and AIDS into the District Development Plans and sector plans.

3.7. Moving Forward with the Multi-Sectoral Response

The process of Vision 2030 and developing the HIV and AIDS chapter in the Fifth National Development Plan (FNDP) has produced several ideas supporting our goal of national prominence in Sub-Saharan Africa in the fight against HIV and AIDS. Almost all of these suggestions have merit, and have earned acknowledgment in this chapter. They can best be thought of in relation to the ‘Three Ones’ principles, in that success will require a multi-sectoral response that is jointly coordinated, prioritised and monitored.

4.0. VISION, MISSION, GOAL and GUIDING PRINCIPLES

4.1. Our Vision (for HIV and AIDS by 2030)

A nation free from the threat of HIV and AIDS

4.2. Our Mission

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

4.3. Our Goal

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

4.4. Our Guiding Principles[11]

We agree to work to these guiding principles as the core values of the response

- **Adoption of a human rights approach** which requires that the rights of the people of Zambia, to equality before the law and freedom from discrimination, are respected, protected and fulfilled. This in turn means that programmes and interventions are **people centred** and **culturally sensitive** supporting and empowering communities, families and individuals to develop their own competencies and to learn from the experience of others. This approach further calls for strong **political leadership, commitment and engagement** so as to promote **good governance, transparency and accountability** at all levels and in all sectors.

- The **greater and meaningful involvement of PLHA (GIPA)** at all levels of the response

- **Gender equity and HIV issues** are interconnected

- HIV and AIDS interventions should be **pro-poor with HIV and AIDS mainstreamed** in the national development agenda, sector policies, plans and budgets of the Country in order to ensure **sustainability**. These are to include the Poverty Reduction Strategy (PRSP), National Development Plan (NDP), the Medium Term Expenditure Framework (MTEF) and other national development instruments

- Controlling HIV and AIDS needs the involvement of all sectors of society **through the multi-sectoral response and partnership** in the design, implementation, review, monitoring and evaluation of the National AIDS Strategic Framework (NASF) in order to ensure success and effectiveness of

[11] National HIV and AIDS Policy, 2005

the response. This is in keeping with the nationally supported "**Three Ones" approach:** one national coordinating authority, one strategic framework, and one monitoring and evaluation framework

- Implementation shall be in line with the National **Decentralisation** Policy to ensure maximum participation by communities and to strengthen the leadership by the District Development Coordination Committees

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

Our Impact Indicator for 2015

- HIV prevalence among pregnant women aged 15-19 years (Estimate of HIV incidence)

Our Outcome Indicators for 2010

- Percent of persons with advanced HIV infection receiving ART and are alive 12 months after starting treatment

- Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years increased

- Percent of 15-24 year olds who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

- Percent of 15-24 year olds using condoms during the last sexual act with non regular sexual partner

- Percentage of infants who are born to HIV infected mothers who become infected

- The National Composite Policy Index

5.0. THEMES AND STRATEGIC OBJECTIVES

Our competence in dealing with HIV and AIDS related issues has been growing over the years through the determination of the communities, implementers and Cooperating Partners. This new Strategic Framework 2006-2010 represents an evolution of the previous plans, and of the continuing process to engage and include all sectors of the society to work together to achieve our collective vision and mission. We aspire to be better than we are – by continually expecting and creating a culture of hope and continuous improvement. A culture of hope will set the tone for our future, build on existing strengths, and recognize our commitment to quality in delivering the HIV and AIDS interventions.

In order to be more inclusive and to better represent the multi-dimensional aspects of the response, we have introduced Themes – in themselves multi-dimensional and multi-sectoral in nature. In the spirit of partnership, the themes and hierarchy of objectives have been built on the analysis of the various plans and intentions of the partners, and therefore, does not intend to replace those more detailed plans but rather provide a summary of shared goals and collective action. The six themes represent the summary priority action areas for all sectors and partners active in the multi-sectoral response for controlling HIV and AIDS.

For each of the themes, the basic rationale and the challenges are outlined and strategic objectives and core strategies identified. For the most part, the strategic objectives and strategies of the NAISP 2002-5 have been subsumed in these themes in their entirety in order to make the transition easier, so partners can continue working to their particular strength while beginning to explore other areas in which they may be interested in scaling up activities. The core strategies are built on past and emerging evidence based practices and are best indicative of a core approach to achieving the strategic objective but are not meant to be exclusive of new strategies or to stifle innovation.

The National HIV/AIDS/STI/TB Council (NAC) will lead the coordination of the response by all partners by building on the existing coordination mechanisms which are now in place. Incorporation of themes into the new framework will facilitate partners active in the work of controlling HIV and AIDS to continuously reflect and adjust their individual plans in a more responsive manner, based not only on their individual progress but the related work of other partners.

The partners active in the national multi-sectoral response, which include the districts and provinces, civil society, including the private business sector, and line ministries, have the opportunity to identify the specific thematic area, objectives and strategies in relation to their areas of comparative advantage to develop appropriate programmes, projects and interventions.

Themes – Priority Action Areas

The 6 themes represent priority action areas for 2006-10 and include:

I. Intensifying prevention of HIV
II. Expanding treatment, care and support for people affected by HIV and AIDS
III. Mitigating the socio-economic impact of HIV and AIDS
IV. Strengthening the decentralised response by mainstreaming HIV and AIDS
V. Improving the capacity for monitoring by all partners
VI. Integrating advocacy and coordination of the multi-sectoral response

The Partners of the National Multi-Sectoral Response

There are 5 broad groupings of partners of the multi-sectoral response working together for the benefit of the community. These include:

- Civil Society (CS) comprising
  - Faith Based Organisations (FBO)
  - Community Based Organisations (CBO)
  - Non Government Organisations (NGO): national and international
  - The Media
  - The Trade Unions
- Private Business Sector
  - Large companies (more than 150 employees)
  - Medium size (between 50-149 employees)
  - Small companies (between 6-49 employees)
  - Micro-business (1-5 employees)
  - Informal sector
- Cooperating Partners/Donors
- Public Sector
  - National, Provincial and District Level Government
  - State Enterprises and Parastatals
  - National HIV/AIDS/STI/TB Council
- Politicians
  - Parliamentarians
  - Cabinet
  - The President

Strategic Objectives

The following matrix illustrates the hierarchy of objectives from Vision to Strategic Objectives.

SUMMARY OF THE OBJECTIVES OF THE MULTI-SECTORAL RESPONSE TO HIV AND AIDS

Our Vision
A proud Zambia free from the threat of HIV and AIDS

Our Mission
The National Multi-Sectoral Response, coordinated by the NAC, is committed to controlling HIV and AIDS by integrating HIV and AIDS into the work of every partner and our development agenda.
We will scale up prioritised actions which are rapid and responsive to the needs of the local communities to be served.

Our Goal
Prevent, halt and begin to reverse the spread and impact of the HIV and AIDS by 2010

Our Guiding Principles[12]

- **Adoption of a human rights approach** which requires that the rights of the people of Zambia, to equality before the law and freedom from discrimination, are respected, protected and fulfilled. This in turn means that programmes and interventions are **people centred** and **culturally sensitive** supporting and empowering communities, families and individuals to develop their own competencies and to learn from the experience of others. This approach further call for strong **political leadership, commitment and engagement** so as to promote **good governance, transparency and accountability** at all levels and in all sectors.
- The **greater and meaningful involvement of PLHA (GIPA)** at all levels of the response
- **Gender equity and HIV** issues are interconnected
- HIV and AIDS interventions should be **pro-poor, with HIV and AIDS mainstreamed** in the national development agenda, sector policies, plans and budgets of the Country in order to ensure **sustainability**. These are to include the Poverty Reduction Strategy (PRSP), National Development Plan (NDP), the Medium Term Expenditure Framework (MTEF) and other national development instruments
- Controlling HIV and AIDS needs the involvement of all sectors of society **through the multi-sectoral response and partnership** in the design, implementation, review, monitoring and evaluation of the National AIDS Strategic Framework (NASF) in order to ensure success and effectiveness of the response. This is in keeping with the nationally and internationally supported "**Three Ones" approach:** one national coordinating authority, one strategic framework, and one monitoring and evaluation framework
- Implementation shall be in line with the National **Decentralisation** Policy to ensure maximum participation by communities and to strengthen the leadership by the District Development Coordination Committees
- It is essential that the national response to HIV and AIDS be guided by ethically sound, current **scientific and evidence based research** bringing out **best practices** and using a **public health approach** to guide prioritization and selection of the most cost effective interventions

[12] National HIV/AIDS/STI/TB Policy, June 2005

THEMES

VII. Intensifying Prevention	VIII. Expanding Treatment, Care and Support	IX. Mitigating the Socio-economic impact	X. Strengthening the Decentralised Response and Mainstreaming HIV and AIDS	XI. Improving the Monitoring of the Response	XII. Integrating Advocacy and Coordination of the Multi-Sectoral Response
STRATEGIC OBJECTIVES					
29. Prevent Sexual Transmission of HIV with a special emphasis on youth, women and high risk behaviours 30. Prevent Mother to Child Transmission 31. Prevent HIV transmission through blood and blood products 32. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment 33. Improve access to and use of confidential counselling and testing 34. Mitigate stigma and discrimination against HIV 35. Prevent HIV transmission through intravenous drug use 36. Support development and participation in HIV vaccine clinical trials	37. Provide Universal Access to ART including access to CCT at all Treatment Centres 38. Expand treatment for Tuberculosis, sexually transmitted infections (STIs) and other opportunistic infections (OIs) 39. Strengthen home/community- based care and support including access to comprehensive palliative care and pain management 40. Support the utilisation of alternative and/or traditional medicines which have scientifically demonstrated efficacy 41. Promote appropriate nutrition and positive living for PLHAs	42. Protect and provide support for orphans and vulnerable children 43. Provide social protection for people made vulnerable from the affects of HIV and AIDS 44. Promote programmes of food security and income/ livelihood generation for PLHA and their caregivers/ families	45. Mainstream HIV and AIDS into district level development policies, strategies, plans and budgets 46. Improve capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination 47. Mainstream HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets 48. Develop and implement comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support 49. Support the development of workforce development strategies which prioritise the key sectors critical to the response to HIV and AIDS	50. Strengthen mechanisms and systems for monitoring and evaluation of the multi-sectoral response 51. Improve capacity of implementing partners for monitoring and evaluation of the situation and the response 52. Strengthen operational and behavioural research and access to information on best practice and cost effective interventions	53. Strengthen the institutional and legal framework 54. Improve coordination and resolve areas of duplication and gaps in the multi-sectoral response to HIV and AIDS to include resource management 55. Advocate for mainstreaming, effective policy implementation and fighting stigma and discrimination 56. Promote effective leadership for the multi-sectoral response for HIV and AIDS

6.0 STRATEGIC OBJECTIVES AND CORE STRATEGIES

Core strategies have been built on present and emerging best practice and are at best indicative of a core approach to each strategic objective by theme. It is intended that the range of strategies will be continuously improved and documented in the NASF Operations Manual as they are approved by the Joint Review processes.

6.1. Theme 1: Intensifying Prevention

Summary

An intensified and comprehensive prevention programme consisting of behavioural change communication and behavior change interventions that encourage abstinence among unmarried youth, faithfulness among the married, and condom use for discordant couples, HIV+ individuals, and for individuals unable to abstain or to remain faithful to an uninfected partner; that promote universal HIV testing; and that link HIV prevention activities for youth to programs that support OVCs, educational support programs, and programs that increase income-generation opportunities and vocational training for youth

Overall objective

To strengthen communication and promotive activities in order to prevent and control HIV and STIs

Strategic Objectives

1. Prevent Sexual Transmission of HIV with a special emphasis on youth, women and high risk behaviours
2. Prevent Mother to Child Transmission
3. Prevent HIV transmission through blood and blood products
4. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment
5. Improve access to and use of Confidential Counselling and Testing
6. Mitigate Stigma and Discrimination against HIV
7. Prevent HIV transmission through intravenous drug use

Rationale and Challenges

The national HIV and AIDS response to date has successfully focused on mass media campaigns to sensitise and educate the general population, especially young people, on the ABCs of safer sex and on reduction of stigma and discrimination against people living with HIV and AIDS.

NAC has encouraged strong partnerships in developing, implementing and evaluating behaviour change and communication strategies at all levels: at national level through the Technical Working Group on Advocacy and IEC and at district level through the HIV and AIDS Task Forces.

According to the Zambia Sexual Behaviour Survey (2005), awareness of HIV and AIDS has become universal in both urban and rural areas. 97% of men and women have heard of HIV and AIDS. The same survey indicates that the proportion of males reporting to have a non regular sexual partner has steadily decreased from 39% (1998) to 28% (2000) to 29% (2003 and 2005). Among females the proportion changed from 17% (1998), to 16% (2000, 2003 and 2005).

