



# NATIONAL AIDS STRATEGIC FRAMEWORK 2011 – 2015

*Towards Improving the Quality  
of life of the Zambian People*



25<sup>th</sup> November 2010

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## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIE	Authority to Incur Expenditure
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CA	Community Agents
CBO	Community-Based Organisation
CDC	Centre for Disease Control
CDF	Constituency Development Fund
CHS	Community Health Service
CHW	Community Health Worker
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
DFID	Department for International Development
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DMMU	Disaster Management and Mitigation Unit
EFA	Education for All
FBO	Faith-Based Organisation
FMS	Financial Management System
FSW	Female Sex Worker
GAVI	Global AIDS Vaccine Initiative
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GIDD	Gender in Development Division
GIPA	Greater Involvement of People living with HIV and AIDS
HCBC	Home and Community-Based Care
HCT	HIV Counseling and Testing
HCW	Health Care Worker
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRBA	Human Rights Based Approach
HSS	Health Systems Strengthening
ICC	Inter-Agency Coordinating Committee
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IFMIS	Integrated Financial and Management Information System
JAPR	Joint HIV and AIDS Programme Review
LMIS	Logistical Management Information System
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MDG	Millennium Development Goal
MOH	Ministry of Health
MOT	Modes of Transmission
MOU	Memorandum of Understanding
MSM	Men having Sex with Men

MSW	Male Sex Worker
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
MTR	Mid-Term Review
MYSCD	Ministry Youth Sports and Child Development
NAC	National HIV/AIDS/STI/TB Council
NASA	National AIDS Spending Assessment
NBTS	National Blood and Transfusion Services
NGO	Non-Governmental Organisation
NHSSP	National Health Sector Strategic Plan
NPO	National Plan of Operations
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHMTs	Provincial Health Management Teams
PITC	Provider-initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership(s)
PSI	Project Sub-Implementer(s)
PWD	People With Disabilities
PwP	Prevention with Positives
RBM	Result-Based Management
SACCO	Savings and Credit Cooperative Society Limited
SME	Small and Medium-sized Enterprises
SMS	Short Message Service
SNDP	Sixth National Development Plan
SRPP	Strategic Review and Planning Process
STIs	Sexually Transmitted Infections
SW	Sex Worker
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
ToT	Training of Trainers
TOWA	Total War against HIV and AIDS
UA	Universal Access
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drug Control
UoZ	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medically-Assisted, Adult Male Circumcision
VPP	Voluntary Pooled Procurement
WHO	World Health Organisation

## Foreword

It is now over twenty five years since the HIV and AIDS epidemic emerged in Zambia, and the Government of Zambia declared the epidemic a national emergency. The people of Zambia in collaboration with our partners have developed and implemented diverse programmes to prevent new infections and improve the quality of life of the people. Our efforts have shown some fruits.

A trend review show that HIV prevalence in adults aged 15-49 years has halved since 1990, and the incidence is estimated to be stabilising at 1.6% in 2009 (2% in women, 1.2% in men) . In children aged 0-14 years, the number of new infections has declined dramatically since peaking at 21,189 in 1996 to 9,196 in 2009. HIV prevalence in antenatal clients aged 15- 19 declined from 13.9% in 1994 to 8.5% in 2006/7. The female to male prevalence ratio for young people aged 15-24 has dropped from 3.7 in 2004 to 1.6 in 2007. More people living with HIV (PLHIV) are living longer given the successful implementation of the antiretroviral therapy (ART) programme. Recently the Government reviewed the ART eligibility criteria from CD4 200 to CD4 350 enabling more people to access ART much earlier. Although the numbers of orphans and vulnerable children (OVC) have increased over the years, most are able to access basic care and support.

In spite of this progress, HIV remains a major threat to our nation. Zambia's HIV prevalence (14.3%) is among the highest in the world. In 2009, it was estimated that 226 new adult infections and 25 child infections occur each day. If we cannot stop new infections and start reversing the epidemic our country will continue to be vulnerable to its devastating effects.

The Government of Zambia is cognisant of the need for a concerted multisectoral and decentralised response to the epidemic. In this regard the National HIV/AIDS/STI/TB Council has been spearheading the development of national strategies to guide our response.

This National HIV and AIDS Strategic Framework 2011-2015 is the third in a series of such strategic frameworks. Given the urgency to stop new infections and the need to provide comprehensive and quality care and support, this NASF is evidence and results based. We have shifted our approach from business as usual to focusing on innovative interventions and programming that will lead to the achievement of specific results.

The NASF presents two major results. The first focuses on a reduction in the rate of new infections from 82,000 in 2009 to 40,000 by 2015. The second result focuses on extending the lives of PLHIV, and measures the increased percentage of PLHIV alive more than thirty six months after initiation of ART.

We must take immediate action to implement interventions that work and will yield results. Our duty is to address the drivers of the epidemic including multiple and concurrent partnerships, gender inequalities and to alleviate poverty. It is time to act, and act responsibly. Our legacy for future generations will not be measured by our wealth, but by the quality of life they will inherit – a nation free from the fear of HIV.

I therefore, urge all the people involved in the implementation of this Strategic Framework to fully dedicate themselves to this important national assignment. The Government of Zambia and NAC will remain committed to support you to ensure the successful implementation of the Framework.



**Hon Kapembwa Simbao**  
Minister of Health, and  
Chairperson of the Cabinet Committee on HIV and AIDS

## **Preface**

The National HIV/AIDS Strategic Framework (NASF) 2011-2015 constitutes a multi-sectoral, multi-layer and decentralised response to HIV and AIDS in Zambia. The Framework is designed to provide adequate space and opportunities for communities, civil society, private sector, development partners (bilateral and multi-lateral agencies) and government institutions to actively participate in the implementation based on their mandate and comparative advantage.

NASF has been developed through a participatory and consultative process and reflects the aspirations of the people of Zambia in their efforts to fight the HIV and AIDS epidemic. The framework will support decentralised implementation with meaningful involvement of communities, PLHIV and civil society organisations.

I therefore urge all the stakeholders to formulate and implement innovative interventions plans that are aligned to the NASF and the National Operational Plan. The National AIDS Council will provide policy and technical guidance throughout the process of implementation. It is my sincere hope that all stakeholders shall join the fight against the HIV and AIDS epidemic, through concrete interventions and fulfil the desired results.



**Bishop H. K. Banda**

Chairperson

National HIV/AIDS/STI/TB Council,



## **Acknowledgement**


The National AIDS Secretariat wishes to acknowledge with gratitude the valuable contribution of a large number of individuals and organisations who contributed to the development of this National HIV/AIDS Strategic Framework.

The Council wishes to express special thanks and appreciation to the members of the NASF Development Committee for their invaluable contribution in providing not only policy and technical guidance but also administrative oversight during the process.

The Council further wishes to thank the various stakeholders, government ministries and departments, civil society organisations, PLHIV, Provincial and District AIDS Task Forces and development partners for their meaningful participation. Their participation has helped to improve the quality and comprehensiveness of this document.

Finally, the Government of Zambia and the Council would like to express special thanks to the UN Family, Technical Support Facility (TSF) for Southern Africa and Cooperating Partners for their support in providing technical and financial assistance to support the development and review process.

Finally, I want to express my gratitude to the staff of the National AIDS Council for their dedication and collaboration during the entire process. Without their support the NASF would not have been possible.



**Dr. B.U. Chirwa**  
Director General  
National HIV/AIDS/STI/TB Council

### Overview

The National HIV and AIDS Strategic Framework (NASF) 2011-2015, provides strategic policy and technical orientation for the implementation of the multi-sectoral and decentralised HIV and AIDS response in Zambia. The development of the framework used evidence and results based planning and management approaches that also mainstream gender and human rights dimensions to ensure accelerated implementation of universal access (UA) to HIV and AIDS services.

The mainstreaming of gender is strategically important given the gender bias of the epidemic. More women (16.1%) than men (12.3%) are living with HIV and AIDS. Available evidence also indicates women bear a heavier burden in care and support of PLHIV and orphans and vulnerable children (OVC). To ensure a sustained gender-sensitive response, the NASF integrates a gender-based analysis of the epidemic drivers and other structural factors (gender inequality, poverty, income disparities) that are fuelling the epidemic into the planning and programming of the national response and monitoring and evaluation (M&E). Key outcomes, outputs and strategies in the NASF are informed by this analysis and indicators have further been disaggregated by age and sex.

By mainstreaming human rights, the NASF promotes protection of basic rights especially of PLHIV, orphans and vulnerable children (OVC) and other vulnerable groups including women, girls and people with disabilities. A primary area of focus will be protection from stigma and discrimination, the right to privacy (protecting people from mandatory testing, confidentiality of information), the right to education and information, and access to quality services.

The NASF institutionalises and consolidates the “Three-One” principles of having one coordinating authority, one national strategic framework and one national M&E framework. By aligning the NASF with other national strategic frameworks such as Vision 2030, the Sixth National Development Plan (SNDP), The Poverty Reduction Strategy, and the Gender Plan of Action, the national HIV and AIDS response is anchored in the wider socio-economic development of the country. It is also anticipated that successful implementation of the NASF will contribute to the attainment of Millennium Development Goals (MDG).

The implementation of the NASF will be based on the National Operational Plan (NOP). The NOP will be reviewed annually through the Joint Annual Programme Review process and formally evaluated at the end of three years in 2013. A revised NOP will be developed for the remaining period of the NASF

### Vision Statement

“A nation free from the threat of HIV and AIDS”

### Mission Statement

“A national multi-sectoral response, coordinated by 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 community to be served”

## The National Priorities

Through a consultative process, Zambia has articulated four national priorities<sup>1</sup> for the multi-sectoral HIV and AIDS response--

- i. To accelerate and intensify prevention in order to reduce the annual rate of new HIV infections
- ii. To accelerate the provision of Universal Access (UA) to comprehensive and quality treatment, care and support for people living with HIV and AIDS (PLHIV), their caregivers and their families, including services for tuberculosis (TB), sexually transmitted infections (STIs) and other opportunistic infections (OIs)
- iii. To mitigate the socio-economic impacts of HIV and AIDS especially among the most vulnerable groups, orphans and vulnerable children (OVC), PLHIV and their caregivers /families
- iv. To strengthen the capacity for a well coordinated and sustainably managed HIV and AIDS multi-sectoral response

The successful implementation of selected strategies targeting these priorities will contribute to the achievement of the Zambia Human Development Index, Millennium Development Goals (MDGs), and the objectives of Universal Access, in addition to the specific NASF impact results.

The National HIV and AIDS response is linked to Zambia's ability to improve its Human Development Index (HDI) and obtain the Millennium Development Goals (MDGs). These high-level aspirations are dependent on a healthy and productive population. AIDS is the most important problem that affects human capital and, consequently negatively impacts on all other sector contributions. Zambia's results-based national strategic framework is designed to contribute to HDI and MDGs by reducing risk to infection, help those who are already infected to live longer, reducing vulnerability by most at risk populations, and mitigating against the effects of the epidemic.

The impact level results are:

1. **Prevention:** By 2015, the rate of annual HIV new infections has reduced from 1.6% to below 0.8% (82,000 annual new infections to 40,000) by 2015). Infants born of HIV positive mothers who are infected has reduced to less than 5%<sup>2</sup> by 2015
2. **Treatment, Care and Support:** PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased to 85% by 2015
3. **Impact Mitigation:** Number of vulnerable households<sup>3</sup> is reduced by 50% by 2015
4. **Response Management:** The total NASF service coverage targets (output level results) that have been met in all four pillars has increased to 50% by 2013 and 90% by 2015

These priorities are informed by the epidemiological and response analysis discussed in section two (2) of the Strategic Framework.

## The Guiding Principles

Stakeholders implementing the NASF will be guided and informed by a number of strategic principles including the need to use evidence in the identification of priorities and selection of interventions. The guiding principles will focus on results rather than service delivery only; mainstreaming and operationalisation of the "Three-Ones" principles at all levels of the response; gender equality; equity in

<sup>1</sup> These are also the priorities set out in the 6<sup>th</sup> National Development Plan Chapter on HIV and AIDS, 11<sup>th</sup> June 2010.

<sup>2</sup> This is in line with the concept of Virtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT – presentation to funders, May 10<sup>th</sup> 2010, UNAIDS]

<sup>3</sup> It is estimated that there are 8000 vulnerable households (2010) - Source: A Supplement to NASF 2006-2010 Based on the Joint MTR held in 2008, NAC

access to services for rural and urban populations; and mainstreaming gender and human rights in all aspects of the response. Other guiding principles include: mainstreaming of HIV and AIDS in the workplace and in development programmes; cultural sensitivity, promoting meaningful involvement and participation of PLHIV, and consolidating multi-sectoral and decentralised approaches in the national response.

## **NASF Programme Areas**

The NASF revolves around the four thematic areas of the national response, i.e. prevention, treatment, care and support, impact mitigation and response management. In each of the thematic areas, strategic service delivery areas have been identified given their potential to contribute to the achievement of the above stated results. For each of the service delivery areas, the NASF has further articulated strategies that will inform the implementation process.

The following is a synopsis of the proposed interventions and strategies by thematic areas.

### **Prevention of New HIV infections**

The priority for Zambia is to reduce the rate of new HIV infections by 50% by 2015. This will be achieved through the implementation of a series of interventions using the “combination prevention strategy” and focusing on prioritised epidemic drivers. The focus is to reduce the risk of infection by implementing interventions that will address sexual behaviours, social norms, gender inequalities and poverty. Additional interventions will focus on stigma and discrimination, low levels of education attainment, and gender based violence (GBV). These interventions will be complemented by biomedical interventions such as male circumcision (MC), prevention of mother to child transmission (PMTCT), post exposure prophylaxis (PEP), prevention of STIs and promotion of consistent and correct use of male and female condoms.

The level of comprehensive knowledge of HIV and AIDS will be improved through intensified community, school, and workplace HIV and education programmes. It is anticipated that combined improved knowledge, increased risk perceptions, and better understanding of the implications of risk behaviours will contribute to behaviour change. The involvement and participation of PLHIV in HIV prevention will be strengthened and scaled up in community and health facility settings. Specific interventions will be initiated targeting most at risk populations (MARPS). A comprehensive national survey will be conducted to establish the magnitude of problems associated with MARPS. Provision of life-skills based HIV education will be scaled up for both in and out of school youth. HIV and AIDS youth friendly services will be initiated and incorporated in on-going youth development and recreation programmes.

HIV counselling and testing (HCT) will be scaled up as a key entry point to treatment and accessing prevention services such as behavioural change communication, male circumcision (MC), PMTCT and early treatment of STIs.

Availability of both male and female condoms will be ensured and distribution will be expanded through partnerships with communities, private sector partners and institutions operating in the informal sector. Condom education and distribution will also be integrated with other NASF strategies in MC, prevention of STIs and PMTCT. Condom education will also be intensified and coverage expanded.

The NASF strategy includes scale up of MC services throughout the country and in provinces with low levels of circumcision such as Eastern (3.2%), Northern (3.3%), and Southern (4.4%) provinces and in areas with high HIV prevalence rates (e.g. Copperbelt 17%). The NASF targets neonatal males for circumcision as a strategy to ensure the sustainability of this intervention. Cooperation with traditional male circumcisers will be strengthened to ensure safety and to prevent infections.

PMTCT will be intensified around the four PMTCT prongs with the aim of achieving virtual elimination of mother to child transmission by 2015. The core strategy will be to focus on primary prevention that will also entail greater involvement and participation by men and intensification of family planning (FP) services to all male and female PLHIV. PMTCT services will be linked to the scaling up of antiretroviral therapy (ART). Integration of PMTCT with other clinical services such as maternal, newborn, and child health (MNCH) clinics, HIV treatment centres, HCT, STI clinics, and family planning (FP) clinics will be strengthened. With the adoption of the CD4 350 criteria and in line with World Health Organisation (WHO) recommendations, all HIV positive pregnant women will be on highly active antiretroviral therapy (HAART) starting as early as the 14<sup>th</sup> week of gestation (second trimester) and will continue for the whole period of breastfeeding until a week after secession of breastfeeding.

The coverage and availability of Post Exposure Prophylaxis (PEP) will be improved for both occupational and non-occupational PEP. Training on PEP will be improved and coverage will be expanded. Communities will be mobilised and sensitised on the availability of PEP services especially in the context of victims of rape and survivors of GBV.

Prevention of STIs will be addressed through a comprehensive package that will include interpersonal communication, provision of condoms and encouraging STI clients to notify their partner regarding possible infection. STI services will be integrated in other programmes especially in MC, PMTCT, HCT and condom promotion.

The NASF will emphasize working with cultural leadership systems to address structural drivers of the epidemic that sustain practices that increase vulnerability of women and girls such as gender based violence, social marginalization of vulnerable groups, patrilineal norms and values. Community responses that enhance and sustain HIV prevention will be encouraged. Campaigns such as 'one love kwasila' that confront MCP practice within society will be scaled up and effectively targeted.

### **Improving quality of life through treatment, care and support**

To ensure that more PLHIV access treatment, care and support, Provider Initiated Counselling and Testing (PICT) will be intensified. The referral system will be improved and service providers will be trained to maximise use of the referral system to ensure that people who test positive are able to access facility and community-based treatment, care and support services.

Testing services will be scaled up to ensure access at the lowest possible level. People who test HIV negative will be referred to prevention programmes to help them to make informed choices and decisions in adopting prevention behaviours. Those who test positive and meet the criteria for ART in line with national guidelines will be enrolled on ART. Those who don't meet the criteria will be referred to pre-ART services that help PLHIV live longer and healthier lives before ART enrolment. Pre-ART services will include among others screening and treatment of OIs, provision of prophylaxis, treatment literacy, counselling, nutrition and consistent monitoring of viral load. Zambia has adopted the CD4 350 criteria, which means that more PLHIV will be eligible for ART. Provision of ART will also be extended to people diagnosed with Hepatitis B HIV co-infection.

Expansion of services will address the current inequitable distribution of services, and seek to reach underserved communities. HIV and AIDS will be integrated with other health facility-based services such as sexual and reproductive health. To ensure an expanded capacity for ART, the government will explore the potential for Public-Private Partnerships with the private sector and privately managed health facilities providing services.

With regard to tuberculosis (TB), the NASF strategy promotes the scale up of collaborative efforts that address TB/HIV co-infection. TB services have been rolled out to all health facilities and in the community.

The NASF calls for the acceleration of the implementation of the “Three Is” strategy” of intensified case finding (ICF), provision of Isoniazid Preventative Therapy (IPT), and TB Infection Control (IC). The national capacity for treating TB and monitoring the emergence of multi-drug resistant (MDR) and Extensively Drug Resistant (XDR) TB will be strengthened.

More people previously in need of community and home based care (CHBC) services are now able to return to some form of productivity after successfully adhering to ART. CHBC services will be reviewed and aligned to current needs and demand. Palliative care will be integrated into CHBC and the capacity of service providers to offer palliative care will be strengthened.

### **Mitigating the socio-economic impacts of HIV and AIDS**

The NASF is aligned with the Sixth National Development Plan (SNDP) and the Poverty Reduction Strategy and expands the scope and coverage of impact mitigation. The NASF priority for impact mitigation is to strengthen the capacity of vulnerable households and individuals to cope with the socio-economic impacts of HIV and AIDS within the context of a broader social protection framework. This will entail development and implementation of sustainable livelihoods, improving household food security, strengthening systems that provide social security and reducing household risks and vulnerability.

Some of the poverty reduction activities that will be explored include community revolving micro-credit schemes, backyard and community gardens, and small livestock and poultry initiatives. Communities will be trained in relevant management skills such as marketing, and project and financial management.

Key vulnerable groups identified by NASF include PLHIV, OVC particularly the girl child and child headed households, the elderly, people with disabilities and care givers. Provision of care of OVC and PLHIV remains the greatest challenge for vulnerable households given their limited resources. The NASF supports strategies that address the basic needs of food, shelter, education, clothing, social protection, access to health care, and water and sanitation. In addition, other interventions such as psychosocial support and the provision of services for victims of GBV including physical, emotional and sexual abuse are encouraged.

### **Response Coordination and management**

National response strategies as outlined in the NASF are designed to improve the efficiency and effectiveness of the coordination and management of the national multi-sectoral response at all levels, and in line with implementation of the decentralisation process. Coordinating structures and systems will be reviewed and strengthened. Development partners, civil society and private sector systems will be harmonised and aligned to the national systems within the framework of “Three-ones” in a multi-sectoral and decentralised environment. Roles and responsibilities of the various partners will be articulated and communicated to stakeholders to ensure better understanding of accountability for resources and actions taken. Capacity for governance and leadership will be improved.

The NAC structure will be reviewed and restructured to ensure that it has the requisite capacity for coordinating and managing a multi-sectoral response with diverse stakeholders. Coordinating structures will be reviewed to harmonize them with the orientation of the NASF. This review will include assessing effectiveness of the Theme and Technical Groups as currently constituted and bringing on board required expertise where necessary. The participation of civil society and PLHIV organisations in coordination and implementation will be strengthened and consolidated.

Advocacy work to consolidate and strengthen political commitment and leadership will be intensified at national, sectoral, regional and community levels. The existing strategic partnerships and alliances between government, private sector, civil society and development partners will be further developed. Partners’



operational systems and programmes will be harmonised and aligned with national systems and national priorities.

Each year the partners will conduct an annual joint review of the implementation of NASF based on progress made in the implementation of the National Operational Plan. A formal mid-term evaluation of the NASF will be conducted in 2013 with an end evaluation in 2015.

### **Capacity Development**

Given the impact of the epidemic on human resources and the attrition of skilled and experienced personnel, Zambia will conduct a comprehensive capacity assessment across all sectors. A common survey tool will be developed and then customised to the needs of each sector. Sectors will implement their own portions of the capacity assessment. A national report will be compiled from these sectoral reports. Following the assessment, a capacity development framework will be developed and implemented. The key issues around human resources that the NASF will address are adequacy, skills and retention

### **HIV/AIDS Mainstreaming in Workplaces and in Development Programmes**

While Zambia has made significant progress in mainstreaming HIV and AIDS into the workplace, a lot more work remains to be done to mainstream HIV and AIDS into development programmes. The NASF promotes the scale up of the current workplace initiatives and advocates for intensified efforts in scaling up HIV in development projects across sectors.

Similarly, very little has been done to extend HIV and AIDS services in the informal sector. The NASF promotes strategies that will engage people and institutions and establish partnerships with the informal sector to broaden access to vulnerable populations.

### **Gender Responsiveness**

The capacity of GIDD to coordinate gender programming in the context of HIV will be strengthened. A national technical committee to work with the various NASF thematic areas and monitor progress in implementing gender strategies will be established. Gender dimensions will be strengthened within all research components and in particular the Joint Annual Programme Review and other monitoring programmes.

### **Resource Mobilisation**

Over the five year period of the NASF, Zambia will mobilise resources from domestic and international sources to finance the implementation of the NASF. Resource mapping will be conducted annually and a gap analysis established. This will enable Zambia to focus its resource mobilisation strategies in critical areas. During the same period, Zambia will develop and implement a sustainability strategy that will enable the country to reduce dependence on external resources. A resource tracking mechanism will be developed and operationalised to track HIV and AIDS related financial resources from both the demand (implementing partners) and supply (donor) sides.

### **Monitoring, Evaluation and HIV Research**

A National M&E framework will be developed and aligned to the NASF results framework. The framework will guide and inform NASF monitoring processes, and stakeholders performance reporting. Stakeholders will be encouraged to align their M&E systems with the national M&E system in line with the “Three-Ones” principle.

Zambia has developed a national research agenda to guide both clinical and operations research (OR). Clinical and operations research will inform the HIV and AIDS response in Zambia and will bolster efforts around evidence-based programming and results based management. Data generated from research will also be used to evaluate performance and the attainment of results.

### **The process of developing the NSF**

The development of the NASF was participatory and involved a wide range of stakeholders ranging from government institutions, PLHIV, civil society organisations (CSOs), private sector, and development partners. Consultations were also extended to the provincial and district level.



## Section-1: Introduction

### 1.1 Background

Zambia has one of the highest HIV prevalence rates in the world. With an adult HIV prevalence rate of 14.3% (2007) the country was ranked seventh among the most affected countries in the world (UNAIDS) in 2008. The epidemic has spread rapidly across all sectors of society and threatens to reverse the socioeconomic gains made since independence. For over 25 years, the Government of Zambia, national and international organisations, and international collaborating partners have committed themselves to work together towards UA to prevention, treatment, care and support.

The Government commitment is further enshrined in the country's long-term Vision 2030 that aims to have a *"nation free from the threat of HIV and AIDS by 2030"*. Zambia has further committed itself *"to halt and begin to reverse the spread of HIV"* by 2015 as agreed in the Millennium Development Goals (MDGs).

With the development of the NASF, Zambia in the next five years will focus on high impact interventions that will contribute to a reduction of new infections in the country especially among women, children, young people and key affected groups and populations. This will entail sustained and strong political leadership and commitment to invest and accelerate UA to HIV and AIDS services combined with meaningful participation and involvement of PLHIV and communities.

HIV and AIDS are cross-cutting, multi-faceted and multi-dimensional health, development and human rights issues. Consequently, the national multi-sectoral and decentralised response relies on strategies that address gender and human rights mainstreaming in all aspects of the response from planning, human resources, policy formulation, resource allocation to service delivery and M&E. With gender mainstreaming, the national response will address the gender biases of the epidemic associated with biological, economic, socio-cultural and legal factors that influence the spread and impact of the epidemic especially on women and the girl child.

Given the magnitude of the epidemic and the urgency to achieve UA and stated MDGs, Zambia will consolidate its efforts and strategies for addressing root causes of gender disparities and in-equalities that predispose people to HIV and sustain high levels of infections. Specific efforts will be made to ensure that HIV and AIDS issues are mainstreamed into various policy and development instruments such as ensuring that HIV and AIDS is a key indicator for national development programmes; poverty reduction and Medium Term Expenditure Frameworks.

The implementation of the national multi-sectoral response will be undertaken by a wide range of stakeholders including government agencies, CSOs, private sector partners and communities.

The government response to HIV and AIDS started in 1984 when the first case of AIDS was diagnosed in Zambia. Since then the government has systematically put in place plans and resources to address the challenges of HIV and AIDS. The National HIV/AIDS/STI/TB Council (NAC) was established in December 2002 to coordinate the national multi-sectoral response. A National HIV/AIDS Policy was published in 2005 to provide policy guidelines for the national multi-sectoral response. In 2004, the Government of Zambia declared HIV and AIDS a national emergency that called for a comprehensive emergency response.

The development of the NASF 2011-2015, coincides with the development of the Sixth National Development Plan, the review of the National HIV/AIDS, STI and TB policy, a review of the NAC and accelerated implementation of the National Decentralisation policy. This provides a greater opportunity to re-position and expand the scope of the national HIV and AIDS response.

## 1.2 The country context

Zambia is land-locked with a population of approximately 13 million people living in an area of 752,612 square kilometres. The country is divided into nine provinces and 72 districts. Of the nine provinces three (Lusaka, Southern and Copperbelt) are predominantly urban while the remaining provinces are predominantly rural.