Counselling and testing and prevention of vertical transmission

Counselling and testing services are being provided through two major models, stand alone sites, which currently are predominantly private and attract a significant proportion of males, and integrated sites located in public health facilities that tend to attract more females than males. Currently there are 400 sites offering VCT services. By mid 2005, there were 270 PMTCT health facilities in Zambia. These health facilities are distributed across 31 districts in all 9 provinces.

VCT is the entry point for PMTCT and over 62,000 women were tested in 2004 with 90 percent of women testing HIV positive receiving Nevirapine. According to this data, at least 12 percent of the expected numbers of pregnant women in the country were HIV tested through the PMTCT programme in 2004. The HIV prevalence at PMTCT from these sites was 23 percent higher than the 19 percent national prevalence recorded from sentinel surveillance sites. In 2005, Central Board of Health estimates that 25% of HIV positive pregnant women received a complete course of ARV.

HIV Prevention among Youth

The age at first sexual debut among young people 15-24 year old, has increased from the average of 16 years (1998) to 18.5 (2005) for either gender as well as they are reporting decreasing levels of sex with non-regular partners in the last 12 months with males reporting 24% and females 13%. However, condom use the last time they had sex with a non regular partner, in this age group, remains low and shows a decrease in 2005. Among males, it increased from 28% (1998) to 40% (2003), then in 2005, decreased to 38%. Among females it increased from 24% (1998) to 35% (2003) and reduced to 26% in 2005.

Strengthening Communication efforts

The HIV and AIDS Communication Strategy (May 2005) aims to promote behaviours and policy measures in support of HIV and AIDS prevention, treatment, care and support. It sets out a comprehensive set of communication objectives aimed at improving knowledge, behaviour change communication for safer sexual practices, accessing VCT and treatment, care and support services as well as to reduce stigma and discrimination.

More opportunities for HIV Prevention

The commitment to tackling AIDS is unprecedented. It is essential for Zambia in this next planning period, as access to ART is expanded, that a renewed and intensified prevention programme be implemented. Despite some of the success that has been demonstrated with HIV prevention efforts with small populations, like sex workers, many of these lessons have not been taken to scale for the general population to have an

impact on overall incidence. The epidemic can only be reversed by intensifying effective HIV prevention in scale and scope, so as to control the rate of new infections as the critical step to reducing the prevalence rate as the mortality rate falls and people with HIV survive. In addition, the number of new infections must be dramatically reduced in the next few years, to ensure that ART scale up remains economically and socially sustainable.[13]

This means that there must be a strong additional emphasis on reaching the youth of Zambia to increase their access to treatment and other support services, as well as behaviour change interventions starting with younger children to reduce stigma and discrimination for the growing number of persons who will live with HIV, and to ensure the formation of healthy behaviours.

In addition, emphasis needs to be placed on eliminating or reducing harmful practices such as cross-generational sex, transactional sex, and the practice of having concurrent and multiple sexual partners. Serious attention will need to be paid to changing gender norms and roles that encourage men to have multiple partners, prevent women from negotiating for condoms, and justify trading sex for gifts, grades, food, and support. With more persons living with HIV and AIDS, there will need to be a stronger focus on HIV prevention among HIV+ individuals in care and treatment settings.

Evidence-based best practices in prevention, proven to be effective in the NAISP 2002-05, should be scaled up throughout the country.

The combined impact of intensified HIV prevention **and** expanded access to treatment, care and support will have a multiplier effect for the communities in the longer term.

[13] Intensifying HIV Prevention, UNAIDS August 2005

Theme I: Indicative Core Strategies by Strategic Objective

Strategic Objective	Core Strategies[14]
1. Prevent Sexual Transmission of HIV with a special emphasis on youth, women and high risk behaviours	**1. Improve and expand IEC and BCC activities to ensure people have access to clear, accurate information on safer sexual practices (ABC), and practices that perpetuate HIV transmission, including certain cultural and religious practices, alcohol abuse, gender-based violence, cross-generational sex, multiple sexual partners, and transactional sex** **2. Equip Zambians, particularly youth, with knowledge and life saving skills to prevent new HIV infections** **3. Improve availability, accessibility and affordability of condoms, and other barrier methods, to all sexually active individuals throughout the country** **4. Strengthen prevention and control of sexually transmitted infections (STIs)** **5. Focus relevant BCC interventions on high risk behaviours and groups vulnerable to these behaviours e.g. mobile populations, refugees, truck drivers, prisoners, poor women**
2. Prevent Mother to Child Transmission	**1. Provide family planning services to all Zambians who want to avoid or delay pregnancy** **2. Encourage women and couples considering having a baby to first seek VCT** **3. Ensure that every pregnant woman has access to HIV/STI screening and treatment** **4. Provide specific information to the public on how to prevent mother-to-child transmission of HIV and other STIs** **5. Facilitate and support access to ARVs by HIV-positive pregnant women** **6. Support exclusive breastfeeding among HIV-positive mothers where options for child feeding are not available** **7. Support HIV-positive mothers who choose not to breastfeed with information on appropriate alternatives and potential risks** **8. Provide post-test and post-delivery services to mothers** **9. Encourage and promote male involvement in PMTCT services as well as meaningful involvement of HIV positive PMTCT clients in HIV prevention and community support related activities**
3. Prevent HIV transmission through blood and blood products	**1. Disseminate and ensure compliance with National Blood Safety guidelines** **2. Provide adequate blood donation and transfusion infrastructure and equipment in all major health facilities** **3. Establish a mechanism for letting blood recipients know the safety of blood before transfusion**
4. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment	**1. Disseminate and promote adoption of universal precautions and safe needle practices** **2. Ensure availability to post exposure prophylaxis for health workers** **3. Ensure availability to post exposure prophylaxis for victims of sexual violence or abuse**
5. Improve access to and	**1. Promote the establishment of VCT, static and mobile,**

[14] National HIV/AIDS/STI/TB Policy, Draft January 2005

Strategic Objective	Core Strategies[14]
use of Confidential Counselling and Testing	**services/centres through centres in all its major health facilities throughout the country** **2. Ensure that HIV counselling and testing is offered and available to all out-patients and in-hospital patients** **3. Develop and disseminate appropriate procedures, guidelines and standards (protocols) for VCT services** **4. Ensure that only HIV testing techniques and approaches that meet required national and international standards are utilised** **5. Strengthen and support VCT as an integral component of HIV/AIDS/STI/TB prevention, control and care** **6. Support appropriate training in VCT, and support the institutions and organisations offering VCT training** **7. Develop VCT guidelines for children** **8. Promote community-based and family-based counselling and testing** **9. Standardise guidelines for peer educators and counsellors** **10. Ensure timely forecasting, quantification, procurement and distribution of HIV test kits**
6. Mitigate Stigma and Discrimination against HIV	**1. Educate the public about the need to eliminate stigma and discrimination against PLHA** **2. BCC interventions aimed to reduce discriminatory behaviour against PLHA, with a particular focus on youth and young children** **3. Greater and meaningful involvement of people living with HIV/AIDS in national and community based programmes and activities**
7. Prevent HIV transmission through intravenous drug use	**1. Design and implement harm reduction strategy for IDU and HIV**

6.2. Theme II Expanding Treatment, Care and Support

Summary

The need to expand the treatment, care and support people infected and affected by HIV and AIDS is very critical at this stage of the epidemic. This also includes palliative care and support for chronically ill and families.

Overall objective

To expand access to appropriate care, support and treatment for People living with HIV and AIDS and their caregivers and their families including services for TB, STIs and other opportunistic infections

Strategic Objectives

9. Provide Universal Access to ART including access to CCT at all treatment centres
10. Expand treatment for tuberculosis, sexually transmitted infections (STIs) and other opportunistic infections (OIs)
11. Strengthen home/community-based care and support including access to comprehensive palliative care and pain management
12. Support the utilisation of alternative and/or traditional medicines which have scientifically demonstrated efficacy
13. Promote appropriate nutrition and positive living for PLHA

Rationale and Challenges

Antiretroviral Treatment (ART)

The Zambian Government has made a conscious decision to make Anti Retroviral Drugs (ARV) available to all its citizens requiring this service. By the end of 2003, roughly 3000 people were accessing ARVs through the public sector, a figure that rose to 5,586 by April 2004 and dramatically to 24,000 by the end of 2004. In September 2005, the Government took the decision to make the provision of all Anti Retroviral Treatment (ART) including ARVs and related services (i.e. laboratory procedures, etc) free of charge and by the end of 2005 there were 50,000 people on ART out of an estimated number of 200,000 people living with HIV/AIDS who were in need of the therapy in that year. This implies that ART services catered for only 25% of those in need.

The sex ratio of adults on treatment from reports specifying sex shows more female are accessing treatment than males. The number of private sector facilities providing ART is difficult to monitor as individual doctors may not report to Government. Staff training for the various aspects of ART needs to continue and be scaled up, including the medical and counselling aspects and for community mobilization.

Patient charges, in the form of high patient assessment costs plus a monthly service fee, were said to be out of the reach of most patients and, therefore, these are considered barriers to accessing treatment. However, one of the greatest challenges for those who

are on treatment is the question of maintaining good nutritional status and accessing food supplementation.

For children, the main challenge is development of child friendly HIV and AIDS services including child counselling and treatment adherence counselling as many children are cared for by grandparents or other siblings who, in most cases, are busy fending for their families. Another key issue is obtaining paediatric formulations in syrup form, particularly of fixed dose combinations. Currently children were generally being given adult tablets broken up to approximate dosage. The number of children on treatment had risen to 403.

Tuberculosis and HIV

TB is a major threat in Zambia. Notification rates have increased from 105 per 100,000 in 1985 to 545 in 2002 and 580 in 2004, with the peak age between 20-35 years. Approximately 70% of TB patients are infected with HIV and more than 50% of people with HIV will develop TB in their life time, with TB the leading cause of mortality among PLHA. Closer linkages between the TB and HIV and AIDS are being built in the National Health Strategic Plan in recognition of the need to prioritise TB in the treatment programmes for HIV and vice versa.

Operational research on drug resistance

Currently, a total of thirteen (13) samples have so far been tested for HIV drug resistance in Zambia. Of the thirteen, eight had mutations associated with drug-resistance targeting ARVs in the first line regimens. However, there is need for random sampling across the country in order to have a representative resistance figure.

The challenges include insufficient global scientific work in this area, insufficient capacity of genotyping laboratories to accommodate nation-wide surveillance coupled with a lack of a mechanism of measuring quality and lack of skilled personnel.

Care for PLHA

In response to the burden of the HIV and AIDS epidemic on the formal health care system, communities and households have also taken up the challenge of providing home-based care and support. The numbers of community groups that are providing home-based care have risen dramatically. Many of them are supported by faith-based organizations. There is also an increase in training programmes for community home-based care providers. Linkage and referrals between community home-based care providers and health facilities have also been established.

A study was undertaken to evaluate the information needs at all home based care levels for the development of a comprehensive home based care information system in Zambia and it is envisaged that the implementation of the recommendations should enable the national monitoring and evaluation of community home based care in line with the *National HIV/AIDS/STI/TB Monitoring and Evaluation Plan 2002-05.*

There have been numerous assessments of Palliative Care in Zambia by the African Palliative Care Association. Currently, in Zambia, the composite of activities that makes of good palliative care is unbalanced. It lacks pain assessment and management, the prophylactic use of Cotrimoxizole to prevent opportunistic infections, HIV prevention,

therapeutic feeding/foods, succession planning, and ART adherence and support. These life extending interventions need to be added to home-based, hospice and clinical care.

Traditional and Alternative Remedies

Traditional and alternative remedies have been areas of considerable attention in Zambia. To date, 18 herbal formulations prepared by the traditional healers have been analysed for anti-HIV activity. Two of these had shown to have some anti-HIV activity, but not all the experiments have been conclusive and are pending further analysis. In 2005, clinical trials on traditional medicines and alternative remedies were conducted and finalised on 3 herbal medicines with 5 drug naive patients enrolled for each herbal drug. The results of this trial should be available in mid-2006.

Theme II: Indicative Core Strategies by Strategic Objective

Strategic Objective	Core Strategies[15]
9. Provide Universal Access to ART including access to CCT at all Treatment Centres	**1. Scale-up ARV treatment programmes at all levels of health care** **2. Enforce strict quality, safety, and efficacy registration standards for all domestically-manufactured and imported ARVs** **3. Take a leading role in ARV price negotiations with manufacturers** **4. Create a revolving fund for procurement of ARVs** **5. Create an enabling environment for manufacturing HIV/AIDS drugs in the country** **6. Ensure that appropriate infrastructure, equipment and trained personnel are put in place throughout the country for ARV administration** **7. Promote universal routine counselling and testing of all at-risk patients entering a health facility, i.e. routine opt-out HIV Testing** **8. Provide post-exposure of prophylaxis and access to care for care-givers and public and private sector employees who are exposed to HIV** **9. Monitor compliance and drug resistance on a regular basis** **10. Advocate for strengthened drug/commodity logistics and HMIS systems** **11. Integrating VCT, PMTCT and ART into the public health care delivery system and in private health care services as well as into other existing health care services** **12. Integrating VCT, PMTCT and ART into pre and in-service training of medical personnel (doctors, nurses, clinical offices) as well as training of non-medical community support workers** **13. Introduce mobile VCT and ART follow-up to reach rural populations**

[15] National HIV/AIDS/STI/TB Policy, June 2005

Strategic Objective	Core Strategies[15]
10. Expand treatment for tuberculosis, sexually transmitted infections (STIs) and other opportunistic infections (OIs)	**1. Ensure availability and accessibility of appropriate infrastructure, equipment, drugs and reagents in all health facilities for the prevention, diagnosing and treatment of major opportunistic infections** **2. Strengthen skills in the prevention and management of opportunistic infections at all levels of health care** **3. Include pain assessment and management as an integral part of OI treatment** **4. Facilitate the standardisation of prevention, management and treatment protocols for opportunistic infections in both public and private health facilities** **5. Play a leading role in price negotiations for drugs and supplies for the prevention and treatment of opportunistic infections** **6. Train and retain adequate skilled human resources** **7. Develop viable and sustainable rural retention schemes e.g strengthening bonding system for new graduates tied to provinces where one is trained**
11. Strengthen home/community based care and support including access to comprehensive palliative care and pain management	**1. Improve and standardise the quality of palliative care, including home-based, hospice and clinical care for people living with HIV and AIDS** **2. Link home based and hospice care to VCT, PMTCT, ART and clinical treatment of opportunistic infections** **3. Support the establishment and operations of support groups for people living with HIV and AIDS** **4. Train community members in providing home based care to the chronically ill people enrolled in home based care** **5. Actively support communities and groups engaged in home-based care** **6. Strengthen primary health care and social welfare systems in support of home-based care** **7. Provide psycho-social support and appropriate skills to care givers** **8. Devise strategies to address burnout syndrome and infection risks among home and community service providers** **9. Ensure that the referral system adequately caters for PLHA so as to decrease the fragmented and piecemeal approach to palliative care** **10. Promote and strengthen and expand hospice services and other forms of palliative care** **11. Strengthen quality-nursing care and basic nursing skills of health providers, volunteers, family members and others as an essential component of PLHA care and support** **12. Mainstream PLHA, affected households and support groups in designing prevention, care and support programmes at all levels of the national health care system** **13. Support the development and dissemination of standardised care/training packages, protocols and guidelines for provision of quality palliative care at all levels of care** **14. Promote pain management at all levels of care through standardised training and advocating for regulation of prescription rights for opioids** **15. Ensure the availability and appropriate medical use of drugs to manage pain, including opiods as required** **16. Offer and provide VCT to all home-based care and hospice clients**

Strategic Objective	Core Strategies[15]
12. Support the utilisation of alternative and/or traditional medicines which have scientifically demonstrated efficacy	**1. Facilitate co-operation and collaboration between and among formal and alternative health practitioners with a view to ascertaining positive traditional medical practices that might help in combating the HIV/AIDS pandemic;** **2. Promote public awareness of known benefits and limitations of different types of alternative remedies so as to enable people make informed choices; and** **3. Promote scientific interrogation and verification of traditional medicine and claims of successful treatment of HIV/AIDS, STIs and TB.** **4. Facilitate enacting laws and developing regulations which shall support and promote rational and safe use of traditional/alternative remedies at all levels of health care delivery system**
13. Promote appropriate nutrition and positive living for PLHA	**1. Promote and strengthen nutrition interventions as an integral element of HIV/AIDS/STI/TB treatment, care and support at all levels of the national health care system** **2. Support access to micronutrient supplements and nutritious food for people living with HIV and AIDS (PLHA)** **3. Strengthen nutrition education among PLHA** **4. Encourage further fortification of staple foods with micro-nutrients**

6.3. Theme III: MITIGATING THE SOCIO-ECONOMIC IMPACT OF HIV and AIDS

Summary

Mitigating the socio-economic impact of HIV and AIDS has become a major challenge in the response to HIV and AIDS. This will remain so for the next decade

Overall objective

To provide improved social support services for those made vulnerable from the socio-economic effects of the HIV and AIDS crisis such as orphans and vulnerable children, PLHA and their caregivers/families

Strategic Objectives

14. Protect and provide support for orphans and vulnerable children
15. Provide social protection for people made vulnerable from the affects of HIV and AIDS
16. Promote programmes of food security and income/livelihood generation for PLHA and their caregivers/families

Rationale and Challenges

In terms of current school enrolment the 2001/2 DHS survey estimated that orphans were approximately 26% times less likely to be attending primary school than non-orphans, with the greatest drop being among double orphans. Those whose mother and father had died were 34% less likely to be enrolled in school.

The 1992 and 2001/2 DHS data showed a general decline in school enrolment of approximately the same magnitude for all children in Zambia over that 10-year period. In response to this the Government introduced free primary schooling in 2002 and a subsidy to assist vulnerable children. The *Second PRSP Implementation Progress Report covering the period July 2003 to June 2004* reported that school enrolment of orphans at secondary level increased from 20,437 in 2002 to 29,480 in 2003 and an estimated 30,217 in 2004.

The number of street children is not known, and available data are out-of-date. However, the total is unlikely to have fallen below the figure reported in 1995 of 75,000. Likewise it is difficult to measure the proportion of street children reintegrated into homes, although this is acknowledged to be slow and labour intensive per child. Various initiatives are in place to assist street children, particularly in Lusaka.

The increase in community schools and the provision of bursaries for poor children have contributed to increasing orphan access to basic education. In 2004 total orphan enrolment in schools, according to the Ministry of Education, was 536,672. The ratio of orphaned pupils to non orphans in primary schools was 0.14 in 2002.

Throughout Zambia, there are initiatives in support of orphans and vulnerable children being implemented by government, international donors, NGOs, and several other

groups. There are successful programs that keep children in the community rather than in orphanages. There are currently over 400 organizations with programs that work towards increasing income to vulnerable households. Other programs provide psychosocial and physical help to vulnerable families. Some other additional national achievements include:

1. The development of a child policy that addresses OVC issues comprehensively.
2. The development of a five year national strategic plan.
3. The establishment of district level coordinating mechanisms for OVC in some districts.

Theme III: Indicative Core Strategies by Strategic Objective

Strategic Objective	**Core Strategies**[16]
14. Protect and provide support for Orphans and vulnerable children	**1. Strengthen institutional capacity to support OVC** **2. Provide basic care and support to OVC, including educational assistance, shelter, nutritional support, clothing, medical care, legal assistance, psycho-social and spiritual support and protection against abuse and exploitation** **3. Train community care providers** **4. Integrate OVC and home-based care services** **5. Promote and support community-based care of OVCs and families looking after orphans** **6. Design a data capture mechanism for OVC** **7. Provide guidelines for and monitor operations of orphanages and drop-in centres**
15. Provide social protection for people made vulnerable from the affects of HIV and AIDS	**1. Scale-up relevant social programmes as a way of reducing poverty for those families and communities affected by HIV and AIDS**
16. Promote Programmes of food security and income/livelihood generation for PLHA and their caregivers/families	**1. Provide livelihood alternatives, nutrition supplement, legal assistance and other material support to persons receiving palliative care or on ART and their caregivers/families** **2. Promote appropriate agricultural strategies that ensure food security at individual, family and community level** **3. Promote economic empowerment through viable and sustainable income generation activities for the infected and affected** **4. Prioritise food assistance to food insecure households with chronically ill adults and children** **5. Introduce innovative activities that increase food security, improve nutritional status, and increase income of households with PLHA and OVC**

[16] National HIV/AIDS/STI/TB Policy, June 2005

6.4. Theme IV: Strengthening the Decentralised Response and Mainstreaming HIV and AIDS

Summary

A systematic approach is needed to build local capacity at district level to manage and sustain a comprehensive response to the epidemic through efforts to create a more enabling environment for community based local level initiatives. This will include a focus on strengthening the capacity at district level for managing, coordinating and monitoring of multi-sectoral response and implementation of HIV and AIDS interventions and mainstreaming of HIV and AIDS into the workplace and policies of public, private and civil society organisations to support harmonised and sustainable processes at the district level.

Overall objective

To build capacity at all levels (national, provincial, district and sub district) to manage and sustain a comprehensive response to the epidemic through efforts that create a more enabling environment for community based initiatives.

Strategic Objectives

17. Mainstream HIV and AIDS into district level development policies, strategies, plans and budgets
18. Improve capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination
19. Mainstream HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets
20. Develop and implement comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support
21. Support the development of workforce development strategies which prioritise the key sectors critical to the response to HIV and AIDS

Rationale and Challenges

Overall Implementing Mechanisms

In order to achieve the rapid scale up to halt and begin to reverse the epidemic, making a difference on the ground forms the basis of emphasis in the fight against HIV and AIDS under the Fifth National Development Plan. Provincial and national forums will continue to play important roles, both in the implementation of the HIV and AIDS strategies and recommendations and the wider support to integrated national and regional development planning. It is also recognised that each province or district is unique. Institutional capacities, needs, and progress in implementing the HIV and AIDS strategies and the "Three Ones" principles will differ considerably between provinces and districts, and so programmatic responses are tailored to local realities. This is particularly important in rural and remote districts of the country, which pose considerable challenges.

DHMTs have important implementation mandates on critical HIV and AIDS interventions such as laboratory testing, blood safety, treatment, clinical care, support and referral, research and awareness creation within the health delivery system. However, the Local Authorities and the DDCCs have the other important responsibility of integrating HIV and AIDS within the development context of the district. True joint programming between the traditional response of prevention, care, support and treatment and the social, cultural, political and economic determinants of vulnerability and susceptibility to HIV and AIDS is still elusive. Therefore, there is a tendency to engage sponsors separately, rather than access a common entry point to the full range of AIDS-related services available among the various stakeholders at district level.

In many districts, the DATFs have not succeeded in establishing a truly joint programme that includes the AIDS activities of all sectors at the district level. A particular challenge has been the relationships between the District Commissioners who chair the DDCCs, the District Directors of Health who are responsible for health service delivery at the district level and the Council Secretaries who are the chief officers of the Councils. The three should have complementary roles and responsibilities for the coordination of a multi-sectoral HIV and AIDS response, but in practice these roles and responsibilities are sometimes confused, leaving partners unsure as to who is the leader of the HIV and AIDS agenda at the district level. Stronger mechanisms are needed, as well as more systematic sharing of good practices on District Coordination. The district picture is complicated by a lack of clarity at national level on the division of responsibilities between NAC and the Ministry of Health on one hand and the other Sector Ministries and Civil Society Organisations on the other hand.

Taken together, these issues have reduced the effectiveness of the DATFs and PATFs. To enhance effective coordination and programme implementation at district level it is recommended that:

- The HIV and AIDS roles and responsibilities of the DHMTs, DDCCs, local authorities and other stakeholders be clarified at district level
- The District Planning Office and the Planning Sub-committee of the DDCCs be recognised as the mandated authority on integrated district development planning.

Decentralisation Policy

Under the National Decentralisation Policy, all the ministries and sectors will be expected to gradually, over a period of 10 years commencing in 2005, devolve their management responsibilities to the Local Authorities. The challenge for NAC is to proactively participate in the National Decentralisation process in order to ensure that structures and systems created are harmonised with the scope and direction of National Decentralisation Policy, particularly at the district level and provincial levels.

Technical support for the Decentralised Levels

Currently there is a serious mismatch between the need for technical support and the financing available for it, as well as inefficiencies in the delivery of the support. Financing for programme activities has increased enormously, but this has not been accompanied by a concomitant rise in funding for technical support. Government's reliance on cooperating partners for technical support has generally not resulted in a sufficient

volume of resources within grant agreements being devoted to technical support, and structurally it cannot address the financing of the upstream work of HIV and AIDS programme and proposal development.

Thus while NAC is striving to scale up the response and is asking its implementing stakeholders to scale up the response, there is little or no capacity in some of these stakeholders and instead of building the capacity of these mandated stakeholders new structures are being established by cooperating partners in the form of international NGOs or parallel local level community based structures. Additionally, there is insufficient coordination of technical support, coupled with elements of competition among cooperating partner institutions providing the support.