By 2008 life expectancy at birth was 40 years<sup>4</sup>. The annual population growth rate in 2005 was estimated at 2.7% with projections of a decline to 1.9% by 2015. Similarly by 2015, it is projected that 40% of the population will be under the age of 15 and 37% of the total population will be living in urban centres. Adult literacy is estimated to be 68% (60.4 % for women and 81.3% for men) with a combined primary, secondary and tertiary school enrolment ratio of 60.5<sup>5</sup>

Zambia is a low income country with a gross national income of US dollars 890 per capital. Mining and agriculture remain the mainstays of the Zambian economy. Before the global economic crisis, copper mining accounted for 95% of the export earnings and contributed to approximately 45% of government revenue. Agriculture is the largest employer with 70% of the labour force while the service industry employs 23% of the population. In 2005, the unemployment rate was pegged at 12%. In 2008 GDP was calculated at US\$1,023 and with a human development index value of 0.434.

Zambia has one of the highest incidences of poverty in the world with 68% of people living in extreme poverty<sup>6</sup>. Approximately 87% of the people live on less than two dollars a day<sup>7</sup>. Poverty has remained more prevalent in rural than urban areas (80 and 34%, respectively). Zambia has extreme income inequalities to the extent that income distribution is reflected by a high gini co-efficient of 0.57.<sup>8</sup> According to the per capita income distribution, 20% of the national income is shared by 70% of the population<sup>9</sup>. Both the quality and quantity of human capital in households are diminishing due to deaths, illness or children dropping out of school because they are orphans or need to help in household work<sup>10</sup>.

Although the prospects for attaining the Millennium Development Goals are perceived to have improved, HIV and AIDS remains a significant threat. Zambia has made some progress in alleviating the poverty rate from more than 70% in 1991 to 64% in 2009<sup>11</sup>. HIV continues to negatively affect the demand and supply of education compromising the achievement of universal primary education. The epidemic has significant gender biases. More women are living with HIV and AIDS compared to their male counterparts. Girls continue to drop out of school to provide care and support in AIDS-affected households.

Child mortality remains high and maternal mortality is still a threat to HIV positive women and women in general. The health of HIV positive women during pregnancy is often compromised by HIV infection, raising the chances of maternal deaths during child birth. Universal Access to HIV and AIDS services remains low.<sup>12</sup> These examples illustrate the potential threat of HIV and AIDS to the achievement of MDGs if the threats are not adequately addressed

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<sup>4</sup> Human Development (global Report) Report 2007/08 UNDP

<sup>5</sup> Human Development (Global) Report 2007/2008, UNDP

<sup>6</sup> Zambia Human Development Report, 2007, UNDP

<sup>7</sup> UNAIDS, 2007, Summary of Target setting and outcomes of the country consultation on scaling up towards universal access

<sup>8</sup> Ministry of Finance and National Planning, 2006, Fifth National Development Plan, 2006-2010, Lusaka (FNDP)

<sup>9</sup> Fifth National Development Plan

<sup>10</sup> Human Development Report, 2007, UNDP

<sup>11</sup> The Monthly, Central Statistical Office 2009

<sup>12</sup> Zambia Human Development Report, 2007, UNDP

### 1.3 The Purpose of the NASF

The purpose of the National Strategic Framework for HIV and AIDS is to:

- i. Provide an overall strategy for the planning, coordination and implementation of the multisectoral national response based on available evidence and emerging social and epidemiological issues.
- ii. Articulate national priorities, results and targets that all stakeholders should work towards achieving, based on their respective mandates, resources and comparative advantage to enable Zambia to achieve Universal Access (UA) and Millennium Development goals (MDG)
- iii. Form the basis for agreed framework for multisectoral programme implementation involving civil society, private sector, public sector, development partners in line with the three-ones principles
- iv. Provide the basis for reaching agreement with development partners on their technical and financial support and the management and coordination of the response.

### 1.4 The Vision, Mission and Priorities for the NASF

#### Vision Statement

“A nation free from the threat of HIV and AIDS”

#### Mission Statement

“A national multi-sectoral response, coordinated by 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 community to be served”

#### Priorities for the NASF

The NASF articulates four national priorities<sup>13</sup> for the HIV and AIDS response that are aligned to the Sixth National Development Plan priorities. These priorities are

- i. To accelerate and intensify prevention in order to reduce the annual rate of new HIV infections with special attention to addressing root causes that sustain high levels of societal vulnerability
- ii. To accelerate the provision of universal access to comprehensive and quality treatment, care and support for people living with HIV and AIDS, their caregivers and their families, including services for TB, STIs and other opportunistic infections
- iii. To mitigate the socio-economic impacts of HIV and AIDS especially among the most vulnerable<sup>14</sup> groups, orphans and vulnerable children, PLHIV and their caregivers /families
- iv. To strengthen the capacity for a well coordinated and sustainably managed HIV and AIDS multi-sectoral response

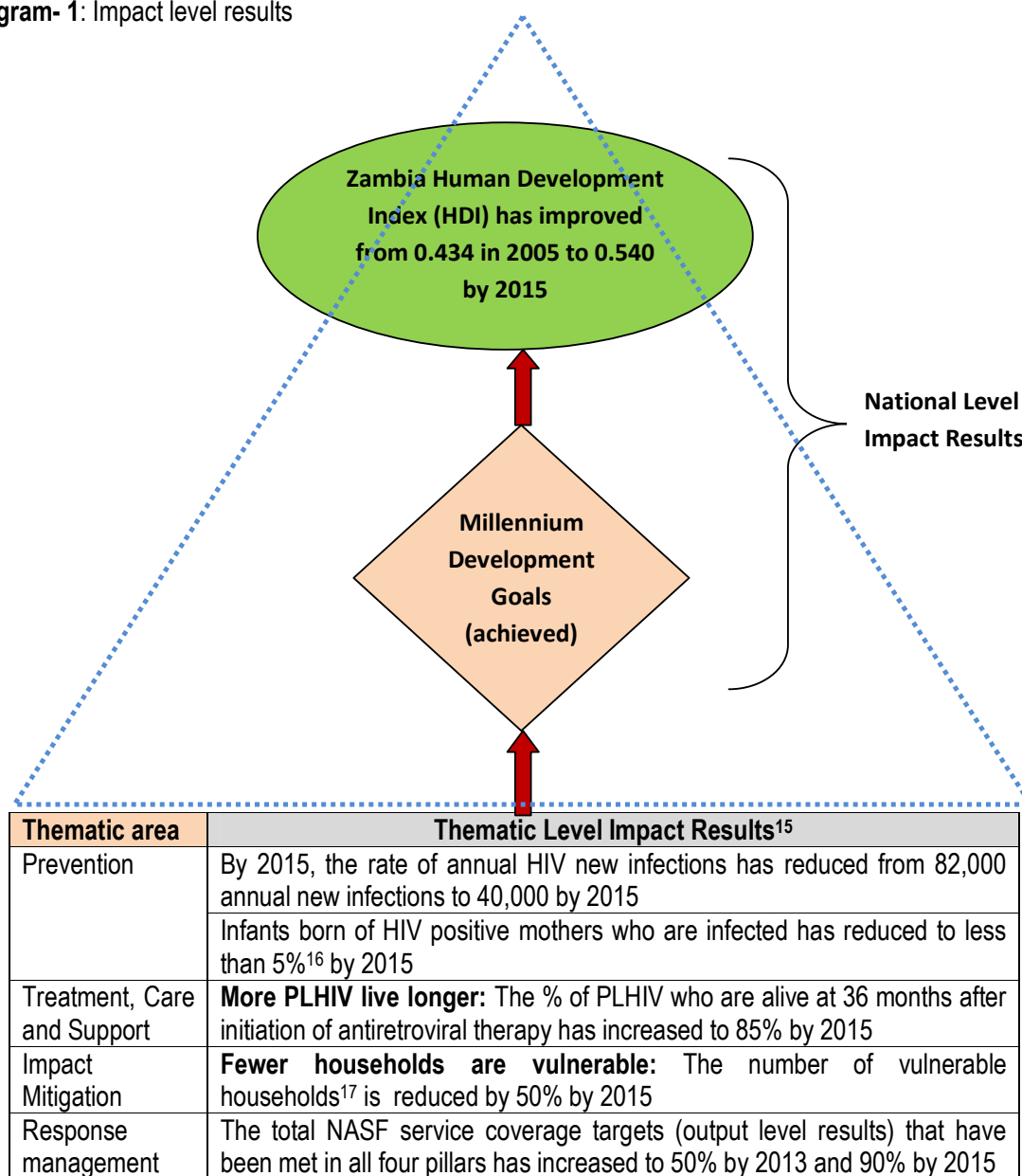
It is anticipated that the implementation of these priorities will contribute to the achievement of the following national impact level results and the Millennium Development Goals (MDG).

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<sup>13</sup> These are priorities set out in the 6<sup>th</sup> National Development Plan Chapter on HIV and AIDS, 11<sup>th</sup> June 2010.

<sup>14</sup> In the context of NASF, vulnerability is defined as individual and groups that are exposed to risk of HIV infection because of biological socio-cultural and economic processes

Diagram- 1: Impact level results



**Note:** The National HIV and AIDS response is only one of the many interventions that will contribute to the achievement of the Human Development Index. The strategic importance of the HIV and AIDS response in this context is that all other multi-sectoral responses will depend on a healthy population. HIV and AIDS is the single most important problem that has affected the human capital and consequently negatively impacted on all the other sector contributions.

<sup>15</sup> these results are harmonised with the inputs for the Sixth National Development Plan

<sup>16</sup> This is in line with the concept of Virtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT – presentation to funders, May 10<sup>th</sup> 2010, UNAIDS]

<sup>17</sup> It is estimated that there are 8000 vulnerable households (2010) - Source: A Supplement to NASF 2006-2010 Based on the Joint MTR held in 2008, NAC

## 1.5 Guiding Principles

The development of the NASF has largely been informed by the policy guidelines contained in the National HIV and AIDS and STI Policy<sup>18</sup> and the Guiding Principles articulated therein. Stakeholders commit themselves to adhere to these guiding principles that constitute the core values of the national HIV and AIDS multi-sectoral response:

- i. **Adoption of a human rights approach:** The design and implementation of specific interventions will respect fundamental basic human rights, and put in place strategies to promote and protect them. By so doing the NASF is engendered, people-centred, culturally sensitive and pro-poor. NASF will promote and support cultural practices and norms that contribute to the prevention of new HIV infections, and support HIV and AIDS services uptake
- ii. **Political leadership, commitment and engagement:** During the period of NASF implementation, Zambia will strengthen and consolidate good governance, transparency and accountability around HIV and AIDS issues at all levels and in all sectors.
- iii. **Greater Involvement of PLHIV (GIPA):** The contribution of PLHIV in prevention and other services uptake has significantly increased the success of the national response. NASF will strengthen and expand the involvement of PLHIV at all levels of the national response
- iv. **Evidence and Results Based Planning:** To get value for money, NASF will promote the use of evidence and results-based planning among all stakeholders. The M&E system will be strengthened to generate the evidence required for decision making, policy formulation and resource allocation.
- v. **Gender sensitive:** Given the gender bias of the epidemic, gender dimensions will be addressed in all programme areas and mainstreamed in all aspects of the response. Results for women, girls and gender equality will be a strong feature, including maternal and child health indicators.
- vi. **Strategic Partnerships and Alliances:** Zambia has adopted a multisectoral, decentralised and participatory approach to the implementation of the national response. Meaningful opportunities will be created for all stakeholders to be part of the response based on their mandate and comparative advantage.
- vii. **“Three-Ones”:** Zambia will mainstream and consolidate the three ones concept to strengthen coordination and management of the national multi-sectoral response by having one national strategic framework (NASF), one national coordinating authority (NAC) and one national M&E framework.
- viii. **Health and Community Systems Strengthening:** The success of the national response is largely dependent on effective and comprehensive health and community systems. A part of the NASF operational strategy is to strengthen these systems to ensure adequate and equitable distribution and access to services in line with principles of Universal Access (UA)
- ix. **Decentralised Implementation:** NASF implementation will be decentralised to provinces, districts communities and within sectors. Support will be provided to implementing partners to develop their individual operational plans that are aligned to the national operational plan. The decentralisation will be in line with the National Decentralization Policy. Roles and responsibilities of the various coordinating structures and implementing partners at all levels of the response will be clarified.

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<sup>18</sup> National HIV and AIDS Policy, NAC, 2005

## **1.6 The Stakeholders Consultative Process**

The preparatory period for the NASF started in 2009 with the involvement of a wide range of stakeholders drawn from government agencies, civil society, private sector and development partners. Sub-national consultations in selected districts were conducted and involved district and provincial government officials, members of the District HIV and AIDS Task Forces (DATF), district planning officers, civil society and business sector representatives and traditional leaders. Public and private sectors and development partners participated at the national level also provided inputs for the NASF development. To ensure that the new NASF embodies a strong gender perspective, consultative meetings were also held during various stages of the NASF development with the Gender Steering Committee which was co-chaired by NAC and the Gender in Development Division (GIDD) and was primarily, but not exclusively, responsible for representing the interest of women and girls. Consultations with other interest groups, such as sex workers and youth were mainly through their representative organisations. Membership includes government, civil society and faith-based organisations (including organisations of PLHIV) and cooperating partners.

Stakeholders participated in different ways during the process of the NASF design including a review of progress in the implementation of the NASF 2006-2010; reviewing the current status of the epidemic and national response; establishing the gaps and challenges encountered to setting national priorities and targets for the period 2011 to 2015.

## **1.7 Alignment to other National, Regional and International Policy Frameworks**

The HIV and AIDS epidemic has many complex social and economic consequences that include declining life expectancy, reduced human productivity, reductions in household investment in education, weakened health systems, reduced agricultural output and limited sustainable human capital development. At the household level, the epidemic is competing for resources, reducing the ability of households to save and invest in addition to increasing household food insecurity. The epidemic threatens to destroy traditional community coping mechanisms and safety nets, making communities even more vulnerable. At the macro level, the epidemic is likely to reduce national and community capacity to absorb and utilise resources earmarked for socioeconomic development, hence contributing to deepening poverty and deprivation of basic needs.

Addressing these consequences requires a comprehensive response anchored in broad national social and economic development frameworks with a clear focus on achieving the MDGs. Achieving the MDGs will also require accelerating UA and implementation of activities that contribute to the Declaration of Commitment on HIV and AIDS and the Universal Access (UNGASS). The core commitments are reflected in the results framework of the NASF.

NASF aligns itself with the Zambia Decent Work Country Programme, given the informal sector has not been systematically mainstreamed into the national HIV and AIDS multisectoral response. Given the nature and scope of informal sector, HIV vulnerability is considered higher than in the formal sector and hence the urgent need to address HIV and AIDS in the informal sector.

For these reasons the NASF is aligned to Vision 2030, the MDGs and Sixth National Development Plan. The NASF is further designed to contribute to the achievement of Zambia's obligations in the context of the African Union Abuja and Maseru (SADC) declarations, and the SADC Protocol on Gender and HIV and AIDS.



The following Table highlights how the NASF is directly linked to and will contribute to the achievement of these strategic frameworks.

**Table 1:** Alignment of the NASF with other Strategic Frameworks

<b>National strategy</b>	<b>What does the strategy say</b>	<b>How NASF will contribute and or complement to this strategic frameworks</b>
Vision 2030	The vision aims to achieve a “nation free from the threat of HIV and AIDS by 2030”	NASF aims to reduce new HIV infections by 50% by 2015 by addressing the drivers of the epidemic while implementing strategies that scale up treatment, care and support to 80 percent by 2015.
Sixth National Development Plan	The 6 <sup>th</sup> NDP aims at generating wealth to improve the quality of life and reduce extreme poverty by 50% by 2015; and accelerating comprehensive and quality treatment, care and support (including impact mitigation	The overall national impact level results of NASF (improvement of human development index <sup>19</sup> ) will contribute to the achievement of NDP and MDG results.
Millennium Development Goals	Refer to the MDG results index	All the goals are addressed and specific results identified for NASF to be achieved by 2015.
UNGASS declaration	Aims to halt and begin to reverse the spread of HIV by 2015	NASF aims to reduce new HIV infections by 50% by 2015, bringing down the annual incidence to 0.8%. This is a level that the epidemic is like to die.
Poverty Reduction Strategy (see also SNDP)	Aims to alleviate poverty among all people living under the poverty datum line	NASF aims at providing effective prevention interventions to keep people from being infected and hence falling sick. NASF will also provide comprehensive and quality treatment and care of PLHIV to ensure that they remain economically productive. Key strategies have been put in place to reduce household poverty under impact mitigation
Gender Plan of Action	Aims to promote gender empowerment, reduce gender related HIV vulnerability	NASF has mainstreamed gender. Most outcome and outputs are gender sensitive. NASF includes specific output results on gender-based violence. Special attention has been paid to gender-related HIV and AIDS challenges facing women and girls. Strategies have also been developed to promote active male involvement in critical areas including HCT, PMTCT, and male circumcision.

The NASF’s contribution to these policy frameworks will be complemented by public sector, civil society, private sector, and cooperating partners’ strategic plans. These include but are not exclusive to: the HIV and AIDS Strategy for the Public Sector (2010-2015); Zambia Decent Work Country Programme; the MOH Strategic Plan; the National Strategic Plan for TB; the National Strategy for the Child that includes OVC; and National Gender Action Plan.

<sup>19</sup> HDI is a summary measure of human development that measures the average achievements in a country in three basic human development dimensions. i.e. a long and healthy life as measured by life expectancy; knowledge as measured by adult literacy (with two thirds weight) and the combined primary, secondary and tertiary gross enrolment ration (with one third weight) and a decent standard of living as measured by GDP per capital in purchasing power parity (PPP) terms in US dollars

## Section-2: Situation and Response Analysis

### 2.1 The Epidemiology of HIV and AIDS in Zambia

#### Prevalence levels and trends

According to Spectrum<sup>20</sup> estimates, adult HIV prevalence peaked in the mid 1990s at about 16% and has stayed above 14% since then<sup>21</sup>. By 2007<sup>22</sup>, the national adult HIV prevalence was estimated at 14.3%. The epidemic has a gender bias with more women (16.1%) living with HIV and AIDS compared to men (12.3%)<sup>23</sup>. However, for women above 40 years, prevalence is lower than men in the same age bracket. In 2009, an estimated 82,681 adults were newly infected with HIV (59% women, 41% men) with 226 new adult infections and 25 new paediatric infections occurring each day<sup>24</sup>.

HIV prevalence is higher in urban centres (20%) than in rural areas (10%). Northern and North Western provinces have the lowest prevalence levels of lower than 7%. The urban provinces of Lusaka and Copperbelt have high HIV prevalence at 21% and 17%<sup>25</sup>, respectively. Prevalence is much higher among residents of urban areas than rural areas (19.7% vs. 10.3%). Significantly higher HIV prevalence was found in mobile urban educated women than women who stay at home (MOT, 2009).

A trend review shows that HIV incidence in adults aged 15-49 years has halved since 1990, and is estimated to be stabilising at a high level of 1.6% in 2009 (2% in women, 1.2% in men)<sup>26</sup>. In children and adolescents aged 0-14 years, the number of new infections has declined dramatically since peaking at 21,189 in 1996 to 9,196 in 2009. Similarly, HIV prevalence levels in ANC clients have shown signs of decline. HIV prevalence in ANC clients aged 15-19 declined from 13.9% in 1994 to 8.5% in 2006/7. The female to male prevalence ratio for young people aged 15-24 has dropped from 3.7 in 2004 to 1.6 in 2007, implying fewer infections in women than men.<sup>27</sup>

About 11% of couples living together are sero-discordant<sup>28</sup>. There are significant geographical variations of sero-discordance with Northern Province having the highest percent (79%) and Copperbelt Province with the lowest percent (52%)<sup>29</sup> of sero-discordant couples.

It is estimated that for every two people on treatment, 5 more are newly infected of whom three are women. Although statistical modelling suggests that the rate of new HIV infections has been slowing<sup>30</sup> the number of PLHIV is expected to continue to increase as more PLHIV access and adhere to antiretroviral therapy (ART) and live longer. In 2009, it was estimated that 927, 693 people were living with HIV and the number is expected to rise to 1,039, 333 by 2015<sup>31</sup>.

Increasing access to treatment since 2003 has had a major effect on mortality in Zambia, where HIV-related deaths among adults 15-49 years has decreased from 82% in 1996 to 54% in 2007<sup>32</sup>. *The Modes of*

<sup>20</sup> Produced by UNAIDS and NAC

<sup>21</sup> Mode of Transmission(MOT) report 2008, NAC, UNAIDS and World Bank

<sup>22</sup> Use original source doc which is DHS... 2007., Zambia HIV prevention response and modes of Transmission Analysis

<sup>23</sup> Central Statistical Office *Zambia Demographic and Health Survey, 2007*

<sup>24</sup> Modes of Transmission, 2009, National AIDS Council

<sup>25</sup> Central Statistical Office *Zambia Demographic and Health Survey, 2007*

<sup>26</sup> Modes of Transmission, 2009, National AIDS Council

<sup>27</sup> Modes of Transmission, 2009, National AIDS Council

<sup>28</sup> Mode of Transmission(MOT) report 2008, NAC, UNAIDS and World Bank

<sup>29</sup> 2009, Zambia HIV prevention response and modes of Transmission Analysis

<sup>30</sup> The 2009 Estimates and Projections Report, Zambia,

<sup>31</sup> The 2009 Estimates and Projections Report, Zambia

<sup>32</sup> 2009 Epidemiological Estimates report.

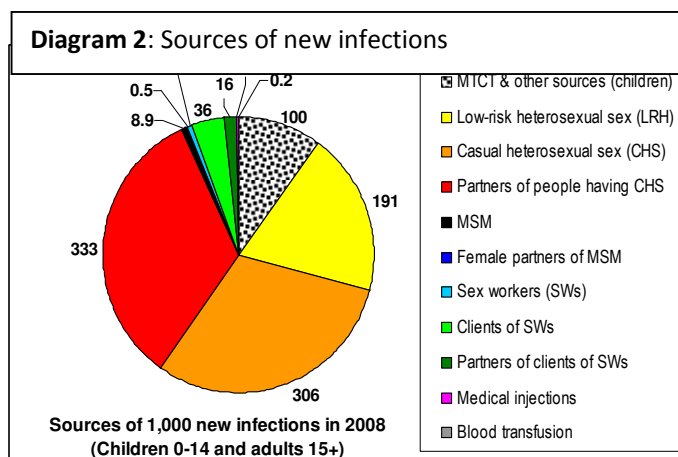


*Transmission Report (2009)* noted that AIDS related mortality among children and adolescents under 14 years peaked in 2003 (14,681 deaths) and has since declined by almost 50% (7282 deaths) in 2009. The decline has been associated with improved access and utilisation of PMTCT and paediatric ART in addition to lower fertility rates.

## New sources of Infection

The main mode of HIV transmission in Zambia is unprotected sex. An estimated 90% (*MOT 2009*) of adult infections are related to unprotected heterosexual activity either with a casual partner, a long-standing partner, or a concurrent sexual partner. Stable relationships such as marriages or people living together have the highest HIV prevalence rates estimated at 16% and 15%, respectively.

The largest contribution to the total HIV incidence comes from individuals whose partners have casual heterosexual sex (37%) followed by individuals reporting casual heterosexual sex (34%), mutual monogamy (21%), clients of sex workers (4%) and men who have sex with men (MSM) (1%)<sup>33</sup>. The transmission of HIV from mother to child during pregnancy, birth or breast feeding is believed to account for 10% of new infections in Zambia. New protocols and guidelines suggest that this can be reduced to less than 5%, making virtual elimination of new HIV infections among infants a reality in Zambia.



## Epidemic Drivers

Zambia has a mature and heterogeneous HIV epidemic driven by a combination of behavioural, structural and biomedical epidemic drivers. Through a consultative process culminating in the National HIV Prevention Conference in November 2009, stakeholders reviewed the drivers of the epidemic and identified the following six drivers as the key contributors to new HIV infection in the country.

- i. **Multiple and concurrent sexual partners:** Multiple and concurrent partner (MCP) behaviour is prevalent among all sexually active age groups, and manifested through sexual concurrency and networks, extramarital relationships, and secondary partners in transactional sex. There is evidence of some partner reduction, e.g. a declining percentage of men and women reporting multiple partner sexual activity. This indicates that risk perceptions, norms and behaviours regarding multiple partners can be changed. According to the *2009 MOT Report* 71% of new infections were a result of casual heterosexual behaviours including people with multiple and concurrent partnerships. Given that viral loads are highest during the first 6-8 weeks of infection, persons (especially among concurrent partnerships) with newly acquired infection are more likely to pass infection to additional sexual partners. Concurrent partnerships raise the number of individuals who are infected over very short time periods – thus accelerating the spread of HIV.<sup>34</sup>
- ii. **Low and inconsistent condom use:** Despite increased availability of both male and female condoms, condom usage remains low especially among key populations such as sex workers, people having casual sex, MCP and discordant couples. Condoms are also not easily accessible

<sup>33</sup> Modes of Transmission, 2009, National AIDS Council

<sup>34</sup> HIV/AIDS in Namibia: behavioural and contextual factors driving the epidemic, MOH, USAID, CDC, PEPFAR, Measure

to vulnerable and most at risk populations such as prisoners or students in primary and secondary schools. Although significant efforts have been made to empower women to take control of their sexual and reproductive health (RH), they have not been adequately empowered to effectively negotiate and or demand the use of condoms with male partners.

- iii. **Low levels of male circumcision in most provinces:** Male circumcision in Zambia remains low with only 13% of men aged 15-49 reporting (2007) having been circumcised. Eastern (3.2%), Southern (4.4) and Central (5.7%) have the lowest levels of MC compared with North-Western (71%) and Western (40.2%) provinces that have among the highest levels of MC. HIV prevalence among circumcised men was 10% compared to 12.5% among uncircumcised men<sup>35</sup>.
- iv. **Mobility and labour migration:** Labour migration is common in Zambia, and people often move within and between provinces in search of employment. Provinces with highly mobile populations and many migrant labourers such as Lusaka and Copperbelt have higher HIV prevalence than provinces with less labour migration<sup>36</sup>. The feminization of migration is evident in Zambia, and certain sectors attract women migrants in particular. Women who migrate are vulnerable to gender-based violence during their journey. Informal cross-border traders – who are usually women - are highly vulnerable to exploitation and abuse, in part because of their irregular migration status. Informal cross-border trade (ICBT) is estimated to make up about 30 to 40 percent of intra-Southern African Development Community (SADC) trade. Sexual exploitation puts female traders at a greater risk of contracting STIs and HIV<sup>37,38</sup>. There are limited targeted interventions for mobile and migrant workers, and the public and private sectors are advised to upscale workplace programmes to address the non-permanent/mobile workforce.
- v. **Sex workers (SW) and men who have sex with men:** More empirical evidence on size estimation of sex workers and their clients and MSM and their partners is needed to adequately inform policy and programming for SW and MSM.
- vi. **Mother to Child Transmission (MTCT):** Mother to child transmission of HIV accounts for 90% HIV infection in children aged 0-14 years. In the initial phases of the roll-out of services, uptake remained low due to stigma associated with HIV, gender based violence, inadequate male involvement in PMTCT and opt-in approach to counselling which relied on women consenting to an HIV test. The opt-out approach is provider initiated and pregnant women who do not want to be tested can still refuse the test.