Public Sector including Local Government (Mainstreaming HIV and AIDS)

Sectoral mainstreaming of HIV and AIDS in the public sector is being addressed. As a first step impact studies have been initiated in some Line Ministries such as the Ministries of Agriculture, Health and Education.

By end of March 2005, Line Ministries had conducted workshops on HIV and AIDS awareness that had reached 17, 290 sector employees. Seventy-six employees from line ministries had been trained in counseling, and 918 had been trained as peer educators. Through the AMICAALL programme, the leadership in all the 72 District Councils have been reached with HIV and AIDS awareness and programming initiatives and Councils are now concentrating on developing workplace programmes and community response initiatives.

Recommendations to strengthen further the mainstreaming efforts into sectoral plans include:

- Ensure that the multi-sectoral nature of the impact of the epidemic and that action centres on HIV and AIDS and gender as a development issue rather than purely a health-sector issue
- NAC provides guidelines on how sectors can come up with workplace policies to address the rights issues and the HIV and AIDS prevention, care and treatment service needs within their organisations and the instruments on how to mainstream HIV and AIDS into development work.

The Civil Society Response

Broadly, civil society is considered to include the media, trade unions, Traditional Healers and youth structures, as well as Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs) and Faith-Based Organisations (FBOs). In Zambia, civil society is considered to play a significant role in strengthening the multi-sectoral response to HIV/AIDS, TB and STIs, and civil society organisations (CSOs) are frequently key role-players in developing and implementing innovative, culturally-sensitive approaches that include elements of mainstreaming, decentralisation, outreach and community participation.

A number of larger NGOs (such as CARE International and Oxfam) are now implementing cutting-edge multi-sectoral programmes that strengthen the linkages between HIV/AIDS, food security and income support. Others, such as SHARe, SNV

and Concern International, are supporting the strengthening of decentralised planning and coordination structures, such as the PATFs and DATFs. There has also been considerable scaling-up and rolling out of prevention, care and support activities (including roll out of ARV services), particularly through US Government funding of FBOs, as well as through more traditional players, such as Development Aid from People to People (DAPP), the Copperbelt Health Education Project (CHEP) and the Kara Counselling and Training Trust (KCTT) .

There are a number of initiatives where consortia of CSOs have come together to strengthen outreach to hard to reach and vulnerable groups within a multi-sectoral framework (for example, the Corridors of Hope Programme targets truck drivers and sex workers in cross-border environments, whilst the C-Safe initiative operates regionally and targets farmers, farm workers and the rural poor). Meanwhile, there are a number of exciting new projects that focus on community mobilisation through thematic issues such as stigma (for example, the International HIV/AIDS Alliance's Stigma & Discrimination Project), treatment advocacy (for example, the Treatment Advocacy and Literacy Campaign (TALC)) and community-based ARV treatment literacy and compliance (for example, the ARV Community Education and Referral (ACER) Project).

Zambia is now making considerable progress in strengthening its grant administration systems for CSOs, especially those in non-metropolitan areas. For example, the membership based Zambian National AIDS Network (ZNAN) is playing a key role in disbursement of accountable grants from the Global Fund, as well as from other cooperating partners (many of whom contribute to a basket fund through a Joint Financing Agreement (JFA)). Similarly, the Church Health Association of Zambia (CHAZ) and the Zambian Inter-Faith Networking Group (ZINGO) now have well-established systems for supporting grant-making to FBOs. Finally, the Community Response to HIV/AIDS (CRAIDS) initiative was established under the World Bank's MAP II programme and has been particularly successful in disbursing grants to smaller CBOs. Nevertheless, it is acknowledged that grant making to CSOs can be bureaucratic and slow and there are significant human resource constraints in providing technical and monitoring support to funded projects.

The role of Traditional Health Practitioners in strengthening the national response to HIV/AIDS, TB and STIs is increasingly acknowledged. The Traditional Health Practitioners Association of Zambia (THPAZ) held skills training and strategic planning workshops for their members in 2004. THPAZ has also been active in natural remedies research and income generating activities, such as crop production and community-based catering.

The Private Sector Response

The Private Sector accounts for an estimated 58.5% of the formally employed workforce in Zambia, that is an estimated 243,645 employees. The design and implementation of workplace programmes in companies and businesses have been largely supported by a private sector network known as ZWAP (Zambia Workplace AIDS Partnership) comprising of four private sector NGOs: Afya Mzuri (formerly known as the Zambia HIV/AIDS Business Sector Project); Zambia Health Education and Communications Trust (ZHECT); the Zambia Business Coalition on HIV/AIDS (ZBCA) and the Comprehensive HIV/AIDS Management Programme (CHAMP).

A workplace survey of 21 of the larger companies in Zambia was completed by NAC in 2005 in order to provide some preliminary information of the range of HIV and AIDS activities and the type of support that was needed to continue the development of the private sector response. There are many examples of Zambian companies undertaking innovative practices in the workplace across prevention, treatment, care and support. While there is generally little sharing of these successful innovations and little cross-fertilisation between companies, companies have expressed interest in improving communication and quality of technical support provided specifically to the private sector.

The challenges in mainstreaming

- Progress in mainstreaming AIDS interventions in developmental and social sectors other than health has been uneven.
- Even in relation to health, as efforts to reach universal access to treatment accelerate, mainstreaming and the integration of AIDS services such as VCT, PMTCT and treatment within existing health-care infrastructures has become more pressing and the problems of parallel delivery more obvious, underscoring the need to create linkages early in the planning process
- Additionally, links between HIV and AIDS initiatives and broader social economic development frameworks are currently underdeveloped. For example, the Poverty Reduction Strategy Paper and the Transitional National Development Plan did not include rigorous analyses of the consequences of HIV and AIDS in the other sectors, and the current HIV and AIDS intervention strategic plan was similarly unconnected to macroeconomic frameworks. This has in most cases caused problems in effecting a multi-sectoral and decentralised approach to the fight against HIV and AIDS and its negative impacts when public expenditure constraints limit development sector spending, restricting the ability of government to rapidly add staff to deliver services essential to an effective AIDS response.
- The challenge for Zambia is to secure ownership by developing capacity to continuously identify HIV and AIDS related problems, set priorities, and establish accountable systems to enable the rapid scaling up of a multi-sectoral response to AIDS at all levels on a continuous basis.

Theme IV: Core Strategies by Strategic Objective

Strategic Objective	Core Strategies[17]
17. Mainstream HIV and AIDS into district level development policies, strategies, plans and budgets	**1. At district level, develop the DATF and coordinating structures in keeping with the "Three Ones" principle, including monitoring and evaluation capacity** **2. Strengthen traditional and local government leadership and action on HIV and AIDS at the local level** **3. Support the establishment and capacitating of Area Development Committees in mainstreaming and community response to HIV and AIDS** **4. Strengthen the coordination role of the District and Provincial Development Coordinating Committees (DDCC and PDCC) in mainstreaming and multi-sectoral response to HIV and AIDS** **5. Support the development of lead sectors in public, private and civil society for mainstreaming HIV and AIDS at district levels**

[17] National HIV/AIDS/STI/TB Policy, June 2005

Strategic Objective	Core Strategies[17]
18. Improve capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination	**1. Align available financial support to national strategies, policies, systems, cycles, and plans** **2. Encourage long term planning by progressively shifting from project to programme financing, and harmonization of programming, financing, and reporting** **3. Harmonise and align donor activity on HIV and AIDS at district levels**
19. Support the development of workforce strategies which prioritise the key sectors critical to the response to HIV and AIDS	**1. Conduct workforce impact studies by HIV and AIDS by sector and develop workforce strategies to address key issues** **2. Strengthen skills and professional development in the area of HIV and AIDS**
20. Mainstream HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets	**1. Conduct HIV and AIDS sector impact analysis at the local level** **2. Develop policies, strategies and action plans to mitigate the impacts** **3. Undertake regular organisational policy and programme reviews with regard to negative impacts on HIV and AIDS at the national, community and individual levels** **4. Direct social responsibility initiatives to areas that reduce community vulnerabilities to HIV and AIDS** **5. Build mainstreaming implementation capacity within the organisations at all levels** **6. Train district, provincial and national planners on HIV and AIDS and mainstreaming** **7. Support the development of integrated HIV and AIDS plans** **8. Ensure that all government sectors and civil society at all levels are referenced and supported in the National Development Plan**
21. Develop and implement comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support	**1. Measure and predict the impacts of HIV and AIDS in the workplaces** **2. Reduce vulnerabilities and risks to HIV infection among the female and male workers in the workplace** **3. Ensure that public and private workplaces care for and supporting the infected and affected members of the organisation** **4. Build leadership, management and motivation capacity in organisations to deal with personnel challenges associated with HIV and AIDS** **5. Promote and implement training policies, working conditions and benefits to accommodate the challenges posed by HIV and AIDS on both female and male workers**

6.5. Theme V: Improving the Monitoring of the Multi-Sectoral Response

Summary
There is need to improve the capacity of all partners to use monitoring and evaluation information for decision making and strengthening effectiveness and efficiency of services delivery, including operational research, financial resources monitoring and performance management mechanisms.

Overall objective

To improve the capacity of all partners to use monitoring and evaluation information for decision making and strengthening effectiveness and efficiency of services delivery, including operational research, financial resources monitoring and performance management mechanisms.

Strategic Objectives

22. Strengthen mechanisms and systems for monitoring and evaluation of the multi-sectoral response
23. Improve capacity of implementing partners for monitoring and evaluation of the situation and the response
24. Strengthen operational and behavioural research and access to information on best practice and cost effective interventions

Rationale and Challenges

One Monitoring and Evaluation Framework

The *National HIV/AIDS/STI/TB Monitoring and Evaluation Plan for 2002-2005* was finalised and it currently forms the framework for process and output indicators. The NAISP Monitoring and Evaluation framework identifies 55 performance indicators that will be used to measure the national HIV and AIDS response. Four (4) of these are at impact level, seventeen (17) at outcome level and thirty four (34) at output level. The framework also sets forth a description of data sources that will be used to gather necessary M&E Information and calculate the recommended indicators as well as the flow of data from all the data sources. With the assistance of collaborating partners a database for VCT/PMTCT has been developed and the VCT/PMTCT directories disseminated. Publications on "The HIV /AIDS Epidemic in Zambia-*Where Are We Now, Where Are We Going*", have been produced and disseminated.

The challenges for the monitoring and evaluation includes the fact that there is no management information system capable of monitoring national program level activities and it is also difficult to track resources by geographical area, by program area and by partners.

It is also recommended that the HIV and AIDS structures at the district and provincial levels (DATFs) and (PATFs) be harmonised within formal existing structures and be supported by government on a permanent basis in order to allow for improved and sustainable implementation, monitoring and evaluation.

Strong monitoring and evaluation is a prerequisite for oversight and accountability, yet it is an area that has not received adequate support from various stakeholders and cooperating partners. Finally, national oversight efforts are hindered by a failure by some international and national stakeholders to systematically share information with NAC. This fragments the national response and constrains national ability to identify problems when they are still nascent, instead allowing them to fester and grow. Further, tools that could assist in this process, such as an elaborate institutional arrangement with clear government legal support from the national level to the province and district have not been adequately utilised.

Continuing M&E challenges

Although the operationalised M&E system was in its infancy stage, needs assessment conducted by both NAC and other cooperating partners continue to reveal that most agencies implementing HIV and AIDS activities have not yet harmonised their M&E systems to feed into the national system. However, among implementing agencies that had M&E system in place, there appeared to be consistency on the definitions and identification of a core set of indicators to measure key HIV and AIDS interventions. Overall, it has been revealed that there was need to build M&E capacity to monitor and evaluate HIV and AIDS programme activities especially at provincial and district level. M&E capacity inadequacies are attributed to (i) lack of computer equipment and software to facilitate M&E activities; (ii) inadequate computer skill (iii) lack of M&E standardised training materials; (iv) lack of staff training in M&E; (v) inadequate financial resources for M&E; and (vi) lack of M&E facilities.

Further, the assessment also revealed other environmental issues and constraints (i) lack of systems in place to provide adequate interaction between provincial and district structures; (ii) weak linkage or synergy between provincial/district structures with data providers e.g. District Health Management Team and other stakeholders; (iii) lack of knowledge about the existence of the operationalised national M&E system among certain stakeholders.

In recognition of existing gaps in M&E skills and infrastructure, NAC will facilitate the strengthening of existing M&E systems to support the realization of the M&E plan. The strategy will include institutional capacity building, strengthening of existing structures and systems, building linkages between ongoing systems, and development of procedures and guidelines for implementation.

Theme V: Core Strategies by Strategic Objective

Strategic Objective	Core Strategies[18]
22. Strengthen mechanisms and systems for monitoring and evaluation of the multi-sectoral response	**1. Institutionalise the HIV and AIDS monitoring and evaluation system to draw data from all sectors and at all levels on a routine and consistent basis** **2. Strengthen the system of data collection, management and flow of information (including GIS Mapping of all HIV and AIDS activities)** **3. Align of the Joint Annual Programme Review and planning and budgeting cycles so that continuous programme redesign and improvement become standard operating procedure** **4. Improve of national biological, behavioural and social surveillance of HIV and AIDS, STIs, and TB** **5. Support essential prevalence, incidence and evaluation research to complement national surveillance** **6. Ensure national financial management monitoring is integrated with programme monitoring for all HIV and AIDS programmes** **7. Complete and operationalise the operations manual, outlining the roles and responsibilities of all public sector institutions, the private sector and civil society at national and district level in terms of HIV and AIDS monitoring of interventions and reporting to the HIV and AIDS coordinating body as part of a national M&E plan**
23. Improve capacity of implementing partners for monitoring and evaluation of the situation and the response	**1. Strengthen capacity to ensure that all stakeholders are able to provide the necessary information for the national M&E system**

[18] National HIV/AIDS/STI/TB Policy, June 2005

24. Strengthen operational and behavioural research and access to information on best practice and cost effective interventions	**1. Develop a national HIV and AIDS research strategy that will contain a clear research agenda** **2. Establish links with research institutions and will promote cooperation between research agencies to maximise utilisation of research findings** **3. Implement appropriate ethical review prior to research being undertaken approve research** **4. Encourage, support and strengthen research related to HIV/AIDS/STI/TB by both local and international researchers** **5. Support identified priority health research and application of research findings** **6. Promote research in traditional/alternative remedies** **7. Provide appropriate infrastructure and funding for HIV/AIDS/STI/TB research programmes** **8. Encourage collaboration and coordination between and among local and international health researchers** **9. Ensure Zambia's participation in vaccine development in partnership with international health research institutions** **10. Invest in appropriate infrastructure and human resources that are requisite for vaccine development and clinical trials** **11. Negotiate for preferential access to outcomes of vaccine research** **12. Organise HIV and AIDS research dissemination seminars where all new biomedical and social research relating to HIV and AIDS will be disseminated**

6.6. Theme VI Integrating Advocacy and Coordination of the Multi-Sectoral Response

Summary

Strengthening capacity for advocacy and coordination by integrating these activities into the work of lead partners and strengthening the enabling framework to facilitate a sustainable scale up of services delivery

Overall objective

To strengthen capacity for advocacy and coordination by all partners and strengthen the enabling framework to facilitate a sustainable scale up of service delivery

Strategic Objectives

25. Strengthen the institutional and legal framework
26. Improve coordination and resolve areas of duplication and gaps in the multi-sectoral response to HIV and AIDS to include resource management
27. Advocate for mainstreaming, effective policy implementation and fighting stigma and discrimination
28. Promote effective leadership for the multi-sectoral Response for HIV and AIDS

Rationale and Challenges

Stimulate effective and responsive National Leadership and Ownership

Zambia has made considerable progress in building national leadership and ownership in the response to HIV and AIDS. Increasing numbers of national political, religious and traditional leaders are voicing their support for efforts to tackle the epidemic, notwithstanding these efforts, considerable challenges still remain. Comparatively very few local level political religious and traditional leaders are involved in the fight against HIV and AIDS.

The National AIDS Council (NAC) is mandated to coordinate, monitor and evaluate inputs, activities, outputs and impacts of HIV and AIDS programs in Zambia. NAC draws its mandate from an Act of Parliament. The wide variety of stakeholders in both technical terms and geographical coverage represents an enormous challenge. To overcome this challenge there is need for effective and responsive leadership at all levels. NAC's role is to facilitate the active participation of various stakeholders in the achievement of the different specific intervention objectives within their sectors and sphere of operation.

For effective coordination, all levels require visionary leadership, strong management and technical systems for integrated development planning and mainstreaming of gender and HIV and AIDS. These are key requirements needed at national, provincial and district levels. NAC is striving to support more effective leadership and coordination in four areas: 1) national level strategic planning and visioning, 2) technical and logistical support to stakeholders, 3) monitoring the course of the epidemic and implementation programmes, and 4) resource mobilization.

The National Development Planning and Constitution Review processes present a timely opportunity to address this institutional arrangement issue, and to reflect on the different mechanisms through which response coordination, financing and wider participation could be achieved within broad mechanisms for integrating HIV and AIDS and gender with all development efforts including coordinating workplace programmes, community responses at the local level and for establishing coordination of interventions for orphans and other vulnerable groups, such as persons with disabilities, refugees and prisoners.

NAC communicates within the context of an existing institutional framework. However, it is yet to be established how NAC should actually communicate with lower level structures and with cooperating partners. The flow of information to NAC from structures at lower levels is not yet clearly outlined. There are a number of interrelated challenges facing the multi-sectoral response to HIV and AIDS: The reviews undertaken so far have indicated that PATFs and DATF's communicate predominantly through meetings and in certain cases, through workshops and seminars and are in most cases transforming into financing arrangements for various financing mechanisms.

The challenges can be summarised as shown below:

1. *Challenges to the understanding and application of the concept of mainstreaming HIV and AIDS in development sector plans and operations*
2. *Challenges of a serious "implementation" gap existing between national plans and strategies on the one hand and operational capacity to implement them at the local level on the other*
3. *Challenges of devolving power, authority, functions and resources including relevant capacity building for HIV and AIDS at the local level*
4. *Challenges to the financing of technical support.*

Taken together, these issues have reduced the effectiveness of Zambia's multi-sectoral response to HIV and AIDS. The current governance structures do not serve the immediate specific needs required to implement a more coherent division of responsibilities among several stakeholders and the NAC Secretariat does not have the authority to hold individual stakeholders and agencies accountable for delivering results in their lead areas. This weakness requires immediate attention during the Fifth National Development Plan period.

If Zambia has to achieve harmony and a well coordinated approach in combating HIV and AIDS, it is imperative that the country have outstanding effective leadership that promotes a culture of excellence in all aspects of the multi-sectoral response to HIV and AIDS.

The Institutional and Legal Framework for coordination

While NAC has made sufficient progress in bringing most stakeholders into the annual joint reviews in an effort towards having a single national review of the AIDS programme, this is not always supported by some bilateral institutions and international partners.

NAC's work on coordination and harmonization has led to agreement that increased use of programme modalities for the delivery of financial and technical support can improve the effectiveness of the multi-sectoral response initiatives. However, recent international

agencies' initiatives on HIV and AIDS have tended more towards heavy utilisation of a project approach. While a project modality may in some cases be useful for rapidly initiating activities, it is likely to militate against longer-term sustainability by entrenching the vertical nature of the response to HIV and AIDS, barricading it off from broader developmental efforts in a manner that is ultimately counterproductive.

The failure to share information between partners about planned activities, missions and reports produced leads to duplications and lessens the ability to build synergies between implementing and financing efforts.

The national response to AIDS at the district level is, at the moment, unevenly coordinated, despite the existence of the Councils, DDCCs, (DATFs) and DHMTs.

Harmonisation of Financing Mechanisms and aligning to Programme Monitoring and Evaluation

Not much effort has been made to improve the harmonization of financing mechanisms such as those under the Global Fund, the World Bank and bilateral institutions other than through the requirement that projects and programmes to be financed should be in line with the National HIV/AIDS/STI/TB Intervention Strategic Plan. However, despite this requirement joint annual reviews have revealed that much more remains to be done to reduce the burden imposed on various implementing and coordination stakeholders receiving support, as they continue to be forced to transact separately with multiple uncoordinated financing institutions and international partners.

Theme VI: Indicative Core Strategies by Strategic Objective

Strategic Objective	**Core Strategies**[19]
25. Strengthen the institutional and legal framework	**1. Adopt and effectively implement the "Three Ones" approach** **2. Strengthen the institutional capacity of the National AIDS Council, Secretariat and partnership mechanisms so as to enable it to effectively coordinate national, provincial, district and community efforts targeted at the prevention and control of HIV and AIDS, STIs and TB** **3. Establish and/or strengthen structures for effective coordination of the multi-sectoral response at national, provincial, district and community levels** **4. Ensure the effective implementation, monitoring and evaluation of the HIV/AIDS/STI/TB Act** **5. Amend and harmonise relevant pieces of HIV/AIDS/STI/TB policy legislation**
26. Improve coordination and resolve areas of duplication and gaps in the multi-sectoral response to HIV and AIDS to include resource management	**1. Continuously liaise with the Decentralisation Secretariat on the implementation of the decentralisation policy** **2. Review and strengthen the role and functioning of the DATFs, DHMTs, and Councils in relation to the district HIV and AIDS response** **3. Establish clear reporting mechanisms at district level in line with the National Monitoring and Evaluation Framework** **4. Establish a Resource Management Strategy including reviewing the feasibility of a National HIV/AIDS/STI/TB Trust Fund** **5. Provide specific budgetary allocations for HIV/AIDS/STI/TB interventions**

[19] National HIV/AIDS/STI/TB Policy, June 2005

Strategic Objective	**Core Strategies**[19]
	6. Improve capacity for donor coordination and realignment of HIV/AIDS/STI/TB resources
27. Advocate for mainstreaming, effective policy implementation and fighting stigma and discrimination	**1. Implement the Advocacy and Communication Strategy aimed at encouraging universal access to prevention, e.g. voluntary counselling and testing for all persons; maintenance of confidentiality by health care providers and employers; elimination of stigma and discrimination against PLHA** **2. Discourage anonymous (without consent) HIV testing, mandatory testing for scholarships and employment** **3. Encourage the insurance industry to develop and apply policies which take into account the insurance needs of persons with HIV/AIDS** **4. Support the mainstreaming of advocacy activities in the multi-sectoral response** **5. Integrate HIV and AIDS services required by people with different abilities in existing health and social welfare delivery systems** **6. Promote positive living among people living with HIV and AIDS**
28. Promote effective leadership for the multi-sectoral response for HIV and AIDS	**1. Establish leadership forums that involve the highest level of political, religious, and traditional leaders in the country to promote key prevention, care and treatment messages** **2. Mobilise and support the media and journalists in the response on HIV and AIDS** **3. Involve influential celebrities from the arts, sports, entertainment, and politics in promoting key prevention, care and treatment messages**

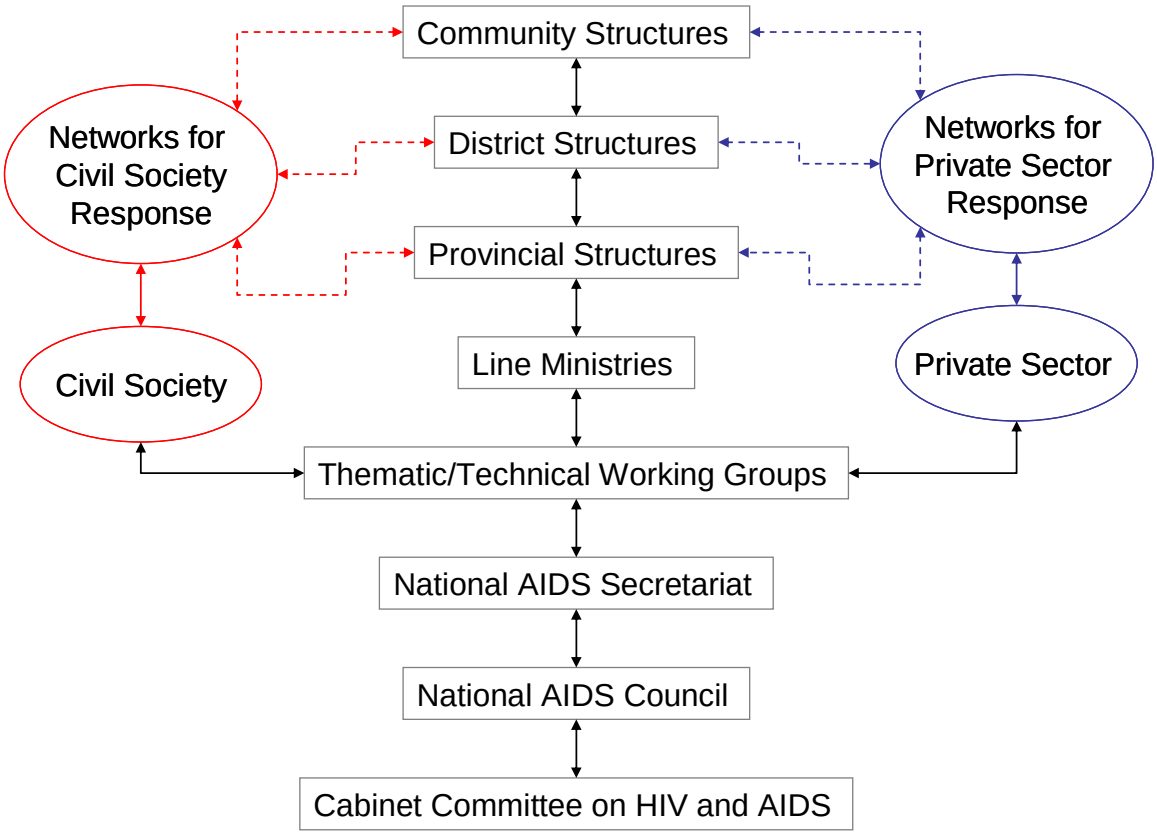
7.0. COORDINATING, MONITORING AND FINANCING THE RESPONSE

Scaling up of Action for HIV and AIDS at the local levels is the key services delivery challenge for 2006-2010. Significant new resources have been mobilised, and it is imperative that these resources be efficiently used for the benefit of the people. Effective coordination, monitoring and resource management are required by all Partners in order to focus on the smaller epidemics, prioritise, allocate and disburse funding to service providers and communities in need.