The spread of HIV is further compounded by other structural factors that are underpinned by social and cultural norms, and limitations in service delivery. Among them are stigma and discrimination, gender inequalities, low levels of education, rural-urban dichotomy in accessing services, and inadequate focus on MARPS, vulnerable groups including women and girls and people with disabilities.

**Stigma associated with HIV and AIDS:** Stigma has been identified as the major barrier to universal access and utilisation of HIV and AIDS related services especially among women because of potential GBV by partners, family or community members. Certain sub-populations in society, such as people with disabilities, are particularly vulnerable to stigma regardless of their HIV status. Consequently, they are doubly disadvantaged in having access to information and services to reduce risk and vulnerability to HIV.

**Gender inequalities:** The dominance of male interests and lack of self-assertiveness on the part of women

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<sup>35</sup> Demographic and Health Survey (2007),

<sup>36</sup> Modes of Transmission report, 2009, NAC

<sup>37</sup> Country Assessment, Zambia IOM (2009)

<sup>38</sup> ILO and UNDP. Report of the Rapid Assessment on the Impact of HIV and AIDS in the Informal Economy in Zambia. 2005

in sexual relations put both men and women at risk<sup>39</sup>. The socialization process predisposes women's limited ability to negotiate safe sex. Culturally, women are taught to never refuse to have sex with their husband regardless of the number of extra-marital partners he may have or his unwillingness to use condoms even when he is suspected of having HIV or other STIs. Socialization processes include traditional and cultural initiation ceremonies where women are taught to accept that men can have multiple partners, and can initiate violence within a marital setting. There is also pressure on women to demonstrate their fertility contributing to low use of condoms in marital and other stable relationships. Inter-generational relationships have also put girls and boys at risk. Inter-generational sex is defined as men having sex with young girls who are 10 years or younger than themselves<sup>40</sup>. This may also include 'transactional sex' or sex in exchange for gifts or favours, especially in urban and informal settlements. These phenomena are associated with the low social status of girls, poverty, income-inequality and, to some extent, the desire for material goods by girls.

**Low levels of educational attainment** by women reduce their access to formal employment, even when jobs are available. According to the 2006 Human Development Index, 59.8% of the female population between ages 15 and above are literate compared to 76.3% of males in the same age category<sup>41</sup>. Women in rural areas are most affected as only 48% can read and understand a simple sentence compared to 75% of rural men. Illiteracy creates dependency as the illiterate person requires someone to provide information on how and where to access services, and how and when to take medications.

**Rural-urban dichotomy in access to services:** According to data from the health management information system (HMIS), rural areas have fewer ART facilities compared to urban areas. Although designated public health facilities provide ART services on a gratis basis, rural-urban disparities (e.g. lack of infrastructure, poor human resource base, drug stock-outs) result in rural-based PLHIVs incurring higher out-of-pocket costs to access treatment or not accessing treatment at all.

**Inadequate focus on vulnerable populations:** Among the most vulnerable people are women and girls, people living with disabilities, and people living in informal settlements, peripheral and underserved areas of the country.

**HIV prevalence in Zambian prisons**<sup>42</sup> is significantly higher (27%) than prevalence in the general adult population. Access to treatment, care and support is available in larger prisons but almost non-existent in smaller settings that are lacking prison-based health services. 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. Children held in detention are placed with adults in some facilities and are exposed to the risk of rape.

**People with disabilities** tend to be socially marginalized and economically disadvantaged, and exposed to stigma and discrimination because of their physical or mental condition. Often they are among the extremely poor because of lack of education and skills training, and unable to afford regular health care because of inability to afford the fees or because the cost of getting to a facility is beyond their financial means.

**Hard to reach and underserved populations** tend to live in peripheral areas of the country, off the railway line and where social and physical amenities are poor because of relative isolation. The absence of all-weather roads and established transportation systems make such areas unattractive for a stable and adequate human resource base to provide prevention, treatment and impact mitigation services. For example, health care facilities in peripheral areas often lack trained personnel and may only be staffed by

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<sup>39</sup> Joint Gender Support Programme – 2008 – 2011, Gender Development Division, Cabinet Office

<sup>40</sup> Although inter-generational sex occurs between women and boys, instances are significantly less than relationships between men and girls.

<sup>41</sup> Human Development Report Office *UN Human Development Indices Table, 2008*

<sup>42</sup> AIDS and Rights Alliance for Southern Africa, Prisons Care & Counselling and Human Rights Watch *Unjust and Unhealthy, HIV, TB and Abuse in Zambian Prisons*, April 2010

non-professional casual workers.

Given that important determinants of inequalities that contribute to HIV vulnerability reside in the broader social and economic development environment, the major challenge for the national multi-sectoral HIV and AIDS response is to anchor the response in the broader socioeconomic development of the country and facilitate adequate resource allocation to address them.

## 2.2 Response Analysis

The national response to HIV and AIDS revolves around four pillars of prevention, treatment, care and support, impact mitigation and response management (coordination and management). It is within the context of these pillars that specific service delivery areas and interventions were identified. The following section reviews the progress made during the implementation of the NASF 2006-2010, and identifies the gaps and challenges that were encountered during the implementation process.

Apart from the implementation of the NASF, a number of other strategies have been developed to complement the scaling up of universal access to prevention, treatment, care and support and impact mitigation in line with the multi-sectoral involvement of stakeholders. The GRZ launched and has been implementing the HIV and AIDS Strategy for the Public Sector (2010-2015) and the *Zambian Decent Work Country programme*. These strategies promote the development of HIV and AIDS workplace programmes in the formal and informal sectors. Similarly, civil society organisations and private sector institutions have also initiated and are implementing various interventions aligned to the previous National AIDS Strategic Framework. The adoption of a multi-sectoral, participatory and decentralised approach will expand and increase the scope and coverage of the national response.

### 2.2.1 Prevention

Prevention is the cornerstone for the national response. Prevention interventions focus on behaviour change, addressing structural barriers and accelerating biomedical interventions.

The general knowledge of HIV and AIDS has consistently improved and remained at 97% in 2005 and 99% in 2007<sup>43</sup>. Among young people (15-24 years) knowledge about how to prevent HIV increased from 40.5% to 65% for females and from 46.1% to 67% for males between 2007 and 2008. However, comprehensive knowledge of HIV has remained low at 36% for women and 39% for men<sup>44</sup>. In 2006, 4567 (out of 7611) schools were providing life skills based HIV education. By 2007, 1,102,637 young people were reached with life-skills based HIV education. The stagnation and decline in knowledge of HIV and AIDS among youth 15-24 years is worrisome as this age group is considered to be the window of hope. The percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission decreased from 48% in 2005 (51% for males and 45% for females) to 35% in 2007 (37% for males and 34% for females).

Between 2002 and 2007, young people aged 15-24 reported abstaining from sexual intercourse (from 46% to 83% for females and from 53% to 84% for males). The median age at first sexual encounter also increased from 16.5 years to 18.5 years. Similarly, the proportion of young people of the same age group reporting multiple concurrent sexual partners reduced from 4% to 2.5% (e.g. from 30% to 20% for females and males respectively).

Analysis of the *Zambia Sexual and Behaviour Survey* (2009), shows that more females aged 15-24 were likely to delay their sexual debut than males aged 15-24. For the males 15-24 years, 8.2% reported that

<sup>43</sup> Joint Mid Term Review of the National AIDS Strategic Framework 2006 – 2010, January 2009, NAC

<sup>44</sup> Zambia Demographic and Health Survey, 2007

they have had sexual intercourse before the age of 15 while for females in the same age group, 6.8% reported having had sex before the age of 15.

Condom use at the last sexual encounter with a non-regular partner among the age group 15-49 years increased from 44% in 2002 to 50% for males and from 33% to 37.4% in females. The percentage of 15-24 year olds using condoms during the last sexual act with a non-regular sexual partner also increased from 42% in 2002 to 48% in 2007 for men, and for women condom usage increased from 33% in 2002 to 38% in 2007. While this is a positive trend condom use remains very low with 78% of young men and 31% of young women aged 15-24 continuing to have unsafe sex. Condom use was reported being lower in stable unions. Stable relationships such as marriage or people living together have the highest HIV prevalence rates estimated at 16% and 15%, respectively<sup>45</sup>. Condom use at the last high risk sex was higher (50%) in urban areas than in rural areas (33%).

HIV prevention in health settings showed some improvements with a reduction in needle prick injuries from 3.9% to 1.6% among clinical waste handlers in 2008. Provision of PEP services also improved with more health facilities (42.8%) providing PEP against the 40% target for 2008.

Although voluntary counselling and testing (VCT) has been integrated in all facilities providing ART and PMTCT, testing and counselling remains low with only 15% of Zambians tested and knowing their status. Some progress was made to roll out HCT in more facilities including mobile testing and fixed sites. Regular testing and early identification of infected adults is a critical path to accessing treatment and care. Despite the challenges the number of people tested for HIV increased from 400,000 in 2005 to 1,550,000 in 2009 partially due to increased HCT sites from 500 to 1,102. Similarly, HCT sites have doubled from 500 in 2005 to over 1102 in 2008. Couples counselling remains a challenge.

During the period January to December 2009, a total of 532,484 pregnant women were tested for HIV (during pregnancy, labour and delivery and the post-partum period), out of which 505,859 received their results.

Overall PMTCT services have improved considerably. The number of HIV infected pregnant women who received antiretroviral drugs (ARVs) to reduce mother to child transmission (MTCT) increased from 29.7% (25,578 of 86,232 people in need) in 2006 to 61% (47,175 of 77,465 in need) in 2009. PMTCT is now integrated in MNCH units. Operationalisation of innovative approaches such as routine opt-out counselling has seen the uptake of PMTCT services to more than 90% at facilities providing the services. Other key policies that have been adopted at the national level and rolled-out to support improvement of maternal, neonatal and child survival include:

- use of more effective prophylactic ARV's (Zidovudine, Nevirapine, Lamivudine tail) for the mother for PMTCT as well as full HAART for her own health if CD4 is less than 350;
- infant ARV prophylaxis during breastfeeding; roll out of early infant diagnosis (EID) using Polymerase Chain Reaction (PCR) on dried blood spot (DBS) samples testing and strengthening the sample transport courier systems to the three central PCR laboratories;
- early treatment for all HIV positive infants and the adoption of the 2010 WHO PMTCT recommendations aimed at reducing MTCT to levels consistent with reducing transmission<sup>1</sup>.

With the adoption of male circumcision as a key prevention strategy, more than 70 doctors have been trained in MC procedures resulting in 2,100 procedures conducted. According to the *2007 Zambia Demographic and Health Survey (2007 ZDHS)* only 13% of Zambians had been circumcised. Zambia has developed a National Male Circumcision Strategy and Implementation plan for the period 2010 to 2020.

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<sup>45</sup> Mode of Transmission report, 2009



Intensifying education and sensitisation of men and potential parents on male circumcision will increase demand for this important intervention.

Zambia has maintained 100% screening of donated blood units in a quality assured manner, an achievement which was also attained during the last reporting period. All Zambia National Blood Transfusion (NBT) facilities and activities are subjected to rigorous External Quality Assessments (EQA) with the RCPA Serology Quality Assurance Programme in Australia for HBV and HCV and with Contract Laboratory Services (CLS) of South Africa for HIV. The ZNBT's Lusaka Laboratory is also periodically audited by the Division of AIDS (DAIDS) of the National Institutes of Health (NIH) in the USA, on HBV and HCV tests only. The number of health facilities providing blood transfusion therapy increased from 90 in 2004 to 118 in 2007. Equally, blood collection has increased from 54,308 units (2006) to 68,056 in 2007. Only 8% of blood collected and screened was discarded in 2006 compared to 25% in 1998.

GBV was identified as a constraint to women accessing HCT or obtaining information on their HIV status if tested in an antenatal clinic. Perpetrators of violence against women are mainly husbands or live-in partners (67.5%), boyfriends (25.0%), male relatives (5.8%), former husband/boyfriends (2.5%) and strangers (1.7%). The data indicates that the majority of victims of forced sex knew their perpetrators, and that sexual violence against females in Zambia remains a daunting challenge. The *2005 Zambia Sexual Behaviour Study (2005 ZSBS)* indicates that 15.1% of female respondents reported having experienced forced sex. This was a slight decrease from the 16.3% of female respondents who reported forced sex in 2003. In 2005, 17.7% of urban females and 13.7% of rural females reported forced sex. Forced sex was most commonly reported among the 20-24 year age group (18.5%).

In the context of HIV and AIDS mainstreaming technical assistance was provided for HIV-related institutional capacity building for 500 local organisations and representatives inclusive of PLHIV and gender groups and those that promote the rights of people living with disabilities. As a result, 98 percent of line ministries and local authorities and 85 percent of private sector companies have established HIV and AIDS workplace policies and action plans.

In spite of the achievements in HIV prevention in Zambia, prevention activities remain fragmented, inadequately coordinated and without sufficient intensity and coverage. The potential to address the contributing factors such as gender inequality, income disparities, socio-cultural norms and stigma is yet to be realised. Equally, the involvement of PLHIV in prevention has been inadequate and often unplanned.

It is necessary to re-think prevention strategies given that computer-generated estimates show a progressive increase in new infections over a four year (2006 to 2009) period (75,075 in 2006, 79,755 in 2007, 80,442 in 2008 and 82,681 in 2009). The female to male distribution of these new HIV infections is 60% to 40%, respectively. In 2009, this translated into approximately 225 new infections every day. The progressive increase in new infections puts into question the efficacy of current prevention strategies.

## **2.2.2 Treatment Care and Support**

The rapid roll-out of most treatment, care and support services has increased access and utilisation of services. Many patients have resumed active, productive lives with reduction in the frequency of illnesses that require in-patient care. By 2008, 355<sup>46</sup> health facilities were providing ART. ART services are available in all the nine provinces.

Approximately 285,000<sup>47</sup> PLHIV (56% women and 44% men) were enrolled on ART by 2009. Eighty-one percent of ART clients are in urban areas and 19% are in rural areas. Paediatric ART uptake increased significantly from 2006 to 2008. Of the 29,100 estimated infants and 40,000 children under 15 years in

<sup>46</sup> Joint Mid Term Review of the National AIDS Strategic Framework 2006-2010, (July 2009), NAC

<sup>47</sup> these number include children

need of ART, 13.7% were on ART at the end of 2006 and 33% were on ART at the end of 2008. The percentage of adults and children with HIV still alive 12 months after initiation of ART dropped from 89.6% (87.8% males, 90.7% females) in 2006 to 87.6% (87% males and 89.9% females) in 2007. By 2009, the number of PLHIV was estimated at 1,027,626 of whom 338, 992 were in need of ART<sup>48</sup>. The demand for ART exceeds the supply both in terms of services and funding.

The scale up of ART especially among people aged 15-49 years has contributed to a reduction of adult deaths from about 82% of the total deaths in 1996 to 54 per cent in 2007. A reduction in adult mortality has delayed or prevented orphanhood. In 2007, HIV accounted for 4% and 22% of total deaths among under-fives and infants, respectively. The recent estimate for ART coverage for paediatrics is at 68%.

The overall quality of care for TB patients is considered high with a cure rate of 85%. However, TB remains one of the main causes of death in AIDS patients. In 2007, approximately 23,356 TB clients were offered and tested for HIV. Slightly more than 16,000 were HIV positive and 6,595 were enrolled on ART.

This outcome can be attributed to the increased number of facilities providing HCT, PMTCT and ART services countrywide. HCT sites doubled from 500 in 2005 to over 1,102 in 2008. PMTCT sites increased from 251 sites in 2005 to 817 in 2007 and 936 PMTCT in 2008. The number of ART service centres for both private and public sectors increased from 107 in 2005 to 355 by March 2008. All the 72 districts continue to provide ART services

In 2007, new ART protocols were introduced and Zambia has already moved from the CD4 200 criteria to the WHO recommended criteria of CD4 350. The recent discussions of developing one standardized National Quality Assurance for HIV is a step in the right direction. The tools being proposed in this system are based on national standard guidelines and standard operating procedures linked to the national site ART accreditation system<sup>49</sup>.

### **2.2.3 Impact Mitigation**

The focus for impact mitigation has been to reduce the socioeconomic impact of HIV and AIDS on individuals, households and communities. As with prevention, impact mitigation services are provided by government and CSOs, inclusive of faith based organisations (FBOs) in collaboration with other development partners.

#### **i. Orphans and vulnerable children**

Zambia has the second highest number of OVC in Africa. Fifty per cent of the estimated 1.3 million OVC in Zambia are as a result of HIV and AIDS<sup>50</sup>. Urban children (27%) are more likely to be orphaned or vulnerable than rural children (16%). The Ministry of Sports, Youth and Child Development (MSYCD) formulates policy for OVC while the Ministry of Community Development and Social Services (MCDSS) coordinates social protection service provision. The MCDSS works with the Child Protection Unit and Victim Support Unit of the Zambia Police Services in the Ministry of Home Affairs to trace relatives of children living on the street and where possible, place them into alternative care. Children at risk for abuse and exploitation are removed from parents/guardians and placed in shelters or with other family members.

Approximately 19.1% of the estimated 1.3 million OVC in Zambia received external basic assistance, from Government, CSOs, FBOs, and international organisations (DHS, 2007). The MCDSS' Public Welfare Assistance Scheme and Cash Transfer Programme targets households caring for OVCs.

<sup>48</sup> National AIDS Council, *Technical Report-Joint Mid-Term Review of National AIDS Strategic Framework*, 2009

<sup>49</sup> Unpublished concept paper; Developing One Standardized National Quality Assurance/Quality Improvement Tool for HIV Services in Zambia presented to ART working group April 2010, Ministry of Health Board Room, 2010

<sup>50</sup> Zambia Situation Analysis of Children and Women, 2008, UNICEF.

The rate of school attendance among orphans aged 10-14 years, who have lost both parents, increased to 76.5% (out of 154) in 2003 to 91.9% (out of 99) in 2005. However, the rate dropped to 81% in 2009.

Although most OVC rely on a network of support from family and community (most often siblings or aged grandparents<sup>51</sup>), the traditional extended family system of providing care and support is overstretched by the magnitude of children needing assistance, and prevailing poverty in the country. As a result some children are forced to live in homes where they are resented and unwelcome, and may be forced to engage in high risk activities that make them vulnerable to HIV infection. Where OVC care at home is not available, children are placed in orphanages or shelters. Country-wide, 4,592 children are living in such arrangements.<sup>52</sup> It is estimated that 150,000 children are living without adult supervision, e.g. alone, under the care of minor siblings, or on the streets.<sup>53</sup>

In Zambia double orphans are more vulnerable, especially girls, and are less likely to be in school and are subjected to abuse, than children with at least one living parent. OVC are vulnerable to exploitative labour conditions, harassment and sexual abuse.

The emergence of street children is widely seen as a failure of traditional family and community networks to absorb children in need of care and support. Often the motive for children working and/or living on the street is to earn a living through begging, car washing/guarding, stealing, or sex work.<sup>54</sup> The number of children living on the streets was estimated at 13,000 in 2006 with projections reaching 22,400 by 2016.<sup>55</sup>

The Public Welfare Assistance Scheme, administered by the Ministry of Community Development and Social Services, has been mandated to provide social protection to OVC. The Ministry works with the Child Protection Unit and Victim Support Unit of the Zambia Police Services in the Ministry of Home Affairs to trace relatives of children living in the streets and where possible, place them into alternative care. Children at risk to abuse and exploitation are removed from parents/guardians or abusive environments and placed into children's homes or orphanages or with other family members.

Community schools provide an estimated one-third of primary school places for children in Zambia. Unlike government schools, community schools have a follow-up process to visit the homes of children who have dropped out or have not attended classes for an extended period. This helps with retention issues because if there is a reasonable cause that has affected the child's ability to continue, s/he can be re-admitted once the problem has been resolved. In addition, some community schools with support from partners have been implementing the school feeding programme, where children are provided with at least one meal during the school day. This has resulted in high enrolments and retention of pupils. Children, also, have a better attention-span in class as a result of the meals.

## ii. Older Persons and Caregivers

Elderly people and in particular women are providing care to OVC and to PLHIV and other relatives with chronic illnesses. Given the burden of care, the epidemic has placed heavy social and financial stress on the elderly and other caregivers. Their capacity to cope is diminished. In the absence of widespread retirement and social security benefits, vulnerable households are experiencing deepening poverty as the public welfare system does not have adequate resources to meet demands for basic needs. The traditional social safety nets are also on the verge of collapsing.

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<sup>51</sup> *Ibid.*

<sup>52</sup> Personal interview with UNICEF personnel, 2010

<sup>53</sup> Ministry of Sports, Youth and Child Development, Situation Analysis, 2004

<sup>54</sup> Ministry of Sports, Youth and Child Development *Orphaned and Vulnerable Children in Zambia* in *Zambia 2004 Situation Analysis*

<sup>55</sup> Ministry of Community Development and Ministry of Sports, Youth and Child Development *Children on the Streets of Zambia: Working Towards a Solution*, 2006



The Senior Citizen Association of Zambia (SCAZ), formed in 1991 has been acting as an advocate for elderly persons. The Association has been lobbying government and other development partners including civil society organisations to facilitate the development and implementation of a comprehensive impact mitigation framework that will not only support provision of basic needs in the short term but also strengthen sustainability of community based livelihoods for elderly persons.

The Public Welfare Assistance Scheme and the Cash Transfer Scheme have prioritized older people and provided cash grants to support OVC<sup>56</sup>. Peer educators and community volunteers have also been trained to provide additional support. The Government of Zambia has also developed an Ageing Policy.

### iii. People Living with HIV

The majority of Zambians, including PLHIV, work in the informal sector<sup>57</sup> where services and support are not always available. Consequently given the loss of income due to illness, they are often unable to meet their basic needs. Transport and nutrition remain a daily daunting challenge that contributes to many PLHIV not adhering to ART.

To strengthen the coping strategies for PLHIV, the Zambian Network of PLHIV (NZP+), UNDP and Zambia Chambers of Small and Medium Businesses Association (ZCSMBA) are developing business opportunities for PLHIV to access loans or credit.

At the community level more PLHIV are accessing community care and support through support groups. By the end of 2008, NZP+ had a membership of 3,500 support groups with approximately 50,000 members in all districts<sup>58</sup>. It is through these support groups that PLHIV access psychosocial support.

#### 2.2.4 Response Management and Coordination

The coordination and management of the national multi-sectoral response has focused on improving the efficiency and effectiveness of existing systems and coordination structures, resource mobilisation in addition to ensuring that the response system generates empirical evidence to support programming, service delivery, policy formulation, capacity development and resource allocation.

**Policy and Legal Environment:** Zambia has signed and ratified several international and regional agreements and declarations. Appropriate legal and national policy frameworks, technical guidelines and protocols have also been developed to support the implementation of the response to HIV and AIDS. The most notable policy instrument is the National HIV/AIDS/STI/TB Policy (2005) that sets the stage for policy and strategic orientation of the national response. Several other legal instruments have been developed.

**Coordination and Management and Decentralisation:** Zambia has adopted a multi-sectoral and decentralised coordination and management framework aligned to the Three-Ones principle. A high level Cabinet Committee of Ministers on HIV and AIDS was established in 2000, and works closely with MOH and NAC to provide policy direction, supervision and monitoring of the implementation of HIV and AIDS programmes. NAC, established as a statutory corporation through an Act of Parliament in 2002 functions as the sole national AIDS coordinating authority. NAC is mandated to coordinate the HIV multi-sectoral response while the Ministry of Health continues to coordinate the health sector response. NAC is a semi-autonomous statutory body administratively situated in the Ministry of Health. The Minister of Health chairs

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<sup>56</sup> Help Age International *Salt, Soap and Shoes for School*, an Evaluation Summary, 2008

<sup>57</sup> The informal sector is part of the 'non-observed economy', which consists of illegal activities, underground activities and the informal sector (Central Statistical Office and Ministry of Labour and Social Security *Labour force Survey Report*, 2005). Of these categories the informal sector and illegal activities such as sex work are targeted by a few implementing organisations for HIV interventions but not to the degree occurring in the formal sector. The majority of workers are not reached.

<sup>58</sup> Sangallo, Gloeria. Impact Mitigation Assessment for the NASF 2011-2015, a study commissioned by NAC, 2010.

the Cabinet Committee on HIV and AIDS, which appoints the NAC Board Chairman and supervises NAC activities. The MOH's Permanent Secretary is the Controlling Officer for NAC's income and expenditures, and the Minister represents NAC in Parliament where the national budget is considered and approved.

At the provincial and district levels, coordinating structures have been established and coordinators (e.g. Provincial AIDS Coordinating Advisors and District AIDS Coordinating Advisors) have been appointed. The establishment of the provincial and district coordinating structures is aligned to the Decentralisation Policy, however, the positions have not been formally recognized by the Public Service Commission nor local government authorities. A priority of NAC will be to have these positions embedded into the decentralized administration.

Six theme groups have been established: namely, Prevention; Treatment, Care and Support; Impact Mitigation; Decentralisation and Mainstreaming; Monitoring and Evaluation; and Advocacy and Coordination. Theme groups are expected to provide technical expertise on the various aspects of the HIV and AIDS response. Their membership is multi-sectoral in nature and is drawn from the public and private sector, civil society organisations and development partners based on mandates, interests and technical expertise.

**HIV and Gender Mainstreaming:** A National Gender Policy, a Gender Action Plan and a Gender Based Violence Reduction Plan have been developed. The GIDD has overall responsibility for coordinating gender and development activities and works closely with NAC to coordinate the combination of gender and HIV. A Parliamentary Committee provides oversight and accountability for gender mainstreaming, and the Gender Consultative Forum, which was established under the Gender Policy, is functional<sup>59</sup>. Gender focal point positions exist in each sector ministry and in sub-national administrative structures, and a Gender Sector Advisory Group has primary oversight over gender mainstreaming into all development projects and operational policies.

Gender mainstreaming has contributed to gender parity in primary education and increased convictions of gender based violence cases. The Government has developed a draft bill on Gender Based Violence and has developed a National Strategy for engendering the public service<sup>60</sup>. Implementation of gender related interventions is constrained by lack of adequate capacity and skills especially around gender and policy analysis, budgeting, and reliable data necessary to inform decision making and planning.

While the structures are in place gender mainstreaming is constrained by limited technical capacity including adequate skilled persons in gender analytical skills, gender budgeting and policy analysis. There is also the challenge of inadequate gender related data and information to inform policy development and guide operational strategies. The capacity of Gender In Development Divisions (GIDD) also needs to be strengthened.

**Resource Mobilisation:** For the 2006-2010 NASF, the estimated funding for HIV and AIDS was US\$1,073,246,604 from key funding cooperating partners, private foundations and the GRZ. The actual funds mobilized for the same period amounted to US\$1.5 billion. Although funding for HIV and AIDS is largely dependent on a few major donors, the overall donor base has increased significantly. During the period 2006-2010 the major donors were the USG who contributed approximately US\$ 862,388,327, and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) which contributed a total of US\$ 371,683,389. The government contribution was approximately US\$ 33,056,827<sup>61</sup>.

Donor contributions enabled the government and civil society partners to scale up ART treatment and PMTCT, decentralise the NAC coordination function to sub-national levels, and strengthen community

<sup>59</sup> Joint Gender Support Programme 2008-2011, Gender in Development Division, Cabinet Office.

<sup>60</sup> Gender and Development – Sixth National Development Plan Chapter , Ministry of Finance and National Planning

<sup>61</sup> This figure does not include Government contribution in terms of infrastructure and human resources

systems. For example, the World Bank-funded Zambia National Response to HIV/AIDS enabled the civil service to develop HIV and AIDS workplace programmes in all sector ministries, and to finance community-based initiatives which were identified, planned, managed and operated by communities themselves.<sup>62</sup> Ireland Aid supported decentralization of the coordinated response and JICA supported infrastructure development and TB interventions. Other cooperating partners such as SIDA, Netherlands, Norway, and DFID provided direct support to NAC through a Joint Financing Agreement (JFA).

The dependency on external resources has the potential to compromise the implementation and sustainability of the response if any of the key donors were to withdraw assistance. The GRZ recognises this threat and has initiated a process to develop a fiscal sustainability strategy. The NAC developed a concept paper on the creation of a “National HIV and AIDS Fund” as one of the sustainability strategies.

### **Monitoring and Evaluation and HIV Research:**

Zambia has a functional M&E system that has taken cognisance of the Three-Ones principle of having a comprehensive national M&E framework. A research agenda has been developed and is being implemented. Zambia has conducted several surveys including the *2007 DHS*, the *2009 Sexual and Behaviour Survey*, sentinel surveillance and a number of biomedical studies. Currently M&E and HIV research information and data are being used to inform the development of national reports such as Zambia UNGASS Country Report among others.

Data auditing and supervision are done regularly to check performance of the national M&E system and quality of data being generated.

Despite the success in M&E and HIV research, the national M&E system requires strengthening, especially at provincial, district, sector and civil society levels. Key challenging areas include alignment with the MOH HMIS data collection system, stakeholders’ capacity to collect reliable data, data analysis and interpretation, reporting and eventually, the use of M&E and HIV research information. M&E and HIV research information dissemination channels remain under developed. The current Resource Centre also needs considerable technological and infrastructure capacity development. Analysis of the National AIDS Spending Assessment shows that M&E is under-funded.

## **2.3 Gap and Challenges Analysis**

The following are strategic Gaps and Challenges encountered during the implementation of the NASF 2006 – 2010. If the challenges are not adequately addressed they are likely to compromise the achievement of the NASF 2011-2015 results and the attainment of the UA goals and MDGs.

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<sup>62</sup> Ministry of Finance and National Planning - *Zambia National Response to HIV/AIDS Project (ZANARA) Community Response to HIV/AIDS Annual Report 2006*.

**Table 2:** Operational and Capacity Gaps and Challenges

Area of Assessment	Description of Capacity Gap	Suggested Strategies for mitigation
ART	<ul style="list-style-type: none"> <li>Uptake of ART remains slow in both children and adults.</li> </ul>	<ul style="list-style-type: none"> <li>Build capacity to increase provision of ART including paediatric ART</li> <li>Introduce PRE-ART interventions</li> </ul>
Behaviour change	<ul style="list-style-type: none"> <li>Interventions are fragmented, generic in nature, inadequate coverage and intensity</li> <li>Inadequate targeted interventions for sexually active children and young people<sup>63</sup> No targeted interventions for MARP and vulnerable groups</li> </ul>	Accelerate the implement the National Prevention Operational Strategy with priority actions on epidemic drivers and socio and structural factors that influence the spread of HIV
Comprehensive knowledge of HIV	<ul style="list-style-type: none"> <li>low levels of comprehensive knowledge among the general population</li> <li>Low literacy levels among particular populations, particularly women and girls which compromise access to and utilisation of information</li> <li>Low levels of HIV and AIDS knowledge among young people aged 15-24 years</li> <li>Failure to include a programme of continuous education targeted to new entries into 15-24 year group and exit of others due to aging process</li> </ul>	<ul style="list-style-type: none"> <li>Intensify HIV education using innovative strategies –such as combination prevention, Inter-personal communication, Communication for Behaviour Change (COMBI)</li> <li>Increase quality and coverage of the sexuality education in schools for young people and targeted behaviour change programmes/ campaigns for young people, particularly young women</li> <li>Develop youth targeted interventions including accelerate implementation of life skills based HIV education</li> <li>Develop campaigns for low literacy populations<sup>6</sup></li> </ul>
Community Response	<ul style="list-style-type: none"> <li>Low levels of participation due to resource, knowledge and skills constraints in communities</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement a community-based prevention, management and treatment of HIV and AIDS training programme for district coordination agencies and key actors at district and community level</li> </ul>
Condoms	<ul style="list-style-type: none"> <li>Low levels of condom use among adults and young people above 15 years of age.</li> <li>consistent and correct use of condoms</li> <li>Female condoms are not readily available, are more expensive</li> </ul>	<ul style="list-style-type: none"> <li>Increase distribution points</li> <li>Increase availability and promote use of female condoms</li> <li>Develop campaigns for young people on condom use</li> </ul>

<sup>63</sup> The definition of child is male and females below age 18. Although 15 year old and above are captured in service delivery data, the content, intensity and scope of services for the under-17s particularly the 10-14 year olds is not adequately captured in surveys.

	than male condoms, and require special training to use	<ul style="list-style-type: none"> <li>Intensify condom education and awareness linked the usage with other prevention interventions such as male circumcision, prevention of STI and sexual and reproductive health, and PMTCT</li> </ul>
ART	<ul style="list-style-type: none"> <li>Slow uptake of ART in both children and adults</li> </ul>	<ul style="list-style-type: none"> <li>Build capacity to increase provision of ART including paediatric ART</li> <li>Introduce pre-ART interventions</li> </ul>
Coordination and management	<ul style="list-style-type: none"> <li>The mandate and role of the NAC is not universally accepted by all stakeholders.</li> <li>Weak and under resourced decentralised coordination structures</li> <li>Poor coordination mechanism among civil society organisation</li> <li>Areas of shared responsibility are not fully articulated and addressed, for instance where another agency has coordination responsibility (e.g. GIDD for gender but NAC for HIV)</li> <li>Conflicts among coordination agencies (DATF, DHMT, DC and Local Authorities) on roles and responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>Undertake a comprehensive review and re-structuring of NAC to ensure institutional effectiveness and efficiency in Coordination of the response.</li> <li>Facilitate the harmonisation of civil society and private sector coordination in line with the three-one principle</li> <li>Conduct Organisational Capacity and Systems Assessment (OCSA) for all coordinating structures at national and decentralised level</li> <li>Develop protocols for role and responsibility for lead agencies vs. others in areas where the coordination function is shared especially among national civil society coordinating networks, DATF, local Authority and DHMT</li> </ul>
Customary laws and social norms	<ul style="list-style-type: none"> <li>Some customary laws, social norms and cultural practices negatively impact prevention strategies</li> <li>Failure to recognise and utilise social norms and cultural practices that can facilitate prevention</li> </ul>	<ul style="list-style-type: none"> <li>Review customary laws and practices, and strengthen the capacity of customary courts to take cognisance of negative customary laws, social norms and practices</li> <li>Sensitise traditional leaders on effective HIV prevention strategies at community levels including MCP and Male circumcision among others</li> </ul>
Data (M&E and HIV research data)	<ul style="list-style-type: none"> <li>Data management is extremely weak.</li> <li>Data is missing or not documented.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen data management systems in all sectors including the establishment of a central HIV and AIDS database – that is linked with other key data banks such as HMIS</li> <li>Strengthen the capacity of M&amp;E personnel at all levels.</li> <li>Undertake critical research studies to generate data needed for evidence based decision making, NASF evaluation and planning</li> </ul>
HIV and AIDS Workplace Programmes	Slow pace of developing and implementing workplace HIV and AIDS programmes in both formal and informal sectors	<ul style="list-style-type: none"> <li>Accelerate the implementation of HIV and AIDS in Strategy for public Service (2010-2015)</li> <li>Develop a strategy for HIV and AIDS implementation in the informal sector</li> </ul>

		<p>linked to the implementation of the Zambia Decent Work programme</p> <ul style="list-style-type: none"> <li>• Support the private sector to develop sector wide operational plan linked to the National NASF Operational Plan.</li> </ul>
HIV mainstreaming in development projects	<ul style="list-style-type: none"> <li>• Inadequate mainstreaming of HIV and AIDS in development projects. The Focus has been on workplace programmes.</li> <li>• Development planners and policy makers are unclear of how to operationalise the concept and in particular in determining the mainstreaming results and indicators to measure performance.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement guidelines for mainstreaming HIV and AIDS in development programmes</li> <li>• Train development planners in HIV and AIDS mainstreaming planning and budgeting</li> <li>• Extend Training in Community Capacity Enhancement (CCE) through Community Conversation Approach to all districts</li> <li>• Strengthen capacities for simultaneous mainstreaming (HIV/AIDS, gender and human rights) cross-cutting issues and HIV and AIDS in tertiary institutions' curricula</li> <li>• Strengthen capacity of Local Authorities' Good Governance and Leadership for HIV and AIDS at district level</li> </ul>
Human Resource	<ul style="list-style-type: none"> <li>• Inadequate skilled and experienced human resources</li> <li>• High levels of attrition especially in the health sector and among civil society organisations</li> <li>• Contradictions between the Public Service Management Policy and the national AIDS response HR development requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct a comprehensive capacity assessment in all sectors and levels of the response</li> <li>• Develop a long term HIV and AIDS related capacity development framework</li> <li>• Recruit additional skilled and experienced staff.</li> <li>• Develop a staff retention strategy</li> </ul>
Impact mitigation	<ul style="list-style-type: none"> <li>• Strategies for impact mitigation are insufficient for the level and scope of demand</li> <li>• The quality of services is unclear for all of the agencies providing services</li> <li>• Service delivery system is inadequately coordinated<sup>64</sup></li> <li>• Insufficient data on the extent of vulnerability, the compounded causes of vulnerability and the size of vulnerable populations</li> <li>• Unsustainable impact mitigation strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct a Quality of Impact Mitigations Services (QUIMS0 survey</li> <li>• Agree on systems and guidelines for improving coordination of service delivery</li> <li>• Identify and implement (evidence based) sustainable livelihoods that move vulnerable households from dependency to self-reliance<sup>65</sup></li> </ul>

<sup>64</sup> There is a lack of internal synergies among strategies used by the various organizations and institutions providing impact mitigation, and consensus on who is vulnerable lacking

<sup>65</sup> Presently the focus is on a social welfare response rather than a development response.

Gender mainstreaming / integration	<ul style="list-style-type: none"> <li>• Coordination of gender programming remains weak....</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen capacity of Gender In Development Department (GIDD) to deliver on its mandate</li> <li>• Strengthen capacity of NAC, implementing partners and structures for more effective gender response</li> </ul>
Knowledge management	<ul style="list-style-type: none"> <li>• Lack of documentation of existing knowledge and best practices has compromised the use of such experiences in improving service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Document and disseminate best practices</li> <li>• Strengthen the capacity of Resource Centre to provide easy access to HIV and AIDS information</li> <li>• Improve access, scope and access to NAC web site.</li> </ul>
Monitoring and Evaluation,	<ul style="list-style-type: none"> <li>• Weak M&amp;E capacity especially at provincial and district levels, among and civil society</li> <li>• Inadequate use of M&amp;E information in decision making, planning and resource allocation</li> <li>• Poor alignment and Harmonisation of M&amp;E systems and tools</li> <li>• Inadequate focus on evaluation compared to monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen the capacity of M&amp;E personnel – Training, recruitment of new personnel, and develop a retention strategy</li> <li>• Advocate for use of evidence based information in decision making and planning.</li> <li>• Facilitate harmonisation and alignment of M&amp;E systems and tools .</li> <li>• Strengthening the culture and capacity for reporting</li> </ul>
OVC	<ul style="list-style-type: none"> <li>• There are numerous uncoordinated and fragmented programmes for OVC which are implemented by several organisations but are not planned, designed and budgeted based on qualitative and quantitative evidence of real needs.</li> <li>• OVC residing in the poor and remote regions of the country as well as in the impoverished peri-urban areas are not benefiting from current services.</li> <li>• There is no system for generating evidence and reporting on OVCs.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen the National Child Policy to address growing OVC issues</li> <li>• Develop a National OVC Plan of Action</li> </ul>
Planning	<ul style="list-style-type: none"> <li>• Inadequate HIV and AIDS planning capacity at NAC</li> <li>• Lack of capacity for evidence and results based planning across all sectors and implementing partners.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen the capacity for RBM and Evidence based planning (conduct training and awareness)</li> </ul>
Policies and legal instruments	<ul style="list-style-type: none"> <li>• Most policies have not been reviewed to mainstream HIV and AIDS, and Gender. Where such has been done enforcement and monitoring remains inadequate</li> <li>• Inadequate implementation of the Act that established NAC</li> </ul>	<p>Conduct an inventory of all policies and statutory instruments likely to impact on the HIV and AIDS response.</p> <p>Work with the Decentralisation Secretariat to ensure that HIV and AIDS are embedded into policies that are being revised in the decentralisation process</p>



		Develop the statutory instrument for operationalising the NAC Act.
	•	
Prevention	<ul style="list-style-type: none"> <li>• Low coverage, intensity and inadequate targeting on the key epidemic drivers, other structural factors that influence the spread of HIV</li> <li>• Programme tends to be implemented as vertical interventions.</li> <li>• Inadequate investment in prevention programmes</li> <li>• Inadequate involvement of PLHIV</li> <li>• The quality of prevention interventions is often not monitored.</li> </ul>	<ul style="list-style-type: none"> <li>• Intensify implementation of prevention strategies using combination prevention strategy with emphasis on epidemic drivers and effective biomedical interventions.</li> <li>• Accelerate the implementation of National Strategy for the Prevention of HIV and STIs.</li> <li>• Advocate for increasing funding for HIV</li> <li>• Develop and implement a framework on “prevention with the positives”</li> <li>• develop a quality assurance mechanism</li> </ul>
Programme Development	<ul style="list-style-type: none"> <li>• Inadequate use of evidence in programme design and planning</li> <li>• Programmes are not adequately targeting the key epidemic drivers</li> </ul>	<ul style="list-style-type: none"> <li>• Review programme interventions and apply available evidence in planning</li> </ul>
Quality assurance	<ul style="list-style-type: none"> <li>• Zambia has not yet developed a comprehensive quality assurance system for HIV and AIDS and related services</li> </ul>	<ul style="list-style-type: none"> <li>• Develop quality assurance systems where they don't exist and implement those that exist</li> </ul>
Stigma and discrimination	<ul style="list-style-type: none"> <li>• No guidelines, policy or legislation that overtly bans discrimination or stigmatisation based on actual or perceived HIV status</li> </ul>	<ul style="list-style-type: none"> <li>• Operationalise the Code on HIV and AIDS and Human Rights</li> <li>• Develop national guidelines articulating how stakeholders should address stigma and discrimination in the workplace and the community.</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>• The national response is largely dependent on external funding and Zambia does not have a comprehensive sustainability strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a sustainability strategy and a donor exist strategy.</li> <li>• Review guidelines for financial support of implementing partners projects to include a requirement for implementing partners to articulate a sustainability strategy and how they will dis-engage (exit strategy) with the potential funding agencies</li> </ul>



## Section-3: NASF Strategies and Interventions

### Overview

The NASF interventions revolve around four pillars - prevention, treatment, care and support, impact mitigation and response management and coordination. Specific service delivery areas (SDA) have been identified and implementation strategies articulated. The planning process has taken cognisance that implementation in one area may have implication on another area, hence the need for an integrated approach, that enable complementarity and synergy between different actions. A good example is roll-out of ART to more health facilities that eventually increases access to ART. Provision and adherence of ART will result in a reduction of the viral load, and hence reduce the probability of HIV transmission. The table below provides an overview of the NASF coverage of service delivery areas in each of the four pillars.

**Table 3:** NASF Service delivery areas by thematic pillars

Prevention <sup>66</sup>	Treatment care and support	Impact mitigation	Response Management
<ul style="list-style-type: none"> <li>• Social and behaviour change</li> <li>• HCT<sup>67</sup></li> <li>• Condoms*</li> <li>• Male Circumcision*</li> <li>• PMTCT</li> <li>• PEP</li> <li>• STI</li> <li>• Blood safety</li> </ul>	<ul style="list-style-type: none"> <li>• ART</li> <li>• TB/HIV co-infections</li> <li>• Community Home Based and Palliative Care</li> </ul>	<ul style="list-style-type: none"> <li>• Vulnerable, Communities, Households and Individuals</li> <li>• Orphans and Vulnerable Children</li> </ul>	<ul style="list-style-type: none"> <li>• Enabling Policy and legal environment</li> <li>• Coordination and Management</li> <li>• HIV and AIDS, gender and human rights mainstreaming</li> <li>• Resource Mobilisation</li> <li>• Monitoring and Evaluation , &amp; HIV research</li> </ul>

### Linkage between the NASF and the NOP

The NASF provides strategic and policy orientation to the national response whereas the National Operational Plan (NOP) is the guide for implementation. The NASF ends at outcome level results and the NOP articulates outputs, service delivery areas and specific interventions. The NOP enables stakeholders to prioritise activities that will accelerate the achievement of Universal Access (UA) to prevention, treatment, care and support services and eventually contribute to the attainment of MDGs.

The selection of priority interventions is based on the following criteria.

- i. **Evidence based:** Available evidence was used to inform the selection of the strategic interventions based on their efficacy. In selected instances where national evidence was insufficient, existing evidence was corroborated with regional and international data.
- ii. **Focus on Results:** Specific, measurable results (impact, outcome, outputs) have been articulated. The M&E framework identifies and describes the appropriate indicators that will be used to measure the results. It is anticipated that results will be monitored annually. Evaluations will be conducted at the mid and end terms of the NASF.
- iii. **Feasibility:** Consideration was given to the feasibility (do-ability) of interventions.

<sup>66</sup> Although NASF has advocated for a combination prevention strategy, emphasis will be to scale up interventions that have greater efficacy and are supported by evidence- in the case for NASF this include male circumcision, condoms, and PMTCT.

<sup>67</sup> Including discordant couples

- iv. Resources: Consideration was given to the potential availability of financial, human, physical and information resources required to support the implementation of interventions

### 3.1. Prevention

The priority for Zambia is to stop new infections. The NASF 2011-2015 target is to reduce the annual rate of new infections by 50% (from 82,000 in 2009 to 40,000) by 2015. To achieve this result Zambia will prioritise and implement proven prevention interventions through a “combination prevention” strategy. In Zambia, HIV is mainly spread through heterosexual intercourse and through mother to child transmission of HIV. The NASF therefore addresses five inter-related actions in order to bring the epidemic below the epidemic threshold level:

- *First*, reduce exposure to HIV by building on past successes and continuing to change the sexual behaviours that have caused men and women to infect each other and by continuing to minimise the risk of HIV exposure in health care settings: (BCC, blood safety, HCT for couples, condom use during high risk sex)
- *Second*, reduce the biological probability of HIV transmission where exposure to HIV has occurred: (MC, PMTCT, PEP)
- *Third*, change community social norms and cultural norms as they relate to high-risk sexual practices and attitudes, stigma and discrimination against persons living with HIV;
- *Fourth*, ‘plan with HIV in mind’ in all sectors of society by, for example, offering girls incentives to remain in secondary school and empowering women to make the best possible decisions about their own sexual reproductive health and encouraging men to respect women’s decisions; and
- *Fifth*, “making HIV money work better” by implementing proven cost-effective interventions and doing rigorous evaluations where such cost effectiveness evidence does not yet exist

Zambia has identified six priority epidemic drivers that will be targeted with the aim to improve the level of knowledge and risk perceptions, influence a reduction of inter-generational sexual partners, and strengthen the capacity and determination to use condoms correctly and consistently all the time.

As the number of discordant couples is on the rise, prevention of HIV infection in this groups is imperative. Strategies will include improving knowledge and understanding of discordance, couples-counselling to improve on partner disclosure, promotion of positive living including abstinence during risk periods such as during menstruation, or when one partner has an STI, or other opportunistic infections. In most cases partner disclosure is compromised by fear of GBV.

It is estimated that 62% of women of child bearing age are either married or living together with a man. Fourteen percent (14%) of married women in Zambia are in polygamous unions. Thirteen percent (13%) reported having one co-wife, while 2% have two or more co-wives. The level of polygamy increases with age. The increase among women is from 6 percent among married women age 15-19 to 23 percent among women age 40-44<sup>68</sup>.

In Zambia more women are living with HIV and AIDS (16%) than men (12%). Factors that fuel the increasing feminisation of the epidemic include gender inequality, negative socio-cultural norms, inter-generational sex, GBV which is manifested in physical, sexual and psychological forms. The NASF calls for intensifying activities that deal with the causes of women’s and girls’ vulnerability to HIV, and advocates for implementation of interventions that link HIV prevention with girls’ education and prevention of GBV. In addressing the challenges of HIV and AIDS for women and girls, the NASF will promote interventions that keep girls in school and improve access to skills training; enhance economic empowerment through

<sup>68</sup> Zambia Demographic and Health Survey, 2006/7

protecting women's right to inherit and own property; advocate for improved access to credit and loans; and prevent GBV. The NASF will support creation of an enabling environment that break the culture of silence surrounding one's HIV status and partner disclosure. It will, also, promote the strengthening of processes that enable women and girls to freely access HCT and ART.

Positive health, dignity and prevention efforts will be consolidated and coverage expanded to community and health facility settings. This strategy will only become meaningful when a critical mass of people know their HIV status and start adopting key prevention behaviours<sup>69</sup> in addition to more PLHIV and their discordant partners practicing health seeking behaviours. The role of PLHIV in prevention will be strengthened through training and engagement of PLHIV as agents of change and peer educators.

The strategy of delivering prevention services will change from the traditional approach to a more targeted approach with a clear focus on most potential sources of new infections (i.e. stable relations), and key vulnerable groups such as women and girls. Geographical targeting will be prioritised with urban areas given the highest priority and in districts where prevalence is high. Efforts to mainstream HIV and AIDS, gender and human rights in work place programmes (internal mainstreaming) and in development projects (external mainstreaming) will be consolidated and capacity for service delivery strengthened. This will expand the scope for service delivery and increase coverage.

Although the NASF promotes a combination strategy for prevention, emphasis will be placed on effective strategies including increased male and female condom use, male circumcision, PMTCT, and blood safety. Programming will incorporate emerging evidence, technologies (e.g. microbicides gels) and new strategies for prevention as they become available and demonstrate efficacy.

The following section provides analysis of prioritised service delivery areas, the anticipated outcome and output results and suggested strategies

### **3.1.1 Social and Behaviour Change**

The priorities for the social and behaviour change interventions will be two fold. The first priority will be to improve the level of comprehensive knowledge about HIV and AIDS such that people are able to assess their personal risk and vulnerability to HIV infection. The second priority is to promote social and behaviour changes that will contribute to the adoption of key prevention behaviours. A combination of improved comprehensive knowledge, improved risk perception and people knowing their HIV status will enable people to make informed decisions and choices.

While social and behaviour change interventions will continue being provided to all people specific interventions will target most at risk and vulnerable groups with increased intensity and coverage and emphasis on the prioritised epidemic drivers, social and structural factors that fuel the spread of HIV and AIDS. The quality of interventions, intensity, coverage, and strong monitoring strategies will be put in place to ensure achievement of intended results.

The interventions are intended to achieve the following outcome and output results:

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<sup>69</sup> Behavioural strategies to reduce HIV transmission: how to make them work better, LANCET, August 2008

Outcome Result	Output result
<b>Social and Behaviour Change</b> <b>OC1] More people have comprehensive knowledge<sup>70</sup> of HIV:</b> Female and Male aged 15- 49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15 – 24 years to 51% in 2013 and 70% by 2015	<b>[OP1]</b> Females and males aged 15-25 with knowledge of HIV prevention increased 39% to 50% by 2013 and to 80% by 2015
	<b>[OP2]</b> Females and males aged 15-24 accessing social and behaviour change programmes is increased from 30% to 50% by 2013 and to 80% by 2015
	<b>[OP3]</b> Most at risk population and vulnerable groups reached with HIV prevention programmes has increased from 15% to 25% by 2013 and to 50% by 2015 <i>[disaggregated by MARP and vulnerability category]</i>
	<b>[OP4]</b> In and out of school OVC aged 5-17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015
	<b>[OP5]</b> Young females and males aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV increased from 35% in 2007 to 50% in 2013 and 65% by 2015
<b>[OC2] Fewer persons have multiple and concurrent partnerships:</b> Female and male aged 15-49 in the general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2015.	<b>[OP6]</b> Communities reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015
	<b>[OP7]</b> Female and Male aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50% <sup>71</sup> for Male in 2008 to 65% in 2013 and to 75% for both Female and Male by 2015
	<b>[OP8]</b> Couples (stable and semi-stable relationships) reached with small group or individual social and behaviour change programmes increased to 35% in 2013 and to 70% by 2015
<b>[OC3] Among Females aged 15-49, HIV infection is reduced from 16% in 2009 to 10% in 2013 and to below 8% by 2015</b>	<b>[OP9]</b> Female aged 15-49 reached with interventions that empower them to address gender inequality and gender based violence that predispose Female and girls to HIV infection increased to 40% by 2013 and to 75% by 2015
	<b>[OP10]</b> Female survival of rape accessing post rape care services (counselling, treatment, and legal support) increased from 20.2% in 2007 to 50% in 2013 and 80% by 2015.

The following strategies will be implemented to achieve the above results:

- i. Review policies, legislation and customary laws that place obstacles in promotion and implementation of prevention interventions, especially for women and girls.
- ii. Develop and implement targeted social and behaviour change interventions and conduct social mobilization to address the key structural and proximal drivers of the epidemic specific to the needs of men and women, girls and boys.
- iii. Develop strategies that address structural factors that sustain harmful social norms and high risk sexual behaviours for men and women.
- iv. Scale-up campaigns on risk perceptions and prevention of multiple and concurrent sexual partnerships.
- v. Scale-up evidence-based prevention interventions for females and males aged 15-24 years. Develop and implement interventions targeting alcohol and substance abuse users (create link

<sup>70</sup> Comprehensive knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission and prevention

<sup>71</sup> Baselines are from Zambia UNGASS National Report 2008/2009

- with text and strengthen text what are the issues, relationship, law and policy, GBV)
- vi. Expand coverage of a core package of combination prevention interventions for mobile populations and vulnerable groups (PLHIV, women, prisoners, persons living with disabilities,) among others
- vii. Implement interventions that protect girls and boys from the risk of inter-generational infection
- viii. Strengthen interventions that facilitate and promote girls' completion of the basic education programme
- ix. Develop, implement and monitor interventions that reduce and discourage GBV
- x. Address socio-cultural and structural barriers that prevent women from accessing and utilising HIV prevention services
- xi. Support links between the Poverty Reduction Strategy Programme and HIV and AIDS prevention interventions to reduce structural factors that promote transactional sex, particularly for women and girls
- xii. Strengthen male involvement in PMTCT, family planning and other reproductive health interventions

### **3.1.2 HIV Counselling and Testing**

HCT will be scaled up as a prevention strategy to have more people know their HIV status and make informed choices in adopting key prevention behaviours; and as an entry point for treatment, care and support. The NASF promotes and supports both client-initiated counselling (commonly referred to as Voluntary Counselling and Testing – (VCT) and testing and provider-initiated counselling and testing.