7.1. Coordinating the Response

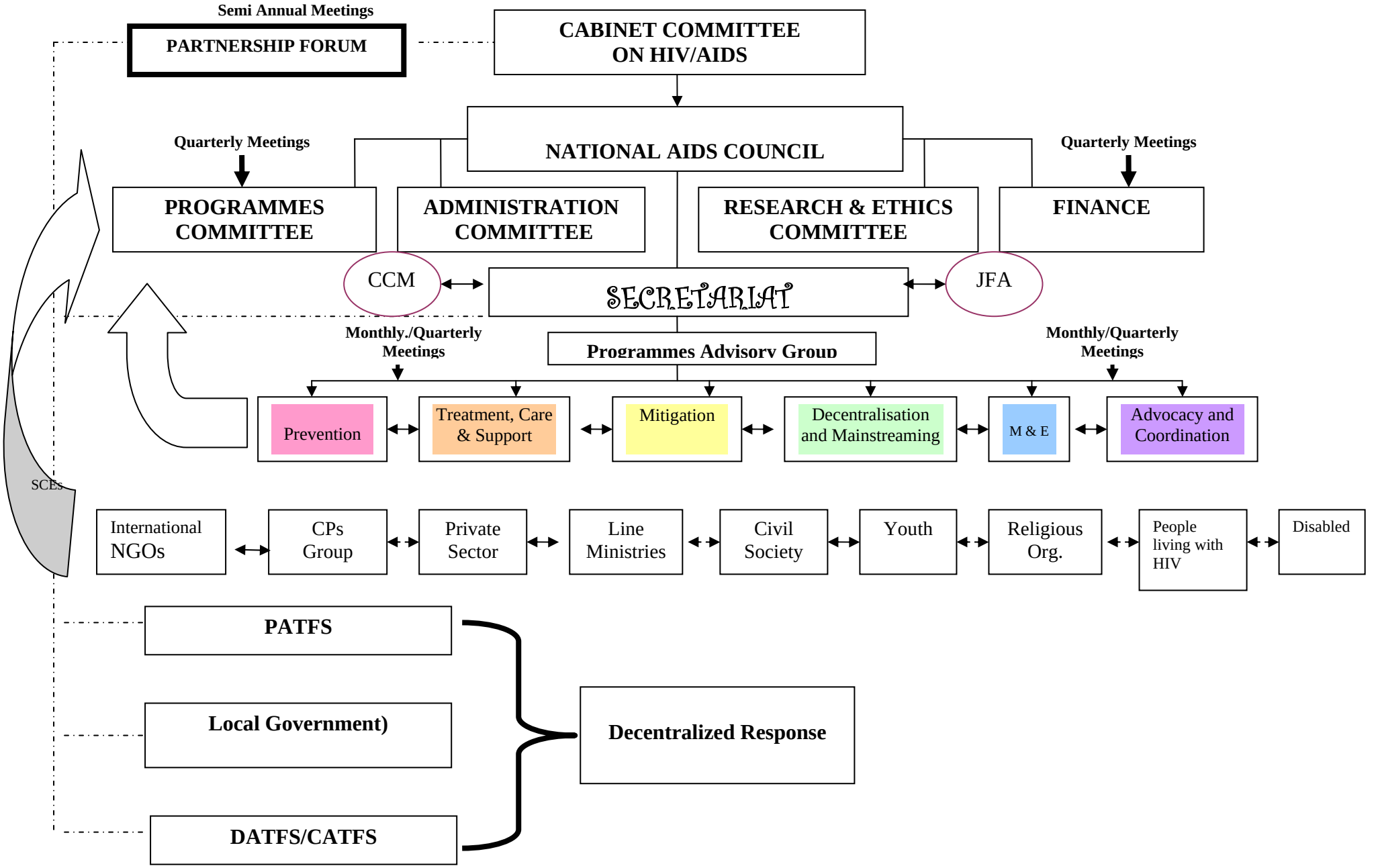
Figure 3 illustrates the conceptual framework for coordination of the multi-sectoral response in Zambia. Through the establishment of the NAC in 2002, a national coordinating authority was established to facilitate and lead this development. Work is ongoing in the establishment and development of the corresponding structures in keeping with the Decentralisation Policy, and also among civil society and private sector networks.

Figure 3: Conceptual Framework for Coordination of the Multi-Sectoral Response



While all partners are committed to the principle of the "Three Ones", it is imperative that coordination is implemented as a dynamic role rather than one that creates a funnelling or bottleneck effect at national or decentralised levels. As such, coordinating structures and mechanisms will need to be flexible and appropriate to local situations. Monitoring and resource management are key functional elements of the coordinating structures. See figure 4 for a diagram of the coordinating structures among the partners in the response.

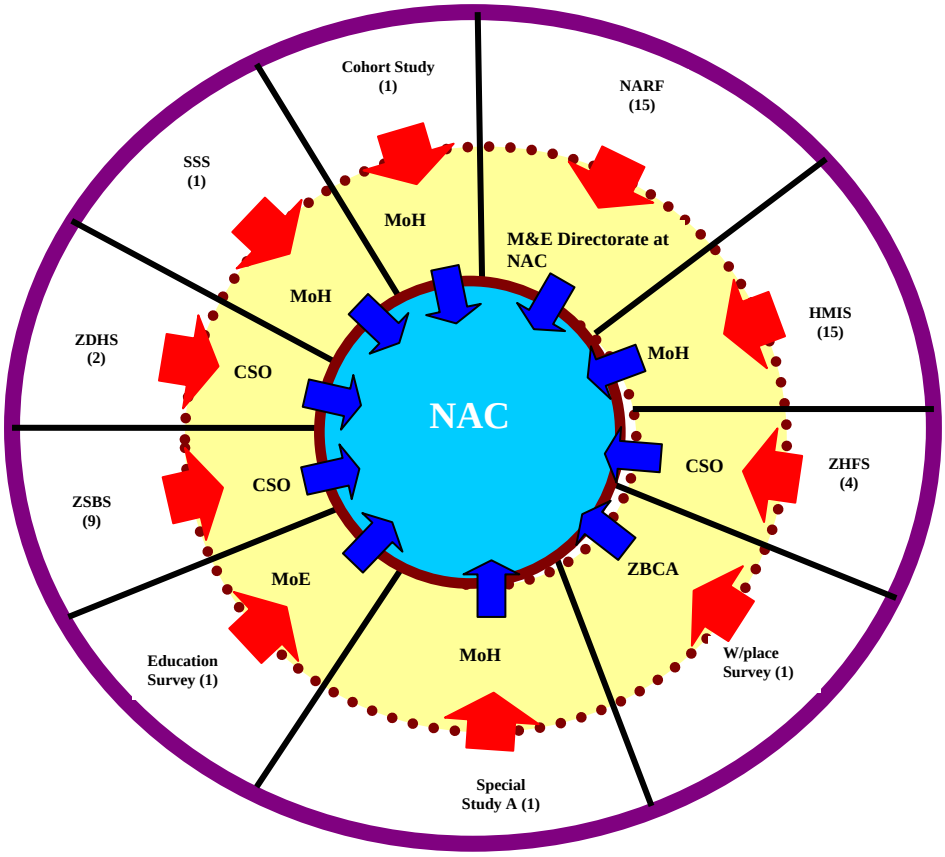
Figure 4: ***Structural Framework for the Partnership Coordination of the Response***



7.2. Monitoring the Response

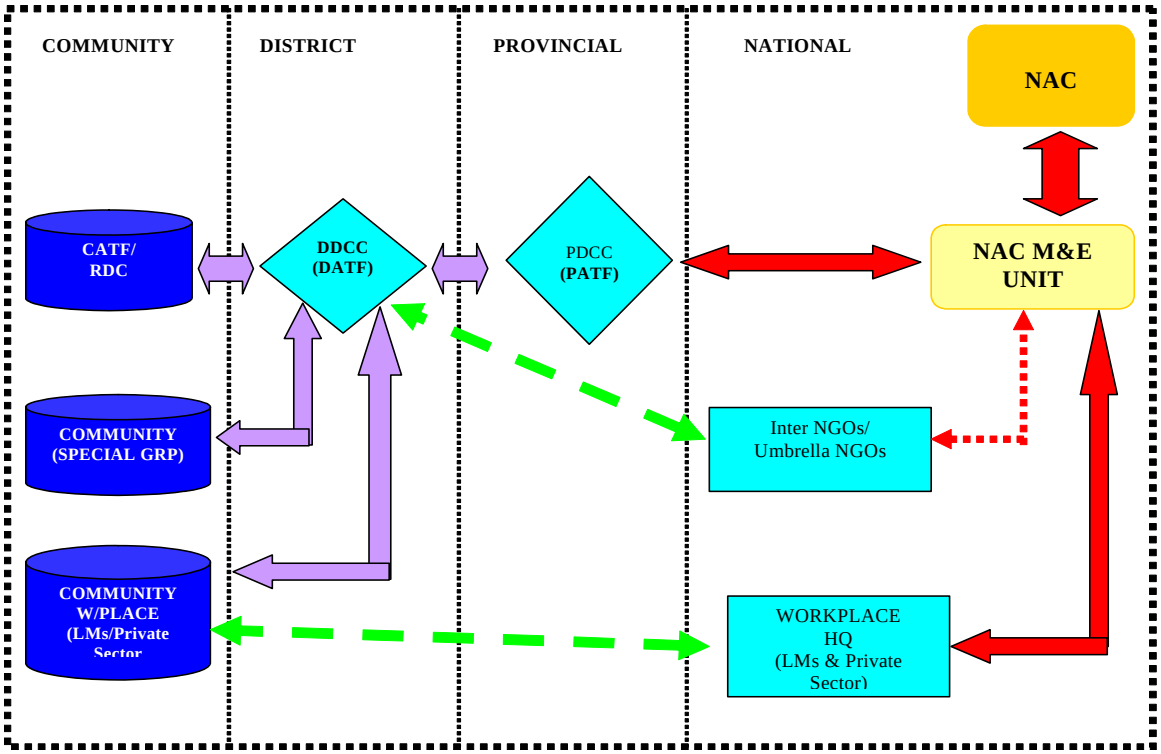
To facilitate effective coordination government, through NAC, has developed a National HIV and AIDS M&E System to allow the country to track its progress towards the goals and objectives as stated in the National AIDS Strategic Framework (NASF). Figure 5 illustrates the conceptual framework of data collection in the context of decentralisation and data sources at national level.

Figure 5: ***Conceptual Framework for Monitoring the Response***



In order to establish a national M&E system, NAC operationalised the NAC activity reporting systems using NAC Activity Reporting Forms (NARFs) as a means of capturing HIV/AIDS programme monitoring data from provincial and district levels.

Figure 6: Structure of NAC Data Reporting System



For 2006-2010, in keeping with the focus on improving coordination at local levels, the implementation of the M&E Plan will continue to elaborate mechanisms for monitoring of the response at local levels. Too often, data is collected to be passed onwards and not enough attention is paid to the use of monitoring data and information for decision making at local or provider levels. Improving on local utilisation of data is imperative for this planning period.

The Joint Annual Programme Review is a key element of the monitoring and coordination of the multi-sectoral response to ensure appropriate responses and value for money at a strategic level. However, it is not meant to replace the continuous monitoring and performance management by providers, but rather build on that to ensure that best practice and value for money aspects are being shared and incorporated into action plans.