The NASF approach is to strengthen existing services and expand coverage especially in the community and the workplace. To date, only 15% of Zambians have been counselled and tested, hence the need to scale up HCT services.

Currently the demand for HCT is on the increase as programmes such as MC, PMTCT, PEP, STI, blood safety and increased outreach to most at risk populations are rolled-out. This demand can only be met through improved and intensified coverage coupled with an organised strategy of recruitment, training and retention of HIV counsellors and testers.

Innovative strategies will be explored including strengthening mobile HCT facilities, establishing youth friendly HCT centres that will also offer adolescent friendly sexual and reproductive health services and complement counselling and testing services. PLHIV will be trained and participate as peer counsellors and community mobilizers. Couples counselling, including regular counselling and testing for discordant couples will be among the core activities. HCT will be carried out in conformity with relevant international human rights standards, respective of the “three Cs” (Consent, Counselling and Confidentiality).

HCT interventions will contribute to the achievement of the following outcome and output results

Outcome result	Output results
<b>HIV Counselling and Testing</b> <b>[OC4]</b> <i>More people test for HIV and know their results:</i> Females and Males aged 15-49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4% in 2008 to 30% in 2013 and 50% by 2015	<b>[OP11]</b> Female and male aged 15-49 who received an HIV test in the last 12 months and know their results has increased from 28% (1910253/6822332) in 2009 to 41% (3,023,728/7330249) in 2013 and 50% (3,816,765/7633530) by 2015
	<b>[OP12]</b> Couples who were counselled and tested in the last 12 months increased to 20% in 2013 and to 50% by 2015
	<b>[OP13]</b> Most at risk population who received an HIV test in the last 12 months and know their status has increased from 20% to 35% by 2013 and to 70% by 2015 <i>[disaggregated by MARP category]</i>
	<b>[OP14]</b> Health and non-health facilities with adequate capacity to provide either provider initiated and client Testing and counselling and or client initiated counselling and testing increased from 60% in 2008 to 80% in 2013 and to 100% by 2015

### Priority Strategies

The following strategies will be operationalised to ensure that the above results are realised:

- i. Intensify education and awareness of HCT especially among the key audiences and interventions such as MARPS, MC, PMTCT, and PEP which will require development and dissemination of social and behaviour change materials
- ii. Develop the human resources capacity to provide HCT services in the community and in the health facilities to ensure supply meets demand for HCT services
- iii. Scale-up access to HCT for couples, including services for discordant couples
- iv. Support community mobilisation to generate and sustain demand for HCT

### 3.1.3 Condom Promotion

The NASF promotes and supports increased distribution and availability of both male and female condoms and the intensification of education and awareness on the need to use condoms consistently and correctly every time a person has higher risk sexual intercourse, as a family planning method during low risk sexual encounters and in stable relationships when couples are sero-discordant. Advocacy and education on female condoms will be intensified.

As part of the outreach programme, condom distribution and education services will be integrated with other services such as male circumcision, prevention of STIs and in other reproductive health services such as family planning.

These interventions will contribute to the achievement of the following outcome and output results

Outcome result	Output results
<b>Condom Marketing and Distribution</b> <b>[OC5]</b> <i>More people consistently and correctly use condoms in their last sex intercourse:</i> Female and Male aged 15-49 who had more than one partner in the past 12 months who used a condom during their	<b>[OP15]</b> MOH increase free condoms distribution per year for Male from 40 million in 2009 to 80million in 2013 and 100 million in 2015 and for Female from 450,000 in 2009 and 650,000 in 2013 and 1,000,000 in 2015 <sup>72</sup>
	<b>[OP16]</b> MOH Condom retail outlets <sup>73</sup> and service centres that reported no condom stock out increased 40% in 2008 to 60% in

<sup>72</sup> Baseline data for male and female condoms is derived Mode of Transmission report, while projection targets are based on the targets proposed in 6<sup>th</sup> NDP Chapter for HIV and AIDS i.e. 40% for 2013 and 50% for 2015.

<sup>73</sup> According to the MOT report (2009) in 2008, there were 15,252 condom outlets



last sexual intercourse increased from 37% for female and 50% for male in 2007 to 45% for female and to 60% for male in 2013 and 55% for female and 70% for male by 2015	2013 and to 100% by 2015 [OP17] Male and Females age 15-49 years have Condom use increased from 37% in 2007 to 55% in 2013 and 73% by 2015
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## Priority Strategies

The following priority strategies will be operationalised to ensure that the outcome and output results are achieved.

- i. Intensified education and awareness on the correct and consistent use of condoms
- ii. Integration of condom distribution and education in other services and in particular male circumcision, sexual and reproductive health, youth friendly services, PMTCT, and STI services
- iii. Advocacy to promote the use of female condoms
- iv. Increase availability and distribution of male and female condoms, and support social marketing of female and male condoms
- v. Strengthen the procurement and supply chain for male and female condoms especially at district and community levels to avoid stock-outs

### 3.1.4 Male Circumcision

Male circumcision has recently been added as a national prevention strategy. Zambia is one of the leading countries in the sub-region rolling out adult MC. Currently, the number of males circumcised reflects the existing capacity of the health system to provide the services.

The NASF promotes MC for all young boys and adults aged one year and above; and for neonates. Currently, only 13% of Zambian men aged 15-49 are circumcised. An intensified approach for MC will lead to an increase in the number of Zambian men who are circumcised and a concomitant reduction in HIV risk among these men. Increases in neonatal circumcision will demonstrate social and cultural acceptance of this practice and ensure a more sustainable approach for the delivery of MC over time. MC will be prioritised in districts where men are largely uncircumcised and in geographical areas where HIV prevalence is high.

Male circumcision services will be provide as part of a comprehensive HIV prevention package and integrated into male RH services such as HCT, STI screening and treatment, FP and provision of condoms. Communities will be mobilised to generate demand for male circumcision.

The capacity for MC will be developed through training of medical and health staff in line with the WHO guidelines. Given the increasing demand, Zambia will consider and institutionalise task shifting to allow qualified nurses to perform male circumcision especially for infants at birth. The roll out of MC to health facilities will be accompanied with the provision of appropriate equipment and supplies. The involvement of traditional male circumcisers will be explored taking into consideration the potential for infection in non-health settings.

Community level awareness campaigns, especially in non-circumcising provinces, to create demand for male circumcision will be supported and the benefits of circumcision that link to protecting the health of women from conditions such as cervical cancer will be integrated into the campaign

These interventions will contribute to the achievement of the following outcome and output results.



Outcome Results	Output results
<b>Medical Male Circumcision</b> <b>[OC6]</b> <i>More male are circumcised by a health professional: male aged 15-49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015</i>	<b>[OP18]</b> Male aged 15-49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015 <sup>74</sup> .
	<b>[OP19]</b> At least 50% of all infants born in a health facility are circumcised in the first week of life
	<b>[OP20]</b> MOH have 50% and 80% of all PMTCT centres integrated with male circumcision service in 2013 and 2015.
	<b>[OP21]</b> Traditional leaders promote MC as an HIV prevention strategy as part of community mobilization efforts in 50% and 100% of communities with low MC practices by 2015 and 2015.

## Priority Strategies

The following priority strategies will be implemented to ensure the scale up of male circumcision:

- i. Strengthen the capacity of health facilities to provide MC in terms of human resources, equipment and appropriate facilities (theatre, for example)
- ii. Conduct community mobilisation and education to promote adult and neonatal circumcisions
- iii. Integrate condom education as part of the pre and post circumcision counselling
- iv. Roll out MC in all health facilities
- v. Train service providers
- vi. Finalise the MC communication strategy
- vii. Strengthen collaboration with traditional circumcisers

### 3.1.5 Prevention of Mother to Child Transmission

PMTCT has proved to be an effective strategy for reducing mother to child transmission of HIV, and promoting provision of comprehensive and quality PMTCT services to all females of reproductive age is a priority for NASF. Zambia has committed to intensify action around PMTCT with the aim of achieving virtual elimination of mother to child transmission by 2015. Successful PMTCT intervention will directly contribute to the attainment of Millennium Development Goals (MDG) 4, 5 and 6.

In scaling up PMTCT, linkages will be developed between PMTCT and the scale up of ART. PMTCT will be integrated into other appropriate clinical based services including MNCH clinics, HIV treatment centres, HCT, STI clinics, and other RH service centres. PMTCT integration with other services will ensure increased availability of PMTCT, coverage and delivery of a comprehensive package of essential services for quality MNCH care that will include routine quality ANC for women regardless of their HIV status. The capacity to provide HCT to pregnant women attending ANC will be strengthened. The MOH will strengthen collaboration with traditional birth attendants (TBAs) and community health workers to increase access to services for women who give birth at home.

In terms of care and support HIV positive women will be placed on HAART as early as 14 weeks of gestation (second trimester) and will be able to continue for the duration of breastfeeding until a week after secession of breastfeeding. Infants will be eligible for both the Cotrimoxazole prophylaxis and ART once they are diagnosed as HIV positive. From 2011-2015, PMTCT protocols will be periodically reviewed and revised to ensure alignment with WHO guidelines. During the period of the NASF PMTCT protocol will be periodically revised to ensure its alignment with WHO guidelines.

<sup>74</sup> The targets for MC are set out in the Zambia National Male Circumcision Strategy 2010-2020

To ensure comprehensive and quality services provision, interventions will focus on the four PMTCT prongs. To promote primary prevention among potential parents, the NASF supports the scale up of social and behaviour change interventions, HCT, correct and consistent condom use, male circumcision and treatment of STIs among others. To prevent unintended pregnancies, family planning services will be integrated with PMTCT. ART prophylaxis will be provided for HIV positive women who meet stated criteria while safe obstetric practices will be strengthened across the health system. Communities will be mobilised to support male involvement and participation in PMTCT interventions..

Community mobilization to increase male participation and support for choices made by women with regard to PMTCT will be enhanced. Traditional leadership system will be utilized for wider outreach to enhance community level care for expectant women. PMTCT interventions will contribute to the achievement of the following outcome and output results

Outcome results	Output results
<p><b>Prevention of Mother to Child Transmission</b>  <b>[OC7]</b> <i>More HIV positive pregnant female receiving ARVs to reduce risk of transmission to child: HIV positive pregnant Female who receive ART to reduce the risk of mother to child transmission is increased from 61% <sup>75</sup>(47,175) in 2009 to 85% (72,828) and to 95% (85,655) in 2015</i></p>	<p><b>[OP22]</b> Pregnant women who were counselled during the ANC for their most recent pregnancy, who were offered and accepted a HIV test and received their test results in the last twelve months increased from 67%<sup>76</sup> in 2009 to 80% in 2013 and 95% by 2015</p>
	<p><b>[OP23]</b> Female aged 15-49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015</p>
	<p><b>OP24]</b> HIV-infected pregnant females who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission increased from 61% (47175/79498) in 2009 to 85% (72828/85708)in 2013 and 95% (85655/90163) by 2015</p>
	<p><b>[OP25]</b> HIV positive mothers, their children and families who have received at least two categories of care at home /community increased from 40% in 2009 to 75% in 2013 and to 100% by 2015</p>
	<p><b>[OP26]</b> Male participation in PMTCT programming increase from 30% to 50% (equivalent of 50% of women on PMTCT) by 2013 and 80% by 2015.</p>
<p><b>[OC8]</b> <i>More infants born from HIV-positive mothers are not infected: Infants born to HIV-infected mothers who are infected has reduced from 7%<sup>77</sup> in 2009 to 5% in 2013 and to less than 2% by 2015</i></p>	<p><b>[OP27]</b> Infants born to HIV-infected females (HIV-exposed infants) receiving ARV prophylaxis to reduce the risk of MTCT has increased from 62%<sup>78</sup>(21050/36215) in 2009 to 50% (31110,39469) in 2013 and 95% 36140/38042)by 2015</p>
	<p><b>[OP28]</b> Infants born to HIV-infected mothers (HIV-exposed infants) started on Cotrimoxazole prophylaxis within two months of birth has increased from 34%<sup>79</sup> in 2009 to 50% by 2013 and to 100% by 2015</p>

## Priority Strategies

The following priority strategies will be implemented

- i. Strengthening commitment and leadership to achieve full coverage of paediatric HIV prevention, care, support and treatment
- ii. Providing technical guidance to optimize quality pediatric HIV prevention, care nutrition support and treatment services

<sup>75</sup> NDP 6 – Chapter on HIV and AIDS (draft), 2010

<sup>76</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID / not targets have been taken from the 6<sup>th</sup> NDP Chapter paper

<sup>77</sup> Zambia UNGASS National Report 2008/2009

<sup>78</sup> SNDP chapter on HIV and AIDS, June 2010

<sup>79</sup> Zambia UNGASS National Report 2008/2009

- iii. Integration of pediatric HIV prevention, care, support and treatment within MNCH and RH programmes promoted and supported
- iv. Reliable and equitable access for all women and children, including the most vulnerable, ensured
- v. Promoting and supporting comprehensive health systems interventions to improve the delivery of HIV prevention, care and treatment services for women and children
- vi. Improving and expanding health information systems to provide effective monitoring and evaluation of programme performance for high impact MNCH and PMTCT outcomes
- vii. Focusing on positive PMTCT outcomes for women and children
- viii. Strengthening partnerships for providing HIV prevention, care and treatment for women, infants and young children and advocate for increased resources Provide HAART to eligible HIV pregnant women and their HIV-exposed babies
- ix. Offer ARV prophylaxis to HIV infected pregnant women and infants once diagnosed
- x. Develop and implement male involvement interventions including developing and producing male targeted IEC materials

### 3.1.6 PLHIV – Promoting Positive Health, Dignity and HIV Prevention

Prevention of new HIV infections is a responsibility of all people regardless of their HIV status. While many people have tested and know their HIV status, the majority have not and hence are ignorant about their status. The US Centre for Disease Control (CDC) has found that people who don't know their HIV status are more than twice likely to engage in high-risk sex than those who are aware of their HIV positive status<sup>80</sup>. The study also shows that about 70% of new infections are from people who are not yet diagnosed<sup>81</sup>. The entry point for the involvement of PLHIV in prevention and treatment activities starts by one knowing one's status and making informed choices and decision to adopt key prevention behaviours or seek treatment.

There are many reasons why the involvement of PLHIV is strategically important to the successful implementation of the NASF. Treatment, alone, cannot control the epidemic. For every two people who are started on ART five others are newly infected<sup>82</sup>, and infection can only be passed from an infected person to uninfected person, e.g. through sexual intercourse, sharing of needles by injecting drug users, transmission from mother to child, contact with infected blood or through other infected products. PLHIV also play a critical role in efforts to reduce stigma and discrimination, and hence strengthen the enabling environment for national response. This has a positive effect on HIV and AIDS services uptake.

A key challenge to PLHIV involvement in the national response is the perception that PLHIV are only service beneficiaries and not strategic partners in the response. This is compounded when PLHIV are excluded from planning and decision making processes. Even where the political, social and legal environment is conducive, specific strategies for PLHIV involvement are inadequately articulated in national policies, programmes and strategic plans.

The NASF will promote greater and meaningful involvement of PLHIV in the national response, particularly in prevention of new infections. Innovative strategies will be operationalised within the context of "*positive health, dignity and prevention*" for and by PLHIV. Through this concept NASF will address the complex nature of behavioural practices by PLHIV. Some of the interventions will include promoting sexual reproductive health rights and access to services, gender equality, social and economic empowerment, ensuring an uninterrupted and comprehensive package of treatment care and support. PLHIV will play a

<sup>80</sup> Marks G, et al. *Meta-analysis of high risk sexual behaviour in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programmes* JAIDS, 39(4):446-53, 2005

<sup>81</sup> Marks G, et al. *Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the HIV virus in the United States.* AIDS 20(10):1447-50, 2006

<sup>82</sup> UNAIDS , *AIDS Epidemic Update 2009*

critical role as peer educators especially among in and out of school youth and in community mobilisation. It is anticipated that by meaningfully involving PLHIV, they will contribute to stigma and discrimination reduction at health facility, community and workplace settings. The capacity of PLHIV as individual or organised forms of support groups will be strengthened.

The involvement of PLHIV in the national response is expected to contribute to the following outcome and output results

Outcome Results	Output Results
<p><b>Prevention with the Positives:</b>  <b>[OC09]</b> PLHIV aged 15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased to X% by 2015</p>	<p><b>[OP29]</b> PLWHIV reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards increased from 30% in 2010 to 60% in 2013 and 80% in 2015</p>
<p><b>[OC10]</b> PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015</p>	<p><b>[OP30]</b> Females and males who received counseling and testing services for HIV and received their test results increase from 15% in 2007 to 50% in 2013 and 80% in 2015</p>

### Priority Strategies

The following priority strategies will be implemented.

- i. Develop national policy guidelines on the involvement of PLHIV in the national multisectoral HIV and AIDS response within the context of universal access
- ii. Strengthen coordination between health and community based facilities involving PLHIV especially around prevention, and treatment care and support
- iii. Strengthen the capacity of PLHIV organisations and support groups. The capacity development will also include strengthen individual PLHIV skills to address HIV and AIDS, including coping mechanisms.
- iv. Strengthen and implement stigma and discrimination reduction strategies both in health facility and community settings. These may include using media, schools, health workers, motivational speakers, leaders and in the workplace
- v. Scale up HIV awareness and education and treatment literacy services
- vi. Strengthen capacity of PLHIV coordinating structures to support community based support groups of PLHIV
- vii. Develop a minimum package of “*positive health, dignity and prevention*”

### 3.1.7 Post Exposure Prophylaxis

The NASF supports initiatives that create awareness of both occupational and non-occupational PEP to prevent HIV infection developing in exposed persons<sup>83</sup>. These interventions will include first aid care; counselling and risk assessment; HCT; and, depending on the outcome of risk assessments, the short term (28-day) provision of ARV with support and follow up.

The vast majority of incidents of occupational exposure to blood borne pathogens, including HIV, occur in health care settings. Health workers will be trained on PEP service provision in health care settings. For non-occupational PEP, the focus is to prevent HIV infection among survivors of rape and other forms of sexual abuse and people exposed to blood products through traffic accidents such as PSV drivers and police. Community based advocacy work will be carried out to sensitise communities on PEP services. In order to strengthen the provision of occupational PEP, Zambia will review the existing PEP guidelines to provide a comprehensive package and cover a wide range of situations, for instance emergency service workers who rescue accident victims in addition to hospital workers. The capacity of health facilities to provide PEP will be strengthened. In 2008, only 43%<sup>84</sup> of health facilities were offering post exposure prophylaxis. PEP education and awareness campaigns will be intensified among health workers and at the community level.

The implementation of PEP interventions will contribute to the achievement of the following outcome and output results:

Outcome results	Output results
<b>Post Exposure Prophylaxis</b> <b>[OC11]</b> <i>All persons who have been accidentally or forcibly exposed to HIV are given drugs to reduce the risk of primary infection:</i> People in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)	<b>[OP31]</b> Health facilities with PEP services available on site and being provided according to the national guidelines has increased from 43% in 2008 to 100% by 2015
	<b>[OP32]</b> Health Workers with reported needle prick injuries in health facilities has reduced from 6.7% <sup>85</sup> in 2008 in 4% by 2013 and to less than 2 % by 2015
	<b>[OP33]</b> People in need of PEP receiving PEP in accordance with the national guidelines in the last 12 months increased to 100% (all in need) and remain that way by 2015

### Priority Strategies

The following strategies will be implemented.

- i. Conduct community outreach to create awareness of PEP
- ii. Roll-out the provision of PEP to health facilities providing ART and PMTCT in particular
- iii. Increased uptake of PEP services by survivors of sexual and gender-based violence, emergency service workers and rescue accident victims through education and awareness
- iv. Train health workers and other service providers including police, firemen and other emergency workers on PEP
- v. Provide PEP for health care workers and victims of sexual abuse

<sup>83</sup> Occupational exposure usually occur in health care settings but can also include emergency services to road traffic accident victims. Non-occupational exposure includes rape and other forms of sexual assault, and GBV.

<sup>84</sup> Joint Annual Programme Review of the National HIV/AIDS/STI/TB Intervention Strategic Plan (2006-2010) and the Operations of the National AIDS Council for the Year 2006, NAC July 2007

<sup>85</sup> Joint MID TERM Review of NASF report- Technical Report, January 2009, NAC

### 3.1.8 Sexually Transmitted Infections (STIs)

STIs remain a major public health concern. According to UNAIDS, the presence of an untreated STI (either ulcerative or non-ulcerative) can enhance both the acquisition and transmission of HIV by a factor of up to 10<sup>86</sup>. According to WHO,<sup>87</sup> STI treatment is an important HIV prevention strategy in a general population. Almost all the measures for preventing sexual transmission of HIV and STIs are the same, as are the target audiences for interventions<sup>88</sup>.

The core NASF strategy for STIs is to interrupt transmission, reduce infections and the duration of infection, and prevent the development of complications in STI clients. Interventions on primary prevention of STIs will be promoted through health education, involving practices such as safer sex behaviour, condom use, and abstinence from sex if a partner is infected with an STI. Health care workers will be trained to diagnose and treat STIs; and to integrate STI services into other care such as MC, FP and PMTCT. At the same time, health care facilities will be equipped with the necessary diagnostic tools and treatment drugs as well as condoms to effectively treat and manage patients with STIs.

The NASF promotes health seeking behaviour for STI clients including consistent and correct use of condoms. Support will be provided and capacity strengthened to integrate STI education and awareness in sexual and reproductive health services in clinical and non clinical settings in addition to ART, PMTCT and male circumcision services. HIV and AIDS workplace programmes will be encouraged and supported to include prevention of STIs as one of their core services.

The implementation of proposed STI interventions will contribute to the achievement of the following outcome and output results:

Outcome Result	Output Result
<p><b>Sexually Transmitted Infections</b>  <b>[OC12] Fewer Females and males have STIs:</b>            Female and Male who report having STI in the past 12 months has reduced for Female from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for Male from 26% 2007 to 13% in 2013 and 5% in 2015</p>	<p><b>[OP34] MOH Primary Health facilities offers comprehensive STI treatment maintains its current 100% of STI services by 2013 and remains at the same level by 2015</b></p>

#### Priority Strategies

#### Priority Strategies

The following priority strategies will be implemented

- i. Develop a National Social and Behaviour Change Strategy for HIV and AIDS inclusive of STI, OI and TB management
- ii. Develop a public education campaign focused on STI and HIV infection to promote early treatment seeking behaviours by the general population and MARPS
- iii. Strengthen health systems to provide comprehensive STI services
- iv. Conduct microbiological surveillance for STI
- v. Offer HIV testing to all patients presenting with STIs

<sup>86</sup> Public Health approach to STI control- UNAIDS update: UNAIDS 1998.

<sup>87</sup> Global Strategy for the Prevention of and Control of Sexually Transmitted Infections 2006 -2015, World Health Organization 2007 and

<sup>88</sup> Global Strategy for the Prevention of and Control of Sexually Transmitted Infections 2006 -2015, World Health Organization 2007



- vi. Provide condoms for STI clients
- vii. Ensure integration of STI diagnosis and treatment into primary health care, reproductive health care facilities, private clinics and others
- viii. Comprehensive case management of STIs - early detection of symptomatic and asymptomatic infections
- xiii. Strengthen and scale-up activities to prevent and manage various opportunistic infections including STIs and TB as they relate to HIV

### 3.1.9 Blood Safety

Blood safety is the most effective strategy for the prevention of transfusion transmissible infections (TTIs), including HIV, viral hepatitis, and syphilis. Zambia currently screens 100% of blood in quality assured laboratories operating under the Zambian National Blood Transfusion Service (ZNBTS). The NASF supports interventions that will maintain blood screening at 100%. This will include ensuring that staff are trained and laboratory capacity for testing is maintained. Education and awareness will be conducted to sensitise the public about the need for blood to encourage people to donate blood. Operational research will be carried out to establish a mechanism for following up on people who have been transfused to ensure that they are protected from exposure from blood that could have been in window period.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results

Outcome results	Output results
<p><b>Blood Safety</b>  <b>[OC13]</b> <i>Donated blood units are screened for HIV and other TTIs in a quality assured manner:</i> Donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100%<sup>89</sup> between 2010 and 2015</p>	<p><b>[OP35]</b> MOH meet national demand of 100% of need using the national blood transfusion of centrally collected blood screened for transfusion transmissible infections .</p>

### Priority Strategies

The following priority strategies will be implemented:

- i. Periodically review the capacity of blood testing laboratories to ensure quality
- ii. Develop a follow up and referral system for blood donors who test HIV positive
- iii. Conduct social mobilization activities for the recruitment and retention of voluntary, non-remunerated blood donors from low risk populations
- iv. Ensure the recruitment and retention of qualified technical, medical and administrative staff
- v. Implement strategies for human capacity development

<sup>89</sup> Joint Mid – Term Review of NASF report- Technical Report, January 2009, NAC



## **3.2 Treatment, Care and Support**

Treatment, care and support are key components of the national strategy for the HIV and AIDS response. The NASF strategy to provide a comprehensive package will improve the quality of life such that more PLHIV live longer (beyond 36 months) after the initiation of ART. Priority interventions in this area include increasing access and enrolment on ART, providing treatment for TB/HIV co-infection and community- and home-based palliative care.

In scaling up access to ART, HCT will be expanded and in particular Provider Initiated Counselling and Testing (PICT) to provide an entry point for treatment. Overall, the NASF supports the implementation of a comprehensive package that will include pre and post test counselling, provision of ART, nutritional information and support, palliative and home based care. As part of the strategy to consolidate services, linkages for the diagnosis and treatment of HIV and TB co-infection will be strengthened and expanded. People with HIV and Hepatitis B will also be placed on ART in line with WHO guidelines. ART will also be provided to HIV positive pregnant women and children identified through PMTCT.

Referral services and tracking of ART clients will be strengthened to minimise the number of clients lost. Human resources, infrastructure including laboratories, and the procurement and supply chain will be strengthened to ensure the timely provision of ART for PLHIV. Issues of stigma and discrimination at health facilities, workplaces and in the community will be addressed as part of the strategy to ensure adherence to treatment protocols.

### **3.2.1 Antiretroviral Therapy**

The priority strategy for ART is to ensure universal access to treatment, care and support. This will entail increased roll out of ART services to more health facilities coupled with adequate human and infrastructure resources to ensure that supply meets the demand for ART. Demand for ART is likely to increase significantly with the adoption of CD4 350 criteria, an increase in PMTCT clients, and from the demand for ART for PEP as more people become aware of the service. WHO has also recommended that persons with Hepatitis B HIV co-infection are also provided with ART.

The NASF promotes strengthening human resources and infrastructure in line with the demand for ART. As part of human resources capacity development, the process of “task shifting” and mentoring of less experienced service providers will be accelerated. More health facilities will be designated as ART sites. The number of ART sites increased from 107 in 2005 to 355 in March 2008. The aim is to roll-out ART to most health facilities at the community level.

Communities will be mobilised to provide HIV counselling and testing as an entry point to treatment, care and support. Communities will also be sensitised on the need for non-occupational PEP for use within the context of road traffic accidents and sexual abuse and in particular, rape. The current referral system will be reviewed and strengthened to ensure HIV positive individuals and others who need ART are effectively linked to ART services.

The procurement and supply systems will be strengthened to avoid stock outs of ARVs in treatment facilities. Nutritional information and services will be provided for adults and children on ART and are malnourished.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results

Outcome Result	Output results
<b>Antiretroviral Therapy</b> <b>[OC14] More PLHIV survive longer on ART:</b> Adults (15 and older, and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015	<b>[OP36]</b> Adults enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to 2015
	<b>[OP37]</b> Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis increased from 34% to 60% in 2013 and 100% up to 2015
	<b>[OP38]</b> Female and Male with advanced HIV infection receiving ART has increased from 68% <sup>90</sup> in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015
	<b>[OP39]</b> Children (aged 0-14) eligible for HIV receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015
	<b>[OP40]</b> Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015

### Priority Strategies

The following Strategies will be implemented

- i. Link testing services to ART, including community-based testing
- ii. Provide ART for all PLHIV who meet the criteria
- iii. Strengthen human and technical capacity of health facilities to provide comprehensive and quality ART services with minimum delays
- iv. Strengthen the drug procurement and supply chain management systems
- v. Provide nutrition for malnourished PLHIV, children and infants
- vi. Strengthen health systems to deliver improved integrated quality and comprehensive HIV treatment, care and support services—this will include acceleration of integration of HIV services with other clinical services
- vii. Strengthen drug monitoring including drug resistance including TB and HIV drug resistance and the Early Warning Indicator System
- viii. Facilitate a single entry system for counselling, diagnosis, treatment and follow-up for HIV and TB patients in both out-patient and in-patient situations
- ix. Integrated patient tracking system for HIV, TB and Hepatitis B strengthened
- x. Strengthen community systems to support HIV and TB related care and support
- xi. Accelerate the implementation of treatment literacy
- xii. Develop and implement an integrated quality assurance management system

### 3.2.2 TB/HIV co-infection

Tuberculosis is the major cause of death among PLHIV. The NASF supports initiatives that strengthen the capacity of health facilities to conduct comprehensive diagnosis of TB/HIV co-infection, provide treatment and monitor drug resistant [TB (MDR-TB and EDR-TB)].

Part of the intensification will be scaling up the implementation of the WHO “Three I’s” strategy that entails Intensified Case Finding (ICF), provision of Isoniazid Preventative Therapy (IPT) and TB Infection Control (IC). The NASF emphasises the holistic adoption of the Three I’s strategy to minimise TB prevalence and to contain its effects on PLHIV.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results

<sup>90</sup> Zambia UNGASS National Report 2008/2009 / and NDP 6<sup>th</sup> Chapter on HIV and AIDS, 2010 (draft) paper

Outcome result	Output results
<b>TB/HIV co-infection:</b> <b>[OC15]</b> <i>More PLHIV with TB/HIV co-infection are successfully treated:</i> PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 and 60 % in 2013 and to 75% by 2015	<b>[OP41]</b> The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 40.6 % <sup>91</sup> in 2007 to 60% 2013 and to 80% by 2015. <b>[OP42]</b> HIV-positive TB patients who are started on ART has increased from 41% (6595) in 2007 to 60% in 2013 and to 75% in 2015.

### Priority Strategies

The following priority strategies will be implemented

- i. Strengthen the capacity of HIV/TB services delivery
- ii. Scale up TB/HIV collaborative initiatives
- iii. Scale up IPT and the Three Is strategy to minimise the incidence of TB among HIV patients
- iv. Strengthen community participation and support to TB and HIV activities to track treatment defaulters and treatment literacy
- v. Strengthen TB case (passive and active) detection
- vi. Offer PITC for all TB suspects / patients
- vii. Expand TB screening as part of HCT
- viii. Intensify continuous training and supportive supervision for health care providers managing TB and HIV clients
- ix. Task shift the administration of IPT responsibilities to all health workers beyond those designated for TB and HIV programmes
- x. Enrol TB patients on ART, if eligible
- xi. Build and strengthen referral systems for HIV positive and TB positive individuals to ensure they receive care for possible co-infection
- xii. Strengthen the capacity to increase the cure rate for TB
- xiii. Provide adequate, skilled and competent human resources to provide comprehensive services for HIV & AIDS and TB
- xiv. Strengthen the provision of provider initiated testing and counselling for HIV to all TB services sites

### 3.2.3 Community and Home Based / Palliative Care Services

Community and Home Based Care (CHBC) are integral components of the continuum of care provided to PLHIV or to patients with chronic illnesses. The NASF takes cognisance that with the rollout of ART, the nature of CHBC has changed as the quality of life of people on ART has significantly improved and many resume productive lives.

The NASF supports and accelerates the implementation of specific activities including: palliative care, nursing care, clinical care, counselling and psychosocial support, treatment adherence and treatment literacy for people on ART, reproductive health, nutritional support for malnourished PLHIV, and referrals to HCT, TB and ART service.

Collaboration with CSOs and support groups for PLHIV will be strengthened given their comparative advantage in community outreach. Training for CHBC volunteers and other service providers will be standardised. CHBC materials will be distributed in line with the National Decentralisation Policy. Providing

<sup>91</sup> Joint Mid Term Review of NASF report- Technical Report, January 2009, NAC

incentives for CHBC volunteers to expand community outreach and the development of support groups will be explored.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results:

Outcome result	Output results
<p><b>Community Home Based Care and Palliative Care</b>  <b>[OC16]</b> Male and Female children 0-17 yrs orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and to 50% by 2015</p>	<p><b>[OP43]</b> People receiving palliative care increased from 157,712 in 2007 to 200,000 in 2013 and 250,000 in 2015</p>

### Priority Strategies

The following priority strategies will be implemented.

- i. Conduct a mapping of CHBC services and service providers
- ii. Strengthen coordination of CHBC
- iii. Strengthen community systems to support the implementation of CHBC services–this will entail recruitment and retention of experienced volunteers, financial support and capacity building
- iv. Revise the home based care guidelines given the impact of ART on patients in CHBC
- v. Standardise training for community CHBC providers
- vi. Train volunteers in basic palliative care skills
- vii. Procure and supply home based care kits

#### Overview – the Policy and Institutional Environment

The impact of HIV and AIDS is unfolding in many different ways at individual, household, and community levels. These manifestations are reflected in growing food insecurity, deepening household poverty, the decline in alternative livelihoods, the weakening or loss of socio-economic support networks and a weakened health service delivery system. As the epidemic unfolds, mortality and morbidity have increased while the quality of life among those most vulnerable continues to erode. Of particular concern is the loss of skilled personnel that traditionally has supported social and economic development. The loss of human resources has weakened the national capacity to absorb development resources and reduced the capacity for communities to cope with the impact of HIV and AIDS.

The rights based approach underpins development and social protection policies in the SNDP and NASF. Statutory laws provide for equality for men and women although implementation is weak, especially in relation to decision-making processes and leadership positions, access and control over productive assets, and socio-cultural practices. A Human Rights Commission functions to monitor and record human rights violations and guide the process of redress when complaints are lodged with the Commission. An HIV and Human Rights Code of Conduct has been formulated but lacks instruments for operationalisation.

In March 2000, the government adopted the National Gender Policy to provide a roadmap for eliminating gender-based discrimination, and to promote social equity in all spheres of Zambian society. A National Plan of Action on *Women, Girls and HIV and AIDS 2010-2014* was developed in 2009 to specifically focus on the drivers that make women and girls more vulnerable than males to HIV infection and its impact. The plan notes that in spite of the number of interventions implemented to mainstream gender into HIV and AIDS programmes, gaps remain. The gaps include lack of capacity to analyse and incorporate gender issues in HIV and AIDS programmes, inadequate legislative framework to fight cultural practices and norms that predispose women and girls to HIV, and limited gender-focused programming.

Several government ministries are responsible for the policy environment for interventions falling under impact mitigation. At the institutional level, the MCDSS spearheads and coordinates all social protection activities within the country. The Ministry is responsible for public policy regarding social protection, provides an entry point for external support to the sector, and sets minimum standards in the implementation of programmes. Gender, HIV and AIDS, disability, and sexual and gender based violence are incorporated in social protection programming.

The Ministry of Labour and Social Security (MLSS) is responsible for developing a comprehensive social security system that includes informal sector workers. MLSS is involved in the enhancement of child survival, development and protection interventions, and support for and protection of OVC, particularly child labour elimination.

The MCDSS and the MYSCD are the two lead government bodies for OVC support. The MYSCD is responsible for child social protection policy while basic social services for orphans fall under the responsibility of the MCDSS. The National OVC Steering Committee was established in 2001, under the direction of the MYSCD.

Education and skills development programmes are implemented by the Ministry of Education (MOE), Ministry of Science, Technology and Vocational Training (MSTVT), the MYSCD and MCDSS. There are many non-government providers of education and training at all levels. These include NGOs, faith based organisations (FBOs), community-based organisations (CBOs) and private providers. During the period of the SNDP, the Education and Skills Development Sector will re-focus its strategies to make a serious impact on poverty reduction, female participation and income growth, especially in the rural areas.

The MOE has a school health programme to identify children in need of health care services and food supplementation, and facilitate access to these services. The aim of the School Health and Nutrition (SHN) Programme is to comprehensively address the health and nutrition problems of school children that influence their access to, participation in and outcomes of the education process. Among the problems addressed are parasitic and other infections, environmental health, water and sanitation, nutrition, HIV and AIDS, violence and substance abuse.

The MOE and MOH waive fees for categories of the most vulnerable population so that they can access education and basic health care services. OVC, children under five, indigent households, and people living with chronic or life-threatening illnesses such as HIV and TB are offered free health services in the public sector or on a cost-sharing basis.<sup>92</sup>

The total number of people with disabilities in Zambia is unknown, consequently WHO parameters are used to estimate the proportion of the overall population affected. WHO suggests that 10-20% of the population are persons with disabilities. The *Zambian Persons with Disabilities Act No. 33* and the *National Policy on Disability* are the primary policy instruments for defining impairment or disability.

Collaborative strategies with MCDSS and civil society organisations facilitate orphans with special learning difficulties to access educational programmes that address their needs. The number of children with special education needs accessing education (46% female and 54% male) increased from 89,269 in 2005 to 207,437 in 2009.<sup>93</sup> The Ministry of Education increased priority to address the situation of children with special education needs, by including them in the mainstream school system.

The Ministry of Agriculture works in collaboration with MCDSS to provide reliable incomes and food to vulnerable groups. Tailor-made programmes for labour-constrained households are designed to reduce food insecurity.

Food insecurity among vulnerable populations is dealt with by MCDSS through food packs; the Disaster Management and Mitigation Unit (DMMU) during droughts and floods; and the MOE in collaboration with World Food Programme with interventions that provide feeding programmes in selected schools, particularly community schools and vulnerable households.

Civil society organisations and the private sector also contribute to social protection programmes through interventions to assist OVC and low capacity-households to acquire skills and micro-finance opportunities. More than 418 registered CSOs are working with OVC<sup>94</sup>.

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<sup>92</sup> Interventions included in the BHCP were selected on the basis of an epidemiological analysis of the diseases and conditions that cause the highest burden of disease and death in Zambia.

<sup>93</sup> Education and Skills Development Chapter in the SNDP

<sup>94</sup> UNICEF *Situation Analysis of Women and Children, 2008*

### 3.3.1 Vulnerable Households and Individuals

The NASF supports the implementation of impact mitigation within the context of the social protection framework. Social protection is a poverty reduction strategy that promotes human development, social equity and human rights. It protects and promotes the livelihoods and welfare of people suffering from critical levels of poverty and deprivation and/or vulnerability to risks and shocks<sup>95</sup>. Key risk factors can occur together (such as poverty, chronic illness, and inadequate health services) and affect particular individuals (such as women and children), entire communities, and people undergoing life cycle events (such as sickness, death of breadwinner, and old age)<sup>96</sup>

The framework is designed to contextualise interventions to enable a reduction of social and economic risks, and vulnerability of individuals and households. Social protection programmes are targeted to reach priority groups especially women, children and persons with disabilities exposed to key risks, shocks and shifting vulnerabilities. Whether aimed at promotion or prevention, social protection is always specifically targeted at key vulnerable groups, forming part of the poverty reduction process, and complementing broad based national development programmes.

The NASF will ensure that the HIV responses are well coordinated and harmonised within the context of social protection interventions. Gender and human rights will be mainstreamed to ensure maximum impact. Gender related interventions will be guided by the National Gender Policy and aligned to National Gender Plan of Action.

The NASF strategy is to improve the capacity of vulnerable households to cope with the impacts of HIV and AIDS. This will be achieved through a series of community based interventions. The key entry point will be to work with the MCDSS, local authorities and civil society organisations to empower vulnerable households with resources and skills that move them beyond welfare material and cash handouts to self reliance. Such strategies include some of the best practices such as the community revolving funds where the communities manage the resources themselves. The NASF supports the establishment and implementation of sustainable alternative livelihoods that have proved to be effective and largely depend on local resources.

Individual vulnerability is associated with lack of income, productive assets and/or a social support system<sup>97</sup>. Because more than 70% of Zambia's adult population earn a livelihood in the informal sector and are not eligible for health and social security benefits, most depend on support from relatives and friends during a crisis or period of non-productivity. Women are more represented in the informal sector than men, and consequently more affected by the lack of health benefits and a secure social security system after retirement. The most vulnerable individuals such as unsupported elderly persons and incapacitated people living with a disability and caring for PLHIV and/or OVC will be addressed in the context of social protection.<sup>98</sup>

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results.

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<sup>95</sup> Ministry of Finance and National Planning *Fifth National Development Plan 2006 – 2010*

<sup>96</sup> (*ibid*, p. 160.)

<sup>97</sup> World Bank *Zambia Poverty Vulnerability Assessment, 2005*

<sup>98</sup> Informal sector employment is defined by the Ministry of Labour and Social Security based on ILO standards as employment where employees are not entitled to paid leave, pension, gratuity and social security, and work in an establishment employing less than 5 persons. Central Statistical Office and Ministry of Labour and Social Security *Labour Force Survey Report 2005*



Outcome result	Output results
<p><b><u>Vulnerable Households and Food Security</u></b>  <b>[OC17]</b> <i>More people receive comprehensive and quality care at home and in the community.</i> Female and male aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41%<sup>99</sup> in 2009 to 50% in 2013 and 60% by 2015..</p>	<p><b>[OP44]</b> Households<sup>100</sup> with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015</p> <p><b>[OP45]</b> Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from 15% in 2007 to 25% in 2013 and to 50% in 2015.</p>

A reduction of household vulnerability will involve a combination of different strategies that are addressed in various sections of the NASF. For instance, preventing new infections will reduce the number of people who are subjected to stigma and discrimination, and that will influence their ability to sustain their livelihoods. Providing comprehensive treatment (ART), care and support will increase opportunities for people to live a dignified life and delay orphanhood, and vulnerability of children living with parents who are HIV positive. Finally, vulnerability reduction through enabling people infected and/or affected to cope with the social and economic impact of HIV and AIDS. This will be done through promotion of sustainable livelihoods, including household poverty reduction, increase in household income through income generating activities, access to productive resources, and social protection.

### Priority Strategies

The following priority interventions will be implemented:

- i. Support the identification and implementation of sustainable livelihoods
- ii. Promote equitable access to productive assets (land, equipment, credit and skills) by females and males in rural and urban settings to enhance sustainable livelihoods
- iii. Provide food and material support to incapacitated vulnerable households (e.g. because of physical or life-cycle status)
- iv. Promote small scale sustainable community or households agricultural projects that will improve household food security. Some of the livelihood initiatives would be more of income generating activities
- v. Prioritise food assistance to food insecure households with chronically ill adults and children
- vi. Provide social protection for females and males made vulnerable from the effects of HIV and AIDS
- vii. Review existing policies to incorporate operational guidelines that promote and support interventions that improve self reliance
- viii. Support the amendment of Zambia labour laws to include access to social, health and welfare benefits by informal sector workers

<sup>99</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>100</sup> Households will be disaggregated by type, Child, Female and or male headed, rural and urban

### 3.3.2 Orphans and Vulnerable Children

Increasingly, OVC have become the face of vulnerability. Strategies to address their needs must be multi-pronged as they experience multiple challenges. The NASF focuses on strategic needs of OVC such as protecting their human rights and ensuring access to adequate food, shelter, basic education and health care services, and providing an enabling environment to eliminate GBV.

A key strategy is to ensure that female and male OVC access and complete a programme of basic education (grades 1-9) in line with MOE policy. In order to attain the MDGs and Education For All (EFA) goals, Zambia is committed to making basic education compulsory, free and available to all.<sup>101</sup> Female students are encouraged to pursue higher education (high school and tertiary) through a quota system that allocates 30% of places to girls (Education and Skills Chapter, SNDP) to combat gender biases in higher education<sup>102</sup>.

To ensure that they are able to cope with the challenges of HIV, female and male in and out-of school OVC will be provided with life-skills based HIV education. Life skills will help them at the individual level to start positively addressing issues related to social and sexual abuse, exploitation, access to services and improvement of self-esteem.

Implementation of the social protection strategy will include collaboration with the Victim Support Unit of the Police Services and the Judiciary to protect male and female children from exploitation, sexual abuse and human trafficking. The Juvenile Act provides the legal framework for protection although implementation has been weak. Strengthening community systems to monitor child welfare practices and to establish systems to protect children from exploitation and sexual abuse will be priorities. The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results.

Outcome Result	Output Results
<p><b>Orphans and Vulnerable Children</b>  <b>[OC18]</b> More OVC receive free external basic support: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16%<sup>103</sup> in 2009 to 25% in 2013 and to 40% by 2015</p>	<p><b>[OP46]</b> A national framework for the protection, care and support of OVC developed</p>
	<p><b>[OP47]</b> Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%<sup>104</sup> in 2009 to 40% in 2013 and 60% by 2015</p>
	<p><b>[OP48]</b> Orphans and vulnerable children under age 18 years whose household had not received any basic external support to care for the child in the last 12 months has decreased from 84% in 2007, to 50% in 2013 and 25% by 2015</p>
	<p><b>[OP49]</b> OVC aged 5-17 possessing three minimum basic material needs<sup>105</sup> increased from 49%<sup>106</sup> in 2007 to 60% in 2013 and to 85% in 2015</p>
	<p><b>[OP50]</b> The ratio of OVC and non-OVC currently attending school is increased from 0.93<sup>107</sup> in 2009 to 1:1 in 2013 and remains that way by 2015.</p>

<sup>101</sup> MOE Chapter in the Sixth National Development Plan.

<sup>102</sup> Girls are more vulnerable to discontinuing formal educational programmes than boys as a result of early marriage and/or pregnancy, lack of support (financial, material, and psychosocial) to continue, and fear of sexual abuse by male students, teachers, or school administrators. Girls continue to drop out of school beyond Grade 4. Ministry of Education. *Educational Statistical Bulletin Enrolment in all Schools by Gender and Year*, 2006

<sup>103</sup> Zambia Demographic and Health Survey 2007

<sup>104</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>105</sup> These needs are defined as a pair of shoes, two sets of clothing and a blanket.

<sup>106</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

## Priority Strategies

The following strategies will be implemented:

- i. Support the implementation of the National Plan of Action for Children, in particular interventions for OVC
- ii. Provide education, psychosocial and material support nutrition, and shelter, and a caregiver to in and out-of-school female and male OVC
- iii. Implement the provision related to OVC in the CRC
- iv. Scale-up and strengthen systems for eliminating gender-based violence, including sexual abuse in formal and informal educational and community settings
- v. Build capacity of community care providers
- vi. Strengthen integration OVC and home-based care services
- vii. Promote and support community-based care of OVCs and families looking after them
- viii. Sensitise and support community leaders to promote post-basic education for girls

### 3.4 National Response Coordination and Management

#### Overview

Zambia has functional coordination and management structures at national, provincial and district levels. The Government of Zambia has demonstrated a strong political commitment for coordination of the multi-sectoral response as evidenced by the political and financial support provided to the National AIDS Council and the mainstreaming of HIV and AIDS in the Sixth National Development Plan in addition to the establishment and funding of HIV and AIDS mainstreaming in the public sector.

The focus for NASF is to improve coordination mechanisms by strengthening institutional capacities, and the policy and legal environment necessary for effective implementation of the national multi-sectoral HIV and AIDS response. By improving coordination and management of the response, the gaps between supply and demand for HIV services will be narrowed, duplication of efforts will be minimised, rational use of resources will improve and equitable distribution of resources and services will be realised. This process dictates the need to form strategic partnerships and alliances with stakeholders including civil society organisations, private sector, development partners, local authorities and communities. It is through improved coordination and monitoring that quality and comprehensiveness of services, accountability, harmonisation and alignment can be achieved.

Mainstreaming of HIV and gender will be given priority in order to expand the scope of the national response. Mainstreaming will focus on development and implementation of HIV and AIDS workplace programmes as part of the internal response, and external mainstreaming in the sector's development programme. The NASF will strengthen this component based on the implementation of the "HIV and AIDS Strategy for the Public Sector 2010-2015". Having mainstreamed gender and human rights in the NASF, advocacy will be carried out to ensure compliance and adherence of the tenets and making sure that all people have equal access and will utilise services without stigmatisation or discrimination. The NASF supports the review and amendments of punitive laws and policies that marginalise key populations and vulnerable groups including women, and people with disabilities.

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<sup>107</sup> Zambia UNGASS Report 2010

Successful implementation of the NASF will, to a large extent, depend on the quality and quantity of human resources, systems and the use of evidence to make informed choices and decision. Capacity development is a core strategy for the NASF.

### 3.4.1 Enabling Policy and Legal Environment

An enabling policy and legal environment is central to the promotion of a rights-based approach to HIV and AIDS, and provides a framework that promotes rights in a manner that reduces vulnerability to infection, mitigates the impact of HIV and AIDS, and empowers communities to respond appropriately. The NASF will focus on strengthening the enabling policy and legal environment through advocacy and dialogue targeting the critical obstacles that prevent people from enjoying their rights in a HIV and AIDS environment.

It is anticipated that an improved environment will increase the utilisation of services, reduce stigma and discrimination associated with HIV and AIDS, remove barriers that sustain marginalisation of most at risk populations, and address gender inequalities. Stigma and discrimination remain key obstacles in the national response. The NASF advocates for the implementation of the provisions of the UN Convention of the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The conventions emphasize the basic human rights especially for vulnerable groups including OVC, women and girls and to some extent to PLHIV and sex workers among others. The NASF will also be guided by the International Guidelines on HIV and Human Rights.

Key activities to reinforce the awareness of people's rights will include education and awareness programmes that include age-appropriate information on HIV, life skills, reproductive health, gender equality, non-violence against women and girls, HIV-related tolerance and non-discrimination, and empowers children against exploitation.<sup>108</sup> The awareness of people's rights such as health, education, freedom of expression, security and privacy, support and protection against sexual and economic exploitation, and discrimination are necessary in order to empower duty bearers and rights holders. Increased awareness of individual and collective human rights increases the ability of vulnerable groups to protect themselves from potential risk to HIV infection.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results.

Outcome Result	Output Results
<p><b>Enabling Policy and Legal Environment</b>  <b>[OC19]</b> <i>The enabling policy and legal environment is improved:</i> Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened</p>	<p><b>[OP51] Social and legal protection of vulnerable people and most at risk populations is strengthened:</b> % of national policies and legal instruments reviewed and incorporated human and legal rights.</p> <p><b>[OP52] Reduction stigma and discrimination:</b> Female and Male aged 15-49 expressing accepting attitudes towards people living with HIV and AIDS increased from 34%<sup>109</sup> in 2009 to 45% by 2013 and by 60% by 2015</p>

### Priority Strategies

The following priority strategies will be implemented

<sup>108</sup> UN AIDS Briefing Note: HIV and Children's Rights

<sup>109</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

- i. Advocate for the review of existing policies and laws to mainstream HIV and AIDS in the context of human rights
- ii. Create public awareness of issues related to stigma and discrimination, and legal barriers that prevent most at risk populations accessing and utilising services adequately
- iii. Develop the capacity of civil society to monitor the legal environment
- iv. Advocate for the implementation of the CRC, CEDAW and International Guidelines on HIV and Human Rights
- v. Ensure human rights are adequately addressed to reduce stigma and discrimination, and to promote the dignity of PLHIV and MARPS
- vi. Address gender inequality, gender based violence and exploitation of women and the girl child.

### **3.4.2 Decentralisation, Coordination and Management**

Coordination of the national multi-sectoral response takes place at four levels i.e. national, provincial, district and community level. Coordinating structures are multi-sectoral in nature and draw representation from government, civil society organisation, development partners and private sector.

#### **Decentralisation**

Decentralisation is an integral element in Zambia's national development strategy as expressed in the Public Service Reform Programme (PSRP) launched in November 1993. The goal of the PSRP is "to improve the quality, delivery, efficiency and cost-effectiveness of public services."<sup>110</sup> In this regard decentralisation is a tool for transferring responsibilities, authority, functions, power and appropriate resources to provincial, district and sub-district levels. The Decentralisation Policy of 2002 provides for the devolution of decision-making and selective service delivery responsibilities to districts. The Decentralisation Implementation Plan 2009-2013 provides a road map on how this is to be achieved.

In line with the SNDP and the Decentralisation Implementation Plan (DIP), the national response to HIV and AIDS will be coordinated and managed through administrative structures at national and sub-national levels and by various actors/institutions. NAC decentralised structures consist of Provincial, District and Community AIDS Task Forces (PATFs, DATFs, and CATFs). Their primary function is to systematically build the capacity of the various administrative levels to manage and sustain a comprehensive response to the AIDS epidemic. The Provincial and District AIDS Task Forces are assisted by Provincial and District AIDS Coordinators in line with Circular No. 1 of 1995 on decentralisation of government services. The Task Forces exist as sub-committees of the Provincial and District Development Coordinating Committees that coordinate popular participation in the overall development process at each administrative level.

Among the line government ministries, the Ministry of Health was a pioneer in decentralising<sup>111</sup> services to the districts. Most health sector HIV and AIDS prevention, treatment care and support services have been devolved to the districts. Other line ministries that have decentralised programmes along with MOH are Agriculture, Education, and Home Affairs. The DIP will extend this to nearly all government ministries over a four year period.

<sup>110</sup> Decentralisation Implementation Plan, Decentralisation Secretariat, Ministry of Local Government and Housing, December 2009

<sup>111</sup> The form of decentralisation is de-concentration, which is the transfer of administrative responsibilities from the central government to local governments. Zambia is moving towards devolution of power, which involves a more substantial transfer of power and authority to local government. Autonomous decision-making, financial and legal powers will become available to Councils and Local Authorities.

The private sector's HIV and AIDS programmes are largely implemented in collaboration with CSOs through contracts and memoranda of understanding. Ability to decentralise programmes is dependent on such agreements. CSOs have decentralised operations to varying degrees dependent on size, institutional arrangement, and scope of operations. Faith-based organisations have been in the forefront of devolving power, authority and resources to community level<sup>112</sup> but have been less successful in coordinating their HIV and AIDS interventions with Councils and Local Authorities.

### **Coordination and Management**

The National HIV/AIDS/STI/TB Policy (2002) provides policy guidelines that inform the functions of these coordinating structures while the NASF provides technical guidelines on the planning and implementation of the national response. The NOP 2011-2115 serves as the primary tool for the NASF implementation.