Table 4 gives a selection of core indicators at output and outcome levels. These indicators are in line with those required for the Fifth National Development Plan (5NDP). This will be further refined in the first stage of operationalising the Framework and detailed to output level in the NASF Operations Manual. It is important that Partners begin to link their activities (or inputs) to the indicators in Annex 1 so as to harmonise reporting systems and improve coordination.

Table 4: NASF 2006-10 Selected Output and Outcome Indicators Baselines & Targets

Sector Indicator Monitoring and Evaluation System for 5 NDP –									
Key Indicators	**Definition / calculations**	**Baseline**	**Annual Targets**				**Overall Target**	**Data Source / Responsible Institutions or Departments**	**Comments (Reasons for Variations between Targets and Achieve-ments)**
		2005	**2006**	**2007**	**2008**	**2009**	**2010**		
Indicator One: **VCT**: # of clients tested for HIV and receiving their test results		400,000		500,000			1,000,000		
		Achievement							
Indicator Two: **PMTCT** % HIV positive pregnant women receiving complete course of ARV to reduce MTCT	# HIV +'ve pregnant women receiving complete course of ARV / # Expected HIV +'ve women delivering	25,000	30,000	35,000	40,000	45,000	50,000		
		Achievement							
Indicator Three: **ART**: % of eligible people accessing ARVs	# people with advanced HIV/AIDS who receive anti retro viral drugs/ Expected # people with advanced HIV/AIDS	**50,000**	**70,000**	**90,000**	**110,000**	**130,000**	**160,000**		
		Achievement							
Indicator Four: **Sectoral Mainstreaming:** # of workplaces, including line ministries, with developed workplace policies and programmes for HIV/AIDS		39							
		Achievement							
Indicator Five: **Finance** Amount of funds spent on HIV/AIDS in the past 12 months									
		Achievement							

7.3. Financing the Response

There is a continued emphasis on **mobilising** financial resources into 2006 - 2010 at national and international levels in anticipation of achieving the scale up of activities needed to control the crisis of HIV and AIDS. However, as more resources are made available nationally, the capacity to **allocate** to prioritised and cost effective actions and **disburse** funds to the providers and communities who implement these action are also critically important. In the strategic management of resources for the National Multi-Sectoral Response, it is imperative that all three aspects of resource management be considered that is mobilisation, allocation and disbursement.

Resource Mobilisation
To achieve effective resource management, sources and flows of financial resources need to be estimated so as to indicate broadly to the Implementing Partners who complete more detailed operational plans the resource envelope in which they should plan. Too often, districts and CSOs are asked to produce plans and indicate budgets to be told after that the financial resources are not available for their plans. It is also not known with any certainty the availability of funding for more than annual budgeting which also constrains partners in their ability to scale up.

Resource Allocation
It is often shown that it is not only lack of funding that constrains implementation, but rather uncertainty and delayed flows of funds. The NASF 2006-2010 represent the broad priority areas for which available resources need to be mobilised and then allocated. In turn, implementing partners need to have a degree of flexibility in the use of these funds to tailor their use to the evolving needs of their local communities. Monitoring of objectives needs should also include financial monitoring so as implementation proceeds it is easier to determine if the adjustments need to be made in the strategic allocations of financing.

Resource Disbursement and Tracking of Funds
Ensuring the timely and efficient transfer and disbursement of funds to implementing partners is also a key element of the management of funds. Given the complexity of HIV and AIDS funding due to the multi-sectoral nature of the response, we expect the systems for resource disbursement and fund tracking to be as equally complex. However, much work is ongoing to harmonise and align international funding sources as well as to strengthen public and civil society capacities for resource management for HIV and AIDS. The strategy to mainstream or integrate HIV and AIDS action into operational plans and budgets will actively facilitate the harmonisation agenda.

These tools are also increasingly important to begin to understand the flow of funds at local levels, including building the capacity to mobilise local resources.
Table 5 broadly illustrates the estimates of available resources for the NASF 2006 -10 from key funding partners: Cooperating Partners, private foundations and Government of Zambia. At the time of compiling the data, there is broad commitment through 2008, after which the estimates are based on an optimistic

scenario in which we have assumed current levels of commitment to HIV and AIDS are maintained with the exception of Government of Zambia, Global Fund and the US Government. Estimates have also been included for contributions from private foundations and sources not captured currently by any of the tracking studies. (For the purpose of strategic resource management, these estimates do not include resources made by the private sector, civil society organisations or households.)

Table 5: Estimated Funding for NASF 2006-10

	2006	2007	2008	2009	2010	2006-10
UN Family (Includes WB)	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000	25,000,000
JICA	3,205,785	3,205,785	3,205,785	3,205,785	3,205,785	16,028,925
USG*	149,000,000	149,000,000	149,000,000	74,000,000	74,000,000	595,000,000
NORAD	2,850,000	2,850,000	2,850,000	2,850,000	2,850,000	14,250,000
Netherlands	1,210,090	1,210,090	1,210,090	1,210,090	1,210,090	6,050,450
DCI (Ireland)	3,751,279	3,751,279	3,751,279	3,751,279	3,751,279	18,756,395
SIDA	3,933,333	3,933,333	3,933,333	3,933,333	3,933,333	19,666,667
Global Fund**	52,800,000	52,800,000	52,800,000	19,800,000	19,800,000	198,000,000
DFID (UK)	7,065,200	7,065,200	7,065,200	7,065,200	7,065,200	35,326,000
EU	4,033,633	4,033,633	4,033,633	4,033,633	4,033,633	20,168,167
Private Charities & Foundations	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000
GRZ***	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	75,000,000
TOTAL	**257,849,320**	**257,849,320**	**257,849,320**	**149,849,320**	**149,849,320**	**1,073,246,604**

* The USG is uncertain of the precise level of commitment after 2008, estimates have included 2006 levels up to 2008 and 50% thereafter.

** Although Zambia will apply for Round 6 Global Funds, estimates have been made on current level of funding available and no additional funding is projected beyond 2008

*** The Government of Zambia is expected to significantly increase inputs for this planning period due to the Debt Dividend to a maximum of US$30,000,000 per year. Conservatively, estimates are made at 50% of the maximum

In keeping with the strategic intent to mainstream into the National Development Plan and the District Development Plans, costings by theme[20] were completed based on the submissions of the Districts and Line Ministries as well as the review of a sample of Civil Society and Private Sector organisations plans for HIV and AIDS. These costings were cross checked against available cost norms and used to estimate resources needed, assuming 50% scale up from a base scenario which had projected full scale up (Round 5 Global Fund Proposal).

Table 6 provides a broad estimate of the resources required, by the main group of implementing partners based on current estimates of funding and leaving the projected costs for scale up unallocated by partner. The estimated funding gap is also provided. Figure 7 illustrates these graphically.

[20] Analysis of the NASF 2006-10 Database compiled from samples District Development Plans, District HIV and AIDS Strategic Plans, Civil Society Organisations Plans, Private Sector NGOs Strategic Plans
Costs and Financing of the NASF 2006-2010: Report to the Joint Financing Technical Working Group: January 2006

Table 6: Estimates of Resources Required for NASF 2006-10 based on 50% scale up and Funding Gap

	2006	2007	2008	2009	2010	2006-10
50% full Scale Up	124,853,452	116,702,712	88,556,876	89,761,768	90,304,000	510,178,808
All Districts & Provinces	84,038,459	86,058,507	87,324,942	96,008,093	94,000,449	447,430,451
Line Ministries	11,862,009	12,609,316	13,227,172	13,875,304	14,555,194	66,128,995
NAC	14,427,831	14,990,345	16,664,145	17,497,352	18,372,220	11,951,894
Civil Society Organisations	24,120,517	25,640,110	26,896,475	28,214,403	29,596,908	134,468,414
Private Sector	8,923,592	9,485,778	9,950,581	10,438,160	10,949,630	49,747,741
Estimated Expenditure	**268,225,861**	**275,486,769**	**242,620,193**	**255,795,080**	**257,778,401**	**1,289,906,303**
Estimated Funding	**257,849,320**	**257,849,320**	**257,849,320**	**149,849,320**	**149,849,320**	**1,073,246,604**
Gap	10,376,541	17,637,449	-15,229,127	105,945,760	107,929,081	216,659,699

These estimates illustrate the success of the last few years of increased attention on resource mobilisation and advocacy for scale up. Given the severity of the HIV and AIDS epidemic and the effects on the workforce, human resource issues will be one of the key constraint for scale up and absorptive capacity. This needs to be taken into consideration in the allocation of resources for scale up on which partner has the comparative advantage for the priorities of the NASF. It is also assumed that this scenario will be refined and data improved as the tracking of financial resources is integrated with the monitoring system so as align financial and programmatic accountability.

Figure 7: Estimates of Funding available against required for NASF 2006-10

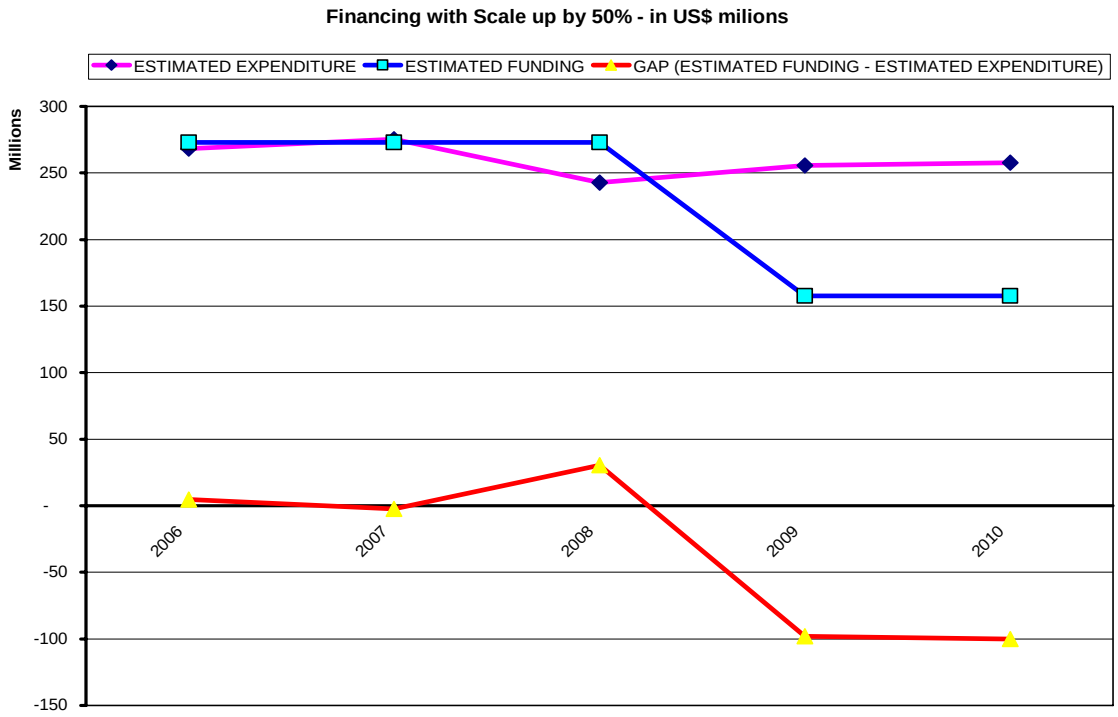


Table 7 illustrates the broad allocation of estimated available resources by Theme based on the analysis of the districts and feedback from the consultative process of developing the new NASF 2006-10. Further work will be needed to allocate further, and this should be done at the thematic level based on the comparative advantage of implementing partners and the needs of the local communities and priority target groups.

Table 7: Allocation of estimated funding by Theme of NASF 2006-10

	THEME	% Allocation	2006	2007	2008	2009	2010	2006-10
	ESTIMATED FUNDING		**273.0**	**273.0**	**273.0**	**157.6**	**157.6**	**1,134.4**
I	Intensifying Prevention	25	68.3	68.3	68.3	39.4	39.4	**283.6**
II	Expanding Treatment, Care, Support	30	81.9	81.9	81.9	47.3	47.3	**340.3**
III	Mitigating S/E Impact	15	41.0	41.0	41.0	23.6	23.6	**170.2**
IV	Strengthening decentralised response and Mainstreaming	15	41.0	41.0	41.0	23.6	23.6	**170.2**
V	Improving Monitoring	10	27.3	27.3	27.3	15.8	15.8	**113.4**
VI	Integrating Advocacy and Coordination	5	13.7	13.7	13.7	7.9	7.9	**56.7**

8.0. CONCLUSION

While the resource requirement to implement this plan may seem daunting, it is clear that there are many partners prepared to provide significant support to Zambia to ensure success in meeting the goals and objectives of this strategic framework. The monitoring and coordination of the many financial and technical inputs is critical in terms of maximising the benefit of the inputs, however, as the coordination structures within Zambia become stronger and more mature, the monitoring process becomes more straight forward.