The Cabinet Committee of Ministers on HIV and AIDS (established in 2000) is the highest policy making body on matters related to HIV and AIDS. The committee works closely with MOH and NAC to provide policy direction, supervision and monitoring of the response. The NAC has the primary mandate for coordinating the multi-sectoral response. The MOH is charged with the responsibility of coordinating the health sector response in collaboration with the NAC. The Minister of Health chairs the Cabinet Committee on HIV and AIDS and the Minister represents NAC in Parliament. NAC is a semi-autonomous statutory body that operates under the auspices of the Ministry of Health. The Cabinet Committee appoints its Board Chairperson and supervises Council activities. The MOH's Permanent Secretary is the Controlling Officer for NAC's income and expenditures,

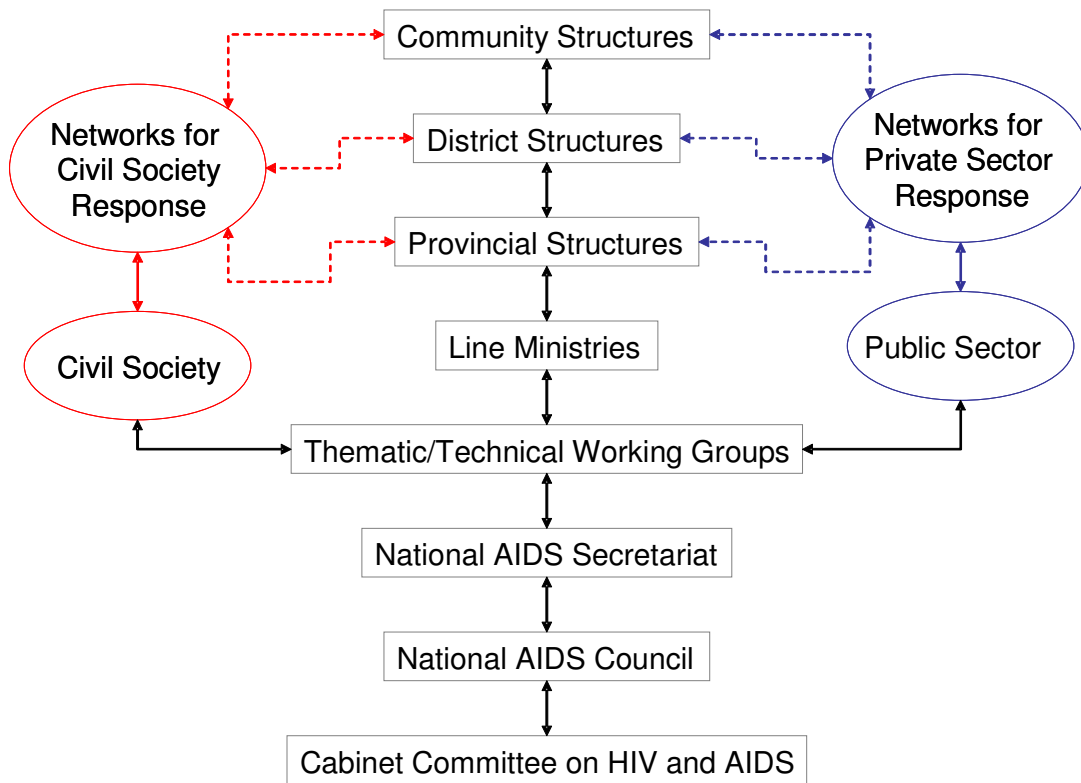
Under the 2006-2010 NASF, six theme groups were established: namely, Prevention; Treatment, Care and Support; Impact Mitigation; Decentralisation and Mainstreaming; Monitoring and Evaluation; and Advocacy and Coordination. Theme groups provide technical advice to the Council and implementing partners. The formation of the Theme Groups is based on the scope and nature of the NASF. The membership is multi-sectoral.

Coordination of the national multi-sectoral response takes place at four levels i.e. national, provincial, district and community level. At each level coordinating structures are multi-sectoral in nature and draw representation from government, civil society organisations, development partners and the private sector. See Diagram 2 for an illustration of their relationship to NAC. The structures are semi-autonomous and self-managing platforms that interact with NAC to represent their constituencies' interests and activities in implementing the national response. Examples of such constituency groups include public service employees, PLHIV, youth, people with disabilities, women's groups, and community-based interest groups.

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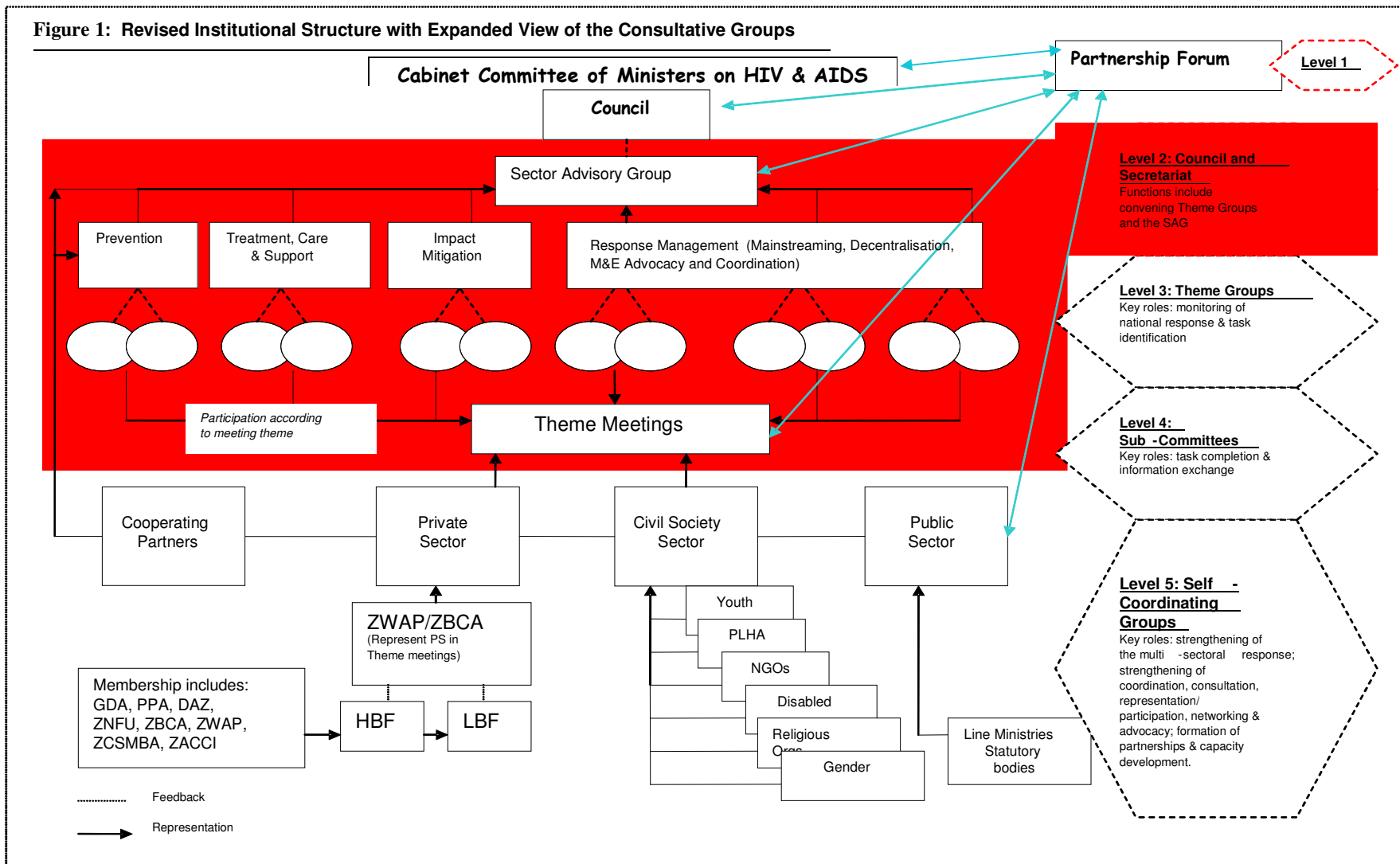
<sup>112</sup> *Decentralisation* by Dr. Michael Chanda, a consultancy report commissioned by the National HIV/AIDS/STI/TB Council, 2010

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





**Figure 1: Revised Institutional Structure with Expanded View of the Consultative Groups**



## **Coordination of the Public Sector**

The Public Service is defined as ‘the civil service, the teaching service, and the Zambia Police and Prison Services, and any other service duly established under the Constitution of Zambia or under an Act of Parliament.’<sup>113</sup> Management and coordination of the Public Sector HIV and AIDS response is the responsibility of the Public Service Management Division (PSMD) in Cabinet Office. PSMD has developed a strategic framework for the period 2010-2015 based on the National HIV and AIDS Strategic Framework 2006-2010. The *HIV and AIDS Strategy for the Public Service (2010-2015)* is designed to guide and support the national response and provide an engendered regulatory framework to all HIV and AIDS workplace interventions within the Public Service. The goal of the strategy for the Public Service is to manage and mitigate the effects of the epidemic on service delivery and all other functions through effective workplace policies, plans, and programmes.

Linked to the strategy is a monitoring, evaluation and reporting system that is harmonised with the National HIV/AIDS/STI/TB Monitoring and Evaluation Plan 2006-2010. The indicators and reporting formats are aligned to the indicators and reporting format in the National M&E Plan.

## **Coordination of Civil Society Organisations and Private Sector**

Civil Society Organisations comprise NGOs, FBOs, CBOs, the media, labour unions, and in some context the private sector. CSOs have demonstrated an important role in extending services to hard to reach or underserved communities, developing innovative or best practice responses, facilitating community consultation, advocacy and policy dialogue, as well as capacity-building and information/skills exchange. CSOs have the comparative advantage of working directly with individuals, groups, and communities to promote prevention, behaviour change, communication, treatment adherence, home-based care and support to PLHIV and OVC. In Zambia, around 75% of CSOs working on HIV and AIDS are local organisations (CBOs and NGOs) and 22% have religious affiliation.

Most CSOs are coordinated through at least two mechanisms: their own special interest umbrella organisations which focus on their core mandate (e.g. health, community development, religion, children and social protection, and support groups for PLHIV) and the HIV and AIDS self-regulating platform. HIV is mainstreamed into the core mandate through organisation-based strategic plans that are linked to the NASF. Using National M&E indicators, DATFs collect information on CSO activities throughout the country.

The private sector HIV response is dominated by the formal sector although it also encompasses the informal sector where the majority of Zambians are employed. Private sector coordination works similarly to CSOs. Formal sector companies are represented by umbrella organisations such as the Zambia Federation of Employees and Zambia Business Coalition on HIV and AIDS who represent the sector in a self-regulating platform. Given the informal sector has not been systematically mainstreamed into the national HIV and AIDS multi-sectoral response, the NASF is aligned with the Zambia Decent Work Country Programme.

Given the nature and scope of the informal sector in Zambia, HIV vulnerability is considered higher than in the formal sector. Thus, there is urgent need to address HIV and AIDS in informal sector populations.

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<sup>113</sup> *HIV and AIDS Strategy for the Public Service 2010-2015*, Public Service Management Division, 2010

Companies have their own HIV policies and workplace programmes. In addition, multinational companies such as Illovo Sugar Limited (Zambia Sugar Company), the Coca Cola Bottling Company, South Africa Breweries/Zambia, and First Quantum Mining Company have international health and well-being policies and programmes that incorporate the local response. Private sector companies, also, are expected to monitor and assess interventions based on national indicators, and submit reports to the Monitoring and Evaluation Unit of NAC.

### Coordination of Development Partners

Development partners primarily consist of bilateral and multi-lateral partners although international NGOs sometimes participate in both civil society and development partner forums. Development partner coordination is facilitated through the Partnership Forum, Cooperating Partners platform, and the Joint United Nations Programme on HIV and AIDS. The UN system develops a strategic framework based on the NASF and each member uses its comparative advantage to support implementation of priority strategies.

Development partners will support the implementation of the NASF on the basis of the Joint Assistance Strategy for Zambia (JASZ) which represents the mutual commitment of the government and partners. JASZ has attempted to harmonise and align donor funding mechanisms and reporting with NAC systems.

The USG Partnership Framework with the Government of Zambia is fully aligned with the SNDP and the NASF 2011-2015. The Partnership Framework results are intended to contribute to the NASF results. The development of the Partnership Framework was participatory and involved key stakeholders including the NAC. The GRZ/USG Partnership Framework will greatly improve sector coordination, alignment and harmonisation.

Effective coordination and management of the response will contribute to the achievement of the following outcome and output results.

<b>Outcome Result</b>	<b>Output Result</b>
<p><b>Coordination and Management:</b>  <b>[OC20]</b> Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework</p>	<p><b>[OP53]</b> National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response.</p>

### Priority Strategies

The following strategies will be implemented

- i. Strengthen the capacity of NAC to provide effective leadership of the national response
- ii. Strengthen the capacity of other national and sub-national coordination institutional and legal framework for coordination
- iii. Develop institutional capacity to advocate for effective right based policy implementation
- iv. Strengthen the use of evidence in advocacy and application of data in policy development

### 3.4.3 HIV and AIDS, Gender and Human Rights Mainstreaming<sup>114</sup>

As a SNDP cross-cutting issue, HIV and AIDS will be mainstreamed into sector programmes to ensure the comprehensive inclusion of key populations, gender, environmental concerns and issues of human rights across Zambia's development agenda. Both external and internal mainstreaming will be pursued. The six drivers of the epidemic will be mainstreamed into the core mandates of each sector.

External mainstreaming focuses on aligning HIV and AIDS to the core mandate (for example education, policies and strategies of the sector or organisation). This means that HIV and AIDS is integrated into all corporate functions ranging from human resources, finance, policies, field operations, to development project planning and implementation. Internal mainstreaming refers to policy and programmes to prevent and respond to the threat of HIV and AIDS on the human resource base of the organisation. Workplace programmes is the most common form of internal mainstreaming.

Mainstreaming the HIV and AIDS response in corporate functions helps organisations minimise the threats posed by the epidemic so that they achieve their goals. The process further helps organisations to ensure that sector practices do not exacerbate the epidemic. Successful mainstreaming of HIV and AIDS depends on how individual sectors and institutions perceive, analyse and address the following issues:

- The HIV and AIDS risk factor to the organization and in particular how the epidemic is likely to affect the goals, objectives and programmes of the organization or sector
- How sector development programmes contribute to the spread of HIV
- Being able to identify sector or institutional comparative advantage in responding to the causes and effects of HIV and AIDS

In addressing these issues, the NASF advocates for a systematic approach to mainstreaming based on the International Labour Organisation (ILO) and national guidelines for mainstreaming. Each sector or organisation is expected to carry out a comprehensive gender analysis given the gender bias of the epidemic and the need to understand some of the gender based epidemic drivers. Unless gender dimensions are adequately addressed through specific and targeted interventions, the implementation of NASF or the sector operational plans will be compromised.

Table 4, below provides a stepwise guide for developing HIV and AIDS mainstreaming programmes.

**Table 4:** Steps in mainstreaming HIV and AIDS

<b>Step</b>	<b>Description of the step</b>
<b>Step 1:</b>	Development of a sectoral or institutional HIV and AIDS Goal and commitment. These are usually policy statements that are backed up with leadership commitment.
<b>Step 2:</b>	Prepare a HIV and AIDS profile of the sector or organisation.
<b>Step 3:</b>	Develop a plan for mainstreaming HIV and AIDS, and gender into the core business / mandate, policies and operations of the institution
<b>Step 4:</b>	Cost and allocate resources to support the plan developed in step 3
<b>Step 5:</b>	Implement and document experiences, progress and challenges encountered during implementation
<b>Step 6:</b>	Monitor and evaluate HIV and AIDS mainstreamed plan

<sup>114</sup> SADC is promoting the concept of simultaneous mainstreaming and appropriate results and indicators are being developed.

For public institutions these steps should be implemented as part of the HIV and AIDS Strategy for the Public service 2010-2015 plan.

### **HIV and Gender Mainstreaming**

Given the importance of gender dimensions in the national HIV and AIDS response, the NASF includes gender mainstreaming aligned to the National Plan of Action for Gender and HIV and AIDS. Alignment will accelerate the process of addressing gender inequalities associated with HIV and AIDS, in addition to dealing with gender-based drivers of the epidemic. Through the gender policy and the action plan, other policy and legal instruments to improve women's status will be addressed.

Mainstreaming HIV and AIDS and gender will take place in both internal and external domains. The core focus of the internal response is to reduce vulnerability of the sector or organisation, particularly employees, to the impacts of HIV and AIDS. Such programmes mainly focus on prevention of new HIV infections, treatment, care and support to the infected, and impact mitigation.

The NASF strategy for sustaining gender sensitive planning and implementation is to ensure adequate political leadership and commitment, funding, policies and legislation. From the mainstreaming perspective, the NASF focuses on firmly anchoring gender and HIV and AIDS issues in development projects and workplace programmes.

Although the epidemic has permeated throughout the Zambian society, more women than men are living with HIV and AIDS indicating a gender bias of the epidemic. Available evidence shows that biological, socio-economic and social norms contribute to their vulnerability. Some of the existing policies, legislation, society practices and gender inequalities contribute to the vulnerability of women to HIV and AIDS.

In developing the NASF, Zambia has taken a gender based approach to understanding the gender dimensions of HIV and AIDS from the perspective of planning, programming and monitoring and evaluation, in order to ensure a sustained gender sensitive HIV and AIDS response. Such a response requires concerted and far-reaching action to challenge and change harmful gender norms and inequality between women and men, as well as focused action to make community environments safe for women and girls. Implementation of the Sixth National Development Plan with its emphasis on infrastructure development has the potential for increasing risk and vulnerability to HIV as well as promoting development, particularly for women and girls in peripheral areas of the country. Opening isolated areas up to interregional transportation, commerce and trade will increase interaction between urban populations where HIV prevalence is higher and rural communities where prevalence is lower. Interventions outlined in the NASF address these issues with gender responsive activities implemented by various multi-sectoral partners.

Capacity will be strengthened for services providers for gender analysis, planning, budgeting, mainstreaming gender in service delivery, tracking of gender and HIV and AIDS related human rights for monitoring performance.

## Mainstreaming Human Rights

Zambia recognises that HIV and AIDS is a health, development and human rights issue. In that context the NASF has used the human rights approach to design strategies that will ensure protection of the basic human rights relevant to HIV and AIDS for PLHIV and those affected by the epidemic. These strategies will empower the target groups to claim their rights, to protect their dignity, and prevent transmission of HIV. In particular, the NASF promotes the Code of HIV and AIDS and Human Rights to strongly advocate to eliminate stigma and discrimination associated with HIV and AIDS, promote the right to privacy (protecting people from mandatory testing, confidentiality of information), the right to education and information, and access to services.

The NASF seeks to strengthen the capacity of service providers to fulfil their obligations and the capacity of health clients to claim their rights to quality health care services. The approach strengthens the articulation of desirable outcomes and processes (participatory, non-discriminatory, inclusive, transparent and accountable) to reach such outcomes without compromising basic rights. Existing policies and legislation will need to be reviewed to effectively mainstream HIV and AIDS including appropriate basic rights.

The implementation of the strategies outlined below will contribute to the achievement of the following outcome and output results

Outcome result	Output results
<b><u>HIV and AIDS, Gender and Human Rights Mainstreaming</u></b> <b>[OC21]</b> Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015	<b>[OP54]</b> 75% of sectors and private sector institutions by 2013 and 100% by 2015 have reviewed their policies and programmes, and mainstreamed HIV and AIDS, gender and human rights in their internal (HIV workplace) and external (development) programmes
	<b>[OP55]</b> Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015
	<b>[OP56]</b> Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 2015.
	<b>[OP57]</b> Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015 <sup>115</sup>
	<b>[OP58]</b> The national action plan on gender and HIV is fully implemented, monitored and periodically reviewed

### Priority Strategies for HIV, Gender and Human Rights Mainstreaming

- i. Strengthen sector capacity for mainstreaming HIV, gender and human rights into capital projects
- ii. Support implementation of the National Gender Plan of Action on HIV and AIDS
- iii. Establish a national Gender and HIV Coordination mechanism
- iv. Support the integration of HIV with gender into environmental impact assessments to examine the differential impact of development initiatives on HIV and gender relations with a particular focus on the status and situation of women and girls
- v. Strengthen the capacity of sectors to develop and monitor gender and human rights budgeting in HIV and AIDS plans

<sup>115</sup> The baseline and the targets are set out in the 6<sup>th</sup> NDP Chapter paper,

- vi. Collaborate with GIDD to support inter-governmental and inter-ministerial partnerships on GBV prevention, management and care
- vii. Support access to basic education and adult literacy programmes through interventions that tackle harmful cultural norms and values, stigma and discrimination and other social barriers, particularly for women and girls
- viii. Promote the greater involvement of people living with HIV, including women, young people and marginalised groups, in planning, programming, budgeting and service delivery
- ix. Review reporting and accountability frameworks to integrate gender and HIV-related obligations
- x. Develop quantitative and qualitative indicators to assess the impact of gender-specific interventions and gender mainstreaming in national HIV and AIDS, and development strategies
- xi. Support the engendering of decentralised HIV monitoring and evaluation systems to ensure that data is disaggregated to allow gender analysis
- xii. Advocate for the implementation of national and international declarations on HIV , gender, and development such as the MDGs and SADC conventions

#### **3.4.4 Capacity Development and Systems Strengthening**

The implementation of the NASF depends on the availability of adequate human, financial and technical resources at all levels. Although some capacity does exist in Zambia, it is not sufficient to meet the need for the national multi-sectoral response. The NASF suggests the development of a national capacity development programme within the context of health systems strengthening, community systems strengthening and developing the capacity of civil society organisations.

With regard to human resources the focus will be improving existing skills and competences, ensuring the adequacy of human resources and developing a retention strategy to avoid loss of skilled and experienced personnel. In the context of organisation development, capacity development will focus on operational service delivery systems, financial management systems, governance and leadership and the use of appropriate technology will strengthened.

In the context of a global economic down turn this aspect of the NASF is critical. As more resources become available the capacity to monitor and track resources becomes a pre-requisite for development. This is in addition to strengthening capacities for resource mobilisation, disbursement, and accountability

##### **Health Systems Strengthening:**

The health system is weakened by a number of organizational challenges including vertical systems that result in uneven quality of care, fragmentation and sometimes duplication of service. In some cases health facility-based systems are inadequate to meet the needs of communities and households around them. Issues of governance and leadership have compromised service delivery especially outside of health facilities. Collaboration between public and private sector health systems remains weak and largely uncoordinated. The Government of Zambia has taken bold steps to strengthen its health system and cascading provision of quality health services in line with the National Decentralisation Policy. The NASF further consolidates these efforts and explores other areas that require systems strengthening.

##### **Community Systems Strengthening:**

Most HIV and AIDS interventions take place at the community level and involve communities primarily as beneficiaries rather than strategic partners. This approach has not been sustainable and lacks community ownership. Given the burden of care and support, and diminishing livelihoods, communities are organising themselves to find community based solutions and implement strategies that are appropriate for them.



Meaningful community engagement and participation in HIV and AIDS are critical to the success and sustainability of interventions. It is on this premise that NASF supports community systems strengthening the focus on critical areas ranging from leadership and governance, community organisation, resource mobilisation, management and conflict resolutions to developing community skills in advocacy, monitoring and resource management. Community systems will be strengthened to ensure adequate, equitable and sustained provision of services. Strengthening of community systems will take cognisance of the need to support alternative sustainable livelihoods that largely depend on locally available resources.

**Strengthening the capacity of civil society organisations:**

Civil society organisations are key players in service delivery at the community level and in advocacy work at the national level. Available evidence indicates that their involvement in the national response has greatly improved service delivery and increased access especially for difficult to reach populations. However, their potential has been compromised by inadequate technical and in some cases, management skills, and inadequate human and financial resources. Capacity development will be necessary if these organisations are expected to realise their potential and contribute meaningfully towards the implementation of the NASF. National level umbrella organisations or other coordinating structures will require capacity development in the following areas:

- i. Policy analysis and formulation
- ii. Evidence and results based planning and programming
- iii. Financial planning and management
- iv. Human resource capacity development
- v. Advocacy and networking

Community based organisations will be accommodated within broad community systems strengthening.

Outcome result	Output result
<p><b>Capacity Development and Systems Strengthening</b>  <b>[OC22]</b> Stakeholders capacity to implement NASF strengthened by 2013 and remains the same by 2015</p>	<p><b>[OP59]</b> 75% of HIV and AIDS implementing partners capacity developed / strengthened in the areas of programme planning, resource mobilisation, service delivery, community mobilisation, monitoring, evaluation and reporting by 2015</p>
	<p><b>[OP60]</b> Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013</p>
	<p><b>[OP61]</b> Community systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013</p>
	<p><b>[OP62]</b> Local Authorities' have good governance and leadership of HIV and AIDS programmes at district level by 2013</p>
	<p><b>[OP63]</b> Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes increased from 20 in 2009 to 73 by 2013 and remain at that level by 2015</p>

**Priority strategies:**

- i. Conduct a comprehensive capacity assessment
- ii. Develop a framework for capacity development
- iii. Conduct Organisation Capacity and Assessment (OCA) and mentorship programme
- iv. Roll-out Community Capacity Enhancement (CCE) through Community Conversations Approach in all districts

- v. Integrate key issues and actors in the roll-out of Local Authorities' Good Governance and leadership training in all districts. This is necessary to provide the required leadership in HIV and AIDS programmes
- vi. Strengthen institutional technological and information capacity necessary for the implementation or the national response.
- vii. Establish a public, private partnership framework necessary for scaling universal access to HIV and AIDS services
- viii. Develop a human resources retention strategy
- ix. Advocate for the establishment of a civil society budget earmarked for HIV and AIDS response.
- x. Strengthen the capacity of civil society organisation to play key in the management of GFATM funding

### 3.4.5 Resource Mobilisation and Management

#### 3.4.5.1 Resource Mobilisation

At the core of any national response is the mobilization of financial resources. A twin pronged approach will be administered to mobilize resources. The first being advocacy work to increase the level of domestic funding and second to encourage cooperating partners to at least maintain their current funding levels and increase their contributions so as to facilitate the scale up of HIV and AIDS activities. Cooperating partners will support the implementation of the NASF based on the Joint Assistance Strategy for Zambia (JASZ), which represent the mutual commitment of the Government and its partners. Funding from the USA Government, which is the major partner, will be managed through multiple channels including PEPFAR, CDC and USAID. In the context of PEPFAR, a Partnership Framework has been signed between the Government of Zambia and USG. Additional funding will be mobilised from other development partners including the Global Fund. Several of the cooperating partners have entered into the Joint Financing Agreement with NAC.

To provide the basis for these considerations, the NASF will be costed at two levels. Level one will focus on the resource needs based on the NASF macro-projections. The second level will be activity based costing using the National Operational Plan. The table below provides an estimation of the resource needs for the implementation of NASF 2011 - 2015.