It is the hope of all Zambians and all partners working in Zambia that there is great success demonstrated through the indicators outlined in the logframe (see Annex 1). Based on the outcome of this strategic period, forward plans will be developed to address on-going areas of weakness, or new areas of concern.

Logical Framework Indicators, Baselines, Targets & Data Sources

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTION	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
GOAL: **Reduce HIV/STD transmission among Zambians and reduce the socio-economic impact of HIV/AIDS**									
IMPACT INDICATORS									
PMTCT 1. % of pregnant women aged 15-19 who are HIV infected[1]			15% ('03)	11%		12%	Biennial	SSS	MoH
HIV Prevalence 2. % of adults aged 15-49 who are HIV infected			16% ('03)			69%	Every 4 yrs	DHS	CSO
3. % of infants born to HIV infected mothers who become infected			39% ('03)	31%[21]		20%	Biennial	Cohort Study	TDRC
Estimate of HIV Incidence 4. % of 15-24 year olds who are HIV positive			8% ('03)			5.8%	Every 4 yrs	DHS	CSO
OUTCOME INDICATORS									
Theme 1: Intensifying Prevention									
Prevent Sexual Transmission of HIV: 5. % of 15-49 year olds using condoms during the last sexual act with non regular sexual partner		Males	41.6 ('03)	37.5	44.0	50.0	Biennial	SBS	CSO
		Females	34.3 ('03)	28.8	36.0	50.0			
6. % of 15- 19 year olds who report being sexually active		Male	24.5 (03)	25.3	23.0	22.0	Biennial		CSO
		Female	48.8 ('03)	40.7	34.0	30.0			
7. % of 15-24 year olds who report being sexually active		Males	33.2 ('03)	34.5	32.0	30.0	Biennial	ZSBS	CSO
		Females	27.7 ('03)	25.4	24.0	22.0			
8. % of 15-24yr-olds who both correctly identify ways of preventing sexual transmission of HIV & reject major misconceptions of HIV transmission		Males	35.6 ('03)	46.1	70.0	90.0			
		Females	31.3 ('03)	40.5	70.0	90.0	Biennial	ZSBS	CSO
9. Median age at first sexual debut		Males	16.5 ('03)	18.5					
		Females	16.5 ('03)	18.5			Biennial	ZSBS	CSO
10. % of schools with teachers who have been trained in life skills education and taught it during the last academic year			60 (05)	70.0	85.0	100	Annual	Ed. Survey	MoE
11. % of school children aged 10 – 18 who report receiving life skills education in school.[2]		Male					Annual	Ed. Survey	MoE
		Female							
12. % of unmarried respondents who report at least 2 sexual partners in the past 12 months		Males	7.5 ('03)	7.0	6.8	6.5	Biennial	ZSBS	CSO
		Females	2.4 ('03)	2.7	2.5	2.0			
13. % of married respondents who report at least 2 sexual non-regular partners in the past 12 months		Male	1.6 (03)	2.0	1.5	1	Biennual	ZSBS	CSO
		Female	0.0 (03)	0.0	0.0	0.0			

[1] Percent of pregnant women aged 15 – 19 who are HIV infected is used as a proxy for measuring incidence of HIV

[2] Proposed indicator to be incorporated into EMIS (NAC to propose to MoE or to be included in Education Survey)

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTION	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
Voluntary Counseling and Testing (VCT):		Males	8.5 ('03)	7.2	10.0	20.0	Biennial	ZSBS	CSO
14.	% of the adult population aged 15-49 years counselled and tested for HIV and received their HIV test results	Females	7.9 ('03)	9.2	12.0	25.0			
Prevent Mother to Child Transmission									
15.	% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		39% ('03)	70%		70.0	Annual	HMIS	CBoH
STI Treatment:		Males					Biennial	ZHFS	CSO
16.	% of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines.		10 ('05)	10	30	50			
		Females	10 ('05)	10	30	50		ZHFS	
17.	**%** of facilities with observed STI treatment protocols		15 (05)	15.0	35.0	60.0		ZHFS	
Blood[22] Safety:									
18.	% of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions[23]		80 ('05)	80%		100%	Annual	ZHFS	CSO
19.	% of transfused blood units screened for HIV			100	100	100	Annual	HMIS	MoH
Theme 2 **Expanding Treatment, Care and Support**									
Anti-Retroviral Therapy:		Males	25.0 (05')	25%	40%		Annual	HMIS	MoH
20.	% of persons with advanced HIV infection receiving ARV therapy	Females	25.0 (05')	25%	40%		Annual	HMIS	MoH
TB:			65 %				Annual	HMIS	MoH
21.	Tuberculosis cure rate under DOTS		(2004)	74%	75%	80%			
22.	Tuberculosis defaulter rate		6% ('02)	5%	4%	3%	Annual	HMIS	MoH
23.	Treatment success rate		79% ('03)	83%	85%	90%	Annual	HMIS	MoH
Care and Support		Male						ZSBS	CSO
24.	% of adults aged 18-59 who have been chronically ill for 3 or more months during the past 12 months and, including those ill for 3 or more months before death whose households have received, free user charges and basic external support in caring for the chronically ill person	Female							
Support for Orphans and Vulnerable Children (OVC):		Males					Biennial	ZSBS	CSO

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Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTION	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
25.	% of orphans and other vulnerable children under 18 living in households whose house holds have received free of user changes, basic external support in caring for the children	Female					Biennial	ZSBS	CSO
		Total	13.4	13.4%	25%	50%			
26.	Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years	Males					Biennial	ZSBS	CSO
		Females							
Theme 4: Mitigating the Socio-economic impact of HIV/AIDS									
Sectoral Mainstreaming: 27.	% of workplaces and large enterprises/ companies with an HIV/ADS policy and programme		60 (05)	70.0	80.0	90.0	Annual	Workplace Survey	TBD
28.	% of Districts with comprehensive HIV and AIDS costed annual workplans		80% (05)	80%	100%	100%	Annual	NARF	DATF/PATF
Theme 5: Improving the capacity for Monitoring and Evaluation by s all Partners									
Monitoring and Evaluation 29.	% of Districts with M&E system and databases providing information on HIV and AIDS activities		0%		40	60	Anuual	NARF	DATF/PATF
Theme 6: Integrating Advocacy, Coordination and Leadership of the Multicultural Response									
Coordination 30.	# of networks/partners involved in the multi-sectoral response							NAC Directory	NAC

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
OUTPUT INDICATORS												
Theme 1 Intensifying Prevention												
Prevent Sexual Transmission	Printed/produced										NARF[24]	[25]NGOs/

[24] NAC Activity Reporting Form
[25] Non government organizations, including community based organizations (CBOs) & faith based organizations (FBOs)
[26] Line Ministries

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
31.	# of IEC materials printed/produced and distributed	distributed										LM[26]
32.	# of peer educators trained in life skills	Male										
		Female										
33.	# of 15-24 yr olds who receive life skills based HIV/AIDS education (incl. through peer education)	Males									NARF	NGOs/ LM
		Females										
34.	# of condom service outlets providing condoms to end users										NARF	NGOs/ LM
Condom Distribution		Male									NARF	NGOs/ LM
35.	# of male & female condoms distributed to end users	Female										
Voluntary Counselling and Testing (VCT)		Male									NARF	MoH
36.	# of clients tested for HIV at VCT receiving their test results	Female										
37.	# of health care facilities providing VCT		400 (05')	400	500	600	700	800	1000	Annual	HMIS	ZVCT
38.	**#** of professional health care providers trained to provide VCT										NARF	MoH
39.	# of lay/community providers trained to provide VCT services										NARF	MoH
Prevention of Mother to Children Transmission (PMTCT) **40.**	of professional care providers trained to provide PMTCT		520 ('04)	500	500	500	500	500	3,500	Annual	HMIS	CBoH
41.	# of lay,community providers trained to provide PMTCT			9,000	9,000	9,000	9,000	9,000	9,000	Annual	NARF/HMIS	PATF/ MoH
42.	# of facilities providing PMTCT services		256 ('05)	256							NARF/HMIS	PATF/ MoH
43.	# of districts with facilities providing PMTCT services		57 (05')	60	65	72	72	72	72	Annual	HMIS	MoH
44.	# of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		21,156 (05)	25,000	30,000	35,000	40,000	45,000	50,000	Annual	HMIS	MoH
45.	# of HIV exposed infants seen in the first 1 month of life for check-up										HMIS	MoH
46.	# of HIV exposed infants receiving co-trimoxazole prophylaxis	Male									HMIS	MoH
		Female										
STI Treatment: 47.	% of health facilities with STI drugs in stock and no STI drug stock outs of >1 month within last 12 months (by district)										HMIS/ DILSAT NARF	MoH
48.	# of service providers trained in the diagnosis and treatment of STIs according to national guidelines	Male										
		Female										
Blood Safety 49.	# of individuals trained in blood safety										HMIS	MoH

There were 282 workplaces, 170 were reached and these had workplace programmes/policies. A total of 112 were not reached and therefore they had no workplace policies/programmes (JAPR, 2005)

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
50.	# of service outlets carrying out blood safety activities										HMIS	MoH
	Infection Prevention										HMIS	MoH
51.	# of service providers trained in national standards for infection prevention and health care waste storage and disposal											
52.	# of health care facilities conducting infection prevention and health care waste storage and disposal										HMIS	MoH
53.	# of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male									NARF	THAPZ/ ZNCN
		Female										
	TB Treatment										HMIS	MoH
54.	% of health facilities with all essential drugs for TB/OI in stock and no stock outs of >1 week in the last 12 months											
	Anti-Retroviral Therapy	Male									NARF/H MIS	MoH
55.	# of persons with advanced HIV infection on ART	Female										
56.	# of service providers trained to provide ART										NARF/H MIS	MoH
57.	# of community adherence supporters trained to provide ART services										NARF/H MIS	MoH
58.	# of public and private health facilities providing ART services										NARF/H MIS	MoH
59.	% of HCFs providing ART services with no drug stock outs of > 2 weeks in the last 12 months										NARF/H MIS	MoH
	Care and Support										HMIS	MoH
60.	# of service outlets providing HIV related palliative care including TB/HIV											
61.	# of individuals provided with HIV-related palliative care including HIV	Male									HMIS	MoH
		Female									HMIS	MoH
62.	# of service providers trained to provide HIV palliative care including TB/HIV	Male									HMIS	MoH
		Female									HMIS	MoH
63.	# of chronically ill people enrolled in community home based care programmes	Male									HMIS	MoH
		Female									HMIS	MoH
64.	# of PLWHA support groups										HMIS	MoH
65.	# of PLWHA enrolled in PLWHA support groups	Male									HMIS	MoH
		Female									HMIS	MoH
Theme 3 Mitigating the Social Impact of HIV and AIDS												
	Support to Orphans and Vulnerable Children	Male									NARF	NGOs/ LMs
66.	# of orphans and other vulnerable children receiving care and support from CBOs,/NGOs/FBOs/DPOs	Female										
67.	# of street children re-integrated/integrated into homes	Male									NARF	

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
		Female										NGOs /LMs
68.	of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs										NARF	LMs
Theme 4 **Strengthening the Decentralised Response and Mainstreaming HIV and AIDS**												
Sectoral Mainstreaming 69.	# of workplaces, including line ministries, with developed workplace policies and programmes for HIV/AID										NARF	LMs/ ZBC
70.	# of Line Ministries, FBOs, CBOs, DPOs and NGOs with HIV and AIDS Action Plans										NARF	NGO /LMs
71.	# of line ministries with HIV/AIDS budget line items										NARF	NGO/ LMs
72.	# of line ministries with full-time focal point persons for HIV/AIDS										NARF	NGO/ LMs
73.	# of employees trained to provide HIV behavior change services to fellow employees (incl. peer educators, counselors, etc,) at workplaces	Males									NARF	LMs/ ZBC
		Females										
74.	# of employees reached through workplace programmes	Males									NARF	LMs/ ZBC
		Females										
Theme 5 **Improve the capacity for Monitoring and Evaluation for all Partners**												
Monitoring and Evaluation (M&E) 75.	# of organizations with functional M&E systems and linked into the national M&E system at national, provincial and district levels										NARF	NGOs
76.	# of persons training in M&E at different levels										NARF	NGOs/ LMs
Theme 6 **Integrate Advocacy, Coordination and Leadership of the Multisectoral Response**												
National Commitment, Leadership and Coordination 77.	Amount of public funds spent on HIV/AIDS in the past 12 months										Financial Resource flow survey	UNAIDS
78.	National Composite Policy Index (NCPI) score										NCPI Survey	UNAIDS