**Table 5:** NASF Resource Estimates for the period 2011 – 2015

Thematic area	2011	2012	2013	2014	2015	Total	%
Prevention	107,218,800	115,260,210	123,904,726	133,197,580	143,187,399	<b>622,768,715</b>	26%
Treatment, Care and Support	164,952,000	77,323,400	190,622,655	204,919,354	220,288,306	<b>958,105,715</b>	40%
Impact Mitigation	94,847,400	101,960,955	109,608,027	117,828,629	126,665,776	<b>550,910,786</b>	23%
Coordination & Management	45,361,800	48,763,935	52,421,230	56,352,822	60,579,284	<b>263,479,072</b>	11%
<b>Total</b>	<b>412,380,000</b>	<b>443,308,500</b>	<b>476,556,638</b>	<b>512,298,385</b>	<b>550,720,764</b>	<b>2,395,264,287</b>	<b>100%</b>

In order to establish the actual resource needs, comprehensive resource mapping will be conducted annually to establish how much funding is available and the financial gap that will require additional

resource mobilisation. The table below presents the estimates of resource available by donor/cooperating partner and by year funds are committed.

**Table 6:** Resource Mapping -Estimated resources for the NASF 2011 – 2015 in US\$ and source

<b>Funding area</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2011-2015</b>
UN	9,235,320	9,235,320	9,235,320	9,235,320	9,235,320	46,176,600
JICA	1,173,697	1,173,697	1,173,697	1,173,697	1,173,697	5,868,486
USG <sup>116</sup>	189,259,972	189,259,972	189,259,972	189,259,972	189,259,972	946,299,858
NORAD	1,103,400	1,103,400	1,103,400	1,103,400	1,103,400	5,517,000
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
Danish (Zambia HIV/AIDS)	2,388,333	2,388,333	2,388,333	2,388,333	2,388,333	11,941,667
SIDA	3,933,333	3,933,333	3,933,333	3,933,333	3,933,333	19,666,665
DFID	1,444,750	1,444,750	1,444,750	1,444,750	1,444,750	7,223,750
EU	4,033,633	4,033,633	4,033,633	4,033,633	4,033,633	20,168,165
International NGOs	1,185,800	1,185,800	1,185,800	1,185,800	1,185,800	5,929,000
UNITAID / CHAI	2,000,000	0	0	0	0	2,000,000
GRZ-MOH	6,433,182	7,076,500	7,784,150	8,562,565	9,418,821	39,275,217
MOH-SWAPs	2,279,783	2,279,783	2,279,783	2,279,783	2,279,783	11,398,914
GRZ- Line Ministries	393,644	433,009	476,310	523,941	576,335	2,403,238
<b>Total</b>	<b>229,826,216</b>	<b>228,508,899</b>	<b>229,259,850</b>	<b>230,085,896</b>	<b>230,994,546</b>	<b>1,148,675,405</b>
GFATM –R8	34,918,830	35,722,800	35,331,254			105,972,884
GFATM – R10	11,338,683	40,925,526	47,795,757	54,880,793	62,907,469	217,848,228
Others	66,262,843	66,262,843	66,262,843	66,262,843	66,262,843	331,314,214
<b>GFATM Total</b>	<b>112,520,356</b>	<b>142,911,169</b>	<b>149,389,854</b>	<b>121,143,636</b>	<b>129,170,312</b>	<b>655,135,327</b>
<b>Grand total</b>	<b>342,346,571</b>	<b>371,420,068</b>	<b>378,649,703</b>	<b>351,229,532</b>	<b>360,164,858</b>	<b>1,803,810,732</b>

The table below 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. Table 10 is being used to establish the financial gap based on the estimated resource need and available resources.

<sup>116</sup> According to the 2005-2006 NASA we apply a 70% to the USG budget allocated to Zambia

**Table 7:** NASF overall resource needs gap analysis

<b>Focus</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2011-2015</b>
1. Resource needs (annual)	412,380,000	443,308,500	476,556,638	512,298,385	550,720,764	2,395,264,287
2. Estimated Funding	342,346,571	371,420,068	378,649,703	351,229,532	360,164,858	1,803,810,732
3. Financial Gap for NASF [1-2=resource gap]	70,033,429	71,888,432	97,906,935	161,068,853	190,555,906	591,453,555

### 3.4.5.2 Resource Allocation

The NASF 2011-2015 represents the broad priority areas for which available resources need to be mobilised and then allocated. The table below establishes the financial need by thematic area, identifies the funding allocated to the thematic area and financial gap. This is a necessary tool for establishing whether financial allocations are aligned to national priorities and results.

**Table 8:** Resource allocation in comparison to resource needs and resource gap by thematic areas

		<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2011-2015</b>
<b>Available Funding Estimates</b>		342,346,571	371,420,068	378,649,703	351,229,532	360,164,858	1,803,810,732
<b>Prevention (26%)</b>	Resource need	107,218,800	115,260,210	123,904,726	133,197,580	143,187,399	622,768,715
	Allocation	<b>89,010,108</b>	<b>96,569,218</b>	<b>98,448,923</b>	<b>91,319,678</b>	<b>93,642,863</b>	<b>468,990,790</b>
	Gap	<b>18,208,692</b>	<b>18,690,992</b>	<b>25,455,803</b>	<b>41,877,902</b>	<b>49,544,536</b>	<b>153,777,925</b>
<b>Treatment Care and Support (40%)</b>	Resource need	164,952,000	177,323,400	190,622,655	204,919,354	220,288,306	958,105,715
	Allocation	<b>136,938,628</b>	<b>148,568,027</b>	<b>151,459,881</b>	<b>140,491,813</b>	<b>144,065,943</b>	<b>721,524,293</b>
	Gap	<b>28,013,372</b>	<b>28,755,373</b>	<b>39,162,774</b>	<b>64,427,541</b>	<b>76,222,363</b>	<b>236,581,422</b>
<b>Impact Mitigation (23%)</b>	Resource need	94,847,400	101,960,955	109,608,027	117,828,629	126,665,776	550,910,786
	Allocation	<b>78,739,711</b>	<b>85,426,616</b>	<b>87,089,432</b>	<b>80,782,792</b>	<b>82,837,917</b>	<b>414,876,468</b>
	Gap	<b>16,107,689</b>	<b>16,534,339</b>	<b>22,518,595</b>	<b>37,045,837</b>	<b>43,827,859</b>	<b>136,034,318</b>
<b>Response Management (11%)</b>	Resource need	45,361,800	48,763,935	52,421,230	56,352,822	60,579,284	263,479,072
	Allocation	<b>37,658,123</b>	<b>40,856,207</b>	<b>41,651,467</b>	<b>38,635,249</b>	<b>39,618,134</b>	<b>198,419,181</b>
	Gap	<b>7,703,677</b>	<b>7,907,728</b>	<b>10,769,763</b>	<b>17,717,573</b>	<b>20,961,150</b>	<b>65,059,891</b>
<b>Annual Resource GAP</b>		<b>70,033,429</b>	<b>71,888,432</b>	<b>97,906,935</b>	<b>161,068,853</b>	<b>190,555,907</b>	<b>591,453,556</b>

**Table 9:** Resource requirement by category of the NASF service providers in US\$ (80% scale up)

Analysis	% Allocation	2011	2012	2013	2014	2015	2011 - 2015
<b>National Scale - up Activities</b>	<b>48%</b>	197,942,400	212,788,080	228,747,186	245,903,225	264,345,967	<b>1,149,726,858</b>
<b>All districts and provinces</b>	<b>22%</b>	90,723,600	97,527,870	104,842,460	112,705,645	121,158,568	<b>526,958,143</b>
<b>Line Ministries</b>	<b>10%</b>	41,238,000	44,330,850	47,655,664	51,229,839	55,072,076	<b>239,526,429</b>
<b>Civil Society Organisations</b>	<b>10%</b>	41,238,000	44,330,850	47,655,664	51,229,839	55,072,076	<b>239,526,429</b>
<b>Private Sector</b>	<b>5%</b>	20,619,000	22,165,425	23,827,832	25,614,919	27,536,038	<b>119,763,214</b>
<b>NAC</b>	<b>5%</b>	20,619,000	22,165,425	23,827,832	25,614,919	27,536,038	<b>119,763,214</b>
<b>Total</b>	<b>100.00%</b>	<b>412,380,000</b>	<b>443,308,500</b>	<b>476,556,638</b>	<b>512,298,385</b>	<b>550,720,764</b>	<b>2,395,264,287</b>

### 3.4.5.3 Resource Disbursement and Tracking

Ensuring timely and efficient transfer and disbursement of funds to implementing partners is a key element of the management of funds and a critical success factor for the implementation of the national response. Given the complexity of HIV and AIDS funding due to the multi-sectoral nature of the response, it is naturally expected that the systems for resource disbursement and funds tracking will be equally complex while remaining effective and efficient. The NASF supports the process of harmonising and aligning international funding sources as well as strengthening public and civil society capacities for resource management. The strategy to mainstream or integrate HIV and AIDS action into operational plans and budgets will actively facilitate the harmonisation agenda and hence help to track funds.

### 3.4.5.4 Financial Accountability

Recent events in the management of finances in the health sector reveal the need to have financial accountability mechanisms that are functional and responsive to an increasing resource envelop. For the next five years in addition to the regular audits, value for money audits will be conducted at regular intervals in randomly selected institutions at each level of the system. The information obtained from these audits will be used to strengthen the financial accountability system at all levels of the response. NASF will promote evidence based funding for implementing partners.

Resource mobilisation strategies are expected to contribute to the following outcome and output results.

Outcome result	Output results
<p><b>Resource Mobilisation and Management</b>  <b>[OC23]</b> By 2015, NASF financial resource needs that have been mobilised, and used efficiently increased to 100% by 2015</p>	<p><b>[OP64]</b> Public<sup>117</sup> and private sectors that have developed annual HIV and AIDS operational plans that are well resourced, aligned and harmonised with the national operational plan has increased to 100% for public and 75% for private sectors by 2015.</p> <p><b>[OP65]</b> Government funding spent on health has increased from 13% in 2010 to 15% by 2015</p>

### Priority Strategies

<sup>117</sup> Including Parastatals

The following interventions will be implemented

- i. Develop a resource mobilisation plan and strategy
- ii. Cost and use the NASF for resource mobilisation
- iii. Strengthen financial management systems to reduce delays in disbursement
- iv. Strengthen the resource tracking from both the demand and supplier sides to ensure equitable distribution of resource across priority areas
- v. Advocacy for increased government and donor funding for HIV and AIDS, health and community systems strengthening
- vi. Develop sustainable financing mechanism for HIV and AIDS such as a HIV/AIDS tax or an endowment fund Expand the donor base such that the response is not dependent on one or two partners
- vii. Encourage and provide incentives to private sector to invest more in the HIV response
- viii. Organise a round table forum to negotiate with donors the funding for the NASF
- ix. Promote efficient and effective utilisation of HIV and AIDS resources

### **3.4.6 Monitoring and Evaluation, and HIV Research**

#### **Overview**

Zambia has adopted evidence and results based management and planning approaches for the development of the NASF. The NASF development process relied on availability of quality and comprehensive data that was generated through the M&E system, Health Management Information System and HIV research studies. While this was useful at the time in providing evidence for the prioritisation of interventions, setting targets, and establishing baselines, the critical part now is tracking the performance of the NASF.

At the onset, tracking the NASF presents organisational challenges, as implementation is premised on a decentralised multi-sectoral implementation approach involving a large number of implementing and cooperating partners. In most cases the M&E systems are not harmonised and the tools are not aligned. The capacities for collecting, analysing and interpreting data is equally lacking. Similarly, the management of data once collected has been compromised by a lack of capacity and operational systems.

M&E and HIV research data has not been efficiently used to inform decision and programming. Mechanisms for information dissemination are underdeveloped. A resource centre located at NAC provides information including posting some of the information on website

#### **3.4.6.1 Monitoring and Evaluation**

In order to strengthen the national M&E system, the NASF prioritises four areas of M&E capacity development:

- i. Strengthening human resources capacity at national, provincial and district levels. Efforts will also be made to support M&E capacity strengthening in the public and private sectors, and with civil society organisations
- ii. Mainstreaming of the national M&E framework in other sectors to ensure harmonisation and alignment within M&E frameworks in line with the three one principles
- iii. Development of the M&E framework and the revision of the M&E Reference guide
- iv. Strengthening the capacity of stakeholders to use the data in decision making and programming

Effective and efficient monitoring of the NASF is in itself an assurance that Zambia will be able to report on MDGs, UNGASS, SADC and Africa Union Commitments on HIV and AIDS. The NASF promotes strengthening existing strategic partnerships and alliances to ensure that the national M&E system is in place

Zambia has developed and disseminated the national HIV research agenda. Zambia will continue to conduct key HIV and AIDS related surveys and surveillance, and behavioural studies. As a starting point, an inventory of HIV and AIDS surveys done in Zambia will be compiled.

In order to improve on the quality of data, data auditing and supervision will be conducted periodically and guidelines for supervising data collectors in non-health facilities will be developed. In addition, the National Ethics and Research Committee will be strengthened.

Dissemination and use of M&E and research data remains weak. The dissemination of data has been limited and consequently has compromised the use of such data and information in decision making, policy formulation and programme planning.

With the development of the NASF, Zambia adopted an evidence and results based approach to HIV and AIDS planning. The strategy demands that the country develops appropriate systems to monitor performance and, in particular, the achievement of the impact, outcome results. Currently, Zambia has a functional M&E system that is being used to collect data. This system is complemented by other systems such as the Health Management Information System run by the MOH.

## HIV Research

The increasing complexity of HIV and AIDS demands the use of strategic information and empirical evidence to make informed choices and decisions on the nature and kind of interventions and strategies to adopt. A pre-requisite to achieve this, is the development of institutional applied research capacities, complemented by an effective M&E system to generate empirical evidence and apply the evidence. The need for empirical evidence is re-enforced by the adoption of the evidence and results-based planning and management approach. A national research agenda has been developed and research priority areas identified. The NASF focuses on the implementation of the gaps and challenges identified in the Research Agenda Strategy and facilitating the research on prioritised areas.

## Outcomes and output results

Outcome Results	Output Results
<b>Monitoring and Evaluation, and HIV Research</b> <b>[OC24]</b> The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NSF results framework by 2013 and 100% by 2015.	<b>[OP66]</b> Key planned research <sup>118</sup> studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015
	<b>[OP67]</b> NAC has a framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011.
	<b>[OP68]</b> The key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015
	<b>[OP69]</b> NAC coordinate the implementation of 80% of the planned research studies and surveys and results disseminated.

<sup>118</sup> This will include DHS, AIDS Indicator Survey (AIS), Quality of Impact Mitigations Services (QUIMS), Sentinel Surveillance, Behavioural Surveys and Studies (various), TB and STI prevalence surveys among others



<p><b>[OCC25]</b> The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF</p>	<p><b>[OP70]</b> Stakeholders capacity for applied research is assessed and strengthened</p>
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#### Priority strategies

- i. Develop a National M&E Framework and Work plan
- ii. Strengthen the capacity of stakeholders to generate data necessary for validating the NASF results
- iii. Conduct quarterly M&E supervision missions especially in the districts and provinces
- iv. Analyse, compile and disseminate an M&E quarterly services coverage report
- v. National capacity development for applied research
- vi. Harmonisation and strengthening of research coordination mechanisms
- vii. Strengthening the capacity of stakeholders to use research information in decision making, programme development, policy making and resource allocation
- viii. Facilitate research in prioritised research areas, e.g. conduct a nationwide survey to establish the size and magnitude of MARPS (e.g. sex workers, prisoners and truck drivers) in Zambia, and develop appropriate responses

## Section 4: Sustainability and Risk of the National HIV and AIDS Response

### 4.1 Sustainability of the National Response

HIV and AIDS remains the greatest and most complex development challenge today. It is evident that resources that would otherwise be earmarked for socioeconomic development are being diverted to support and sustain the national HIV and AIDS response. As the epidemic unfolds more resources will be needed to accelerate universal access to prevention, treatment, care and support.

Accelerating universal access is strategic for a number of reasons. First, investing in prevention has significant benefits if more people remain HIV negative, hence reducing the cost of treatment, care and support, and impact mitigation downstream and ensures a productive and viable labour force in the country. Second, providing comprehensive and quality care and support as evidenced in the provision of ART, treatment of TB/HIV co-infection, and other OIs improves the quality of life of PLHIV helping them to remain economically productive for longer periods and reducing household economic vulnerability.

Sustainability of the national response is a major concern of the Government of Zambia. Zambia views sustainability from a financial and services point of view.

The national response is largely financed by three key partners i.e. the Government of Zambia, Global Fund and PEPFAR. This funding is complemented by a number of other bilateral and multilateral development partners. Dependence on donor funding poses potential risks in the event donor policies or priorities changed, or a global economic crisis negatively impacts on the ability of key donors to continue funding the response. This calls for a review of the current funding mechanisms to ensure a gradual

movement from dependence to sustainable financing of the response. In the context of financial sustainability, Zambia is cognisant of the need to develop sustainability mechanisms. One such mechanism is establishing a National HIV and AIDS Fund as far back as 2002, in the Act that legally established the NAC. Subsequent to the Act, and in partnership with development partners, Zambia has developed a concept paper that will guide the discussions and operationalisation of the Fund.

The movement towards sustainability of the response should go beyond funding to including organisational, community ownership, sustained accountability and good governance, and efficiency in service delivery. The emphasis should be on achieving and sustaining results, being cost effective and efficient, and addressing the right priorities. Integration of HIV and AIDS financial sustainability strategies in the broader national health care and national social security systems should also be considered.

During the period of the NASF implementation, Zambia will work systematically to develop a comprehensive sustainability strategy moving beyond the HIV and AIDS Fund alone. The strategy will complement efforts to move from emergency scaling up of interventions to long term strategies that will increasingly explore the use of community solutions and domestic resources. Such strategies will heavily depend on evidence to make hard choices and prioritise the interventions for the response.

Within the context of sustainable financing Zambia will review and consider broader strategies including the following:

- i. Strategies to mobilise and increase domestic funding from government and private sector in particular. This may entail consideration for incentives including tax exemptions of funds used to support HIV and AIDS related work
- ii. Improved efficiency of available resources
- iii. Establishment of a HIV and AIDS tax or levy
- iv. Strengthening public-private partnerships
- v. Strengthening Health Systems to allow integration of services including HIV and AIDS
- vi. Establishment of National HIV and AIDS Fund
- vii. Moving towards greater integration and systems strengthening.

## 4.2 NASF Assumptions, Risks and Mitigation strategies

Zambia is cognisant of potential risks that may impact negatively on the implementation of the national response and hence compromise long term sustainability. The table below identifies such risks and suggests possible interventions to mitigate the risks.

**Table 10:** Assumptions, risks and mitigation strategies

#	Assumptions	Risks	Risk Mitigation
1	USG and GFATM, as the two primary sources of external assistance, continue to provide support to Zambia within the NASF.	<ul style="list-style-type: none"> <li>• If USG significantly reduced its support for AIDS in Zambia, this would leave a very substantial proportion of the NASF unfunded.</li> <li>• If the Global Fund R8 funds are withdrawn or suspended, this would negatively affect various programmes</li> <li>• If the Zambia proposal to the GFATM Round 10 for HIV were to be rejected, this would severely challenge the sustainability of the NASF-2011-2015</li> </ul>	<ul style="list-style-type: none"> <li>• The USG Partnership Framework already at advanced stages of negotiations and available funding factored into the current NASF</li> <li>• Develop, implement and monitor the action plan to respond to GFATM queries and recommendations.</li> <li>• The Zambia Global Fund proposal development for round 10 has strictly followed GFATM guidelines</li> </ul>

#	Assumptions	Risks	Risk Mitigation
2	Sustainability and predictability of funding for the NASF can be established within the lifetime of the Strategic Plan.	<ul style="list-style-type: none"> <li>Resource allocation as articulated in NASF could prove to be an insufficient framework for USG and GFATM to commit to;</li> <li>Proposals requesting for substantial increase to GRZ funding for HIV does not succeed.</li> </ul>	<ul style="list-style-type: none"> <li>NASF has been developed with the engagement of development partners.</li> <li>NAC will continue to advocate increased domestic funding for HIV response, including the establishment of an AIDS Fund..</li> <li>Negotiations to have USG partnership framework aligned with NASF.</li> <li>HIV continues to be an important priority for the Government. HIV is the condition that could undermine the country's ability to meet Vision 2030 and MDGs by 2015.</li> </ul>
3	GRZ political commitment to HIV and AIDS response sustained.	<ul style="list-style-type: none"> <li>A failure in GRZ political commitment would see HIV 'lost' among the many competing priorities of Vision 2030 and the National Development Plan.</li> </ul>	<ul style="list-style-type: none"> <li>There will be continued advocacy to ensure that the Government's commitment is sustained.</li> </ul>
4	Multi-sectoral response to HIV and AIDS continues to be coordinated by NAC secretariat	<ul style="list-style-type: none"> <li>Due to success of ART, bio-medical response dominates the HIV and AIDS response.</li> <li>Structures at NAC secretariat duplicating those of the Ministry of Health.</li> <li>Sectors only replicate MOH activities through HIV and AIDS workplace programs.</li> </ul>	<ul style="list-style-type: none"> <li>NAC continues to advocate for a developmental response to HIV and AIDS.</li> <li>There is an ongoing institutional restructuring of NAC that will focus on the core functions of the secretariat.</li> <li>Sectors being encouraged to respond to HIV and AIDS based on their comparative advantage using mainstreaming as a tool.</li> </ul>
5	Complete harmonization of data collection formats, reporting and analysis	<ul style="list-style-type: none"> <li>Fragmented M and E negatively impacting the implementation of NASF.</li> </ul>	<ul style="list-style-type: none"> <li>The new M&amp;E Framework has been developed to support the implementation of NASF with clear roles and responsibilities articulated.</li> <li>Funding committed to the implementation of the new comprehensive M &amp; E</li> </ul>
6	No delay in the release of funds from centre to operational level.	<ul style="list-style-type: none"> <li>Failure of funds to move effectively and efficiently to the various implementers will negatively affect the implementation of NASF.</li> <li>Failure of districts to account for funds disbursed</li> </ul>	<ul style="list-style-type: none"> <li>Business process mapping and re-engineering to reduce the risks brought about by bureaucracy.</li> <li>Random regular audits to minimize risk of fraud.</li> </ul>
7	The implementation of the decentralization policy will improve context and evidence based HIV programming at district and community level.	<ul style="list-style-type: none"> <li>Failure to implement the decentralization policy which will have a negative impact on the ability of districts to design context based HIV plans</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy with Ministry of Local Government and Housing to ensure HIV is taken into account in the process of the implementation of decentralization policy. Initial discussions with Ministry of Local Government and Housing.</li> </ul>

## Section 5: NSF Annexes

### Annex 1: The NASF Results Framework

#### (a) National Impact level result

Zambia Human Development Index<sup>1</sup> (HDI) has improved from 0.434<sup>1</sup> in 2005 to 0.450 by 2015 and the attainment of the Millennium Development goals

#### (b) Prevention

Impact Result	Outcome Result	Output result
<p>By 2015, the rate of annual HIV new infections reduced from 1.6% to below 0.8% (82,000 annual new infections to 40,000)</p> <p>The number of infants born of HIV positive mothers who are infected has reduced to less than 5%<sup>119</sup> by 2015</p>	<p><b>Social and Behaviour Change</b></p> <p><b>[OC1]</b> <i>More people have comprehensive knowledge<sup>120</sup> of HIV:</i> Female and Male aged 15- 49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15 – 24 years to 51% in 2013 and 70% by 2015</p>	<p><b>[OP1]</b> Females and males aged 15-25 with knowledge of HIV prevention increased 39% to 50% by 2013 and to 80% by 2015</p> <p><b>[OP2]</b> Females and males aged 15-24 reached with social and behaviour change programmes is increased to 50% by 2013 and to 80% by 2015</p> <p><b>[OP3]</b> Most at risk population and vulnerable groups reached with HIV prevention programmes has increased from 15% to 25% by 2013 and to 50% by 2015 <i>[disaggregated by MARP and vulnerability category]</i></p> <p><b>[OP4]</b> In and out of school OVC aged 5-17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015</p> <p><b>[OP5]</b> Young females and males aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV increased from 35% in 2007 to 50% in 2013 and 65% by 2015</p>
	<p><b>[OC2]</b> <i>Fewer persons have multiple and concurrent partnerships:</i> Female and male aged 15-49 in the</p>	<p><b>[OP6]</b> Communities reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015</p>

<sup>119</sup> This is in line with the concept of Virtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT – presentation to funders, May 10<sup>th</sup> 2010, UNAIDS]

<sup>120</sup> Comprehensive knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission and prevention

	<p>general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2015.</p> <p><b>[OC3]</b> Among Females aged 15-49, HIV infection is reduced from 16% in 2009 to 10% in 2013 and to below 8% by 2015</p>	<p><b>[OP7]</b> Female and Male aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50%<sup>121</sup> for Male in 2008 to 65% in 2013 and to 75% for both Female and Male by 2015</p> <p><b>[OP8]</b> Couples (stable and semi-stable relationships) reached with small group or individual social and behaviour change programmes increased to 35% in 2013 and to 70% by 2015</p> <p><b>[OP9]</b> Female aged 15-49 reached with interventions that empower them to address gender inequality and gender based violence that predispose Female and girls to HIV infection increased to 40% by 2013 and to 75% by 2015</p> <p><b>[OP10]</b> Females who have received post rape care services (counselling, treatment, and legal support) have increased from 20.2% in 2007 to 80% by 2015.</p>
	<p><b><u>HIV Counselling and Testing</u></b></p> <p><b>[OC4]</b> <i>More people test for HIV and know their results:</i> Females and Males aged 15-49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4% in 2008 to 30% in 2013 and 50% by 2015</p>	<p><b>[OP11]</b> Female and male aged 15-49 who received an HIV test in the last 12 months and know their results has increased from 28% (1910253/6822332) in 2009 to 41% (3,023,728/7330249) in 2013 and 50% (3,816,765/7633530) by 2015</p> <p><b>[OP12]</b> Couples who were counselled and tested in the last 12 months increased to 20% in 2013 and to 50% by 2015</p> <p><b>[OP13]</b> Most at risk population who received an HIV test in the last 12 months and know their status has increased from 20% to 35% by 2013 and to 70% by 2015 [<i>disaggregated by MARP category</i>]</p> <p><b>[OP14]</b> Health and non-health facilities with adequate capacity to provide either provider initiated and client Testing and counselling and or client initiated counselling and testing increased from 60% in 2008 to 80% in 2013 and to 100% by 2015</p>
	<p><b><u>Condom Marketing and Distribution</u></b></p> <p><b>[OC5]</b> <i>More people consistently and correctly use condoms in their last sex intercourse:</i> Female and Male aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 37% for female and 50% for male in 2007 to 45% for female and to 60% for male in 2013 and 55% for female</p>	<p><b>[OP15]</b> MOH increase free condoms distribution per year for Male from 40 million in 2009 to 80million in 2013 and 100 million in 2015 and for Female from 450,000 in 2009 and 650,000 in 2013 and 1,000,000 in 2015<sup>122</sup></p> <p><b>[OP16]</b> MOH Condom retail outlets<sup>123</sup> and service centres that reported no condom stock out increased 40% in 2008 to 60% in 2013 and to 100% by 2015</p> <p><b>[OP17]</b> Male and Females age 15-49 years have Condom use increased from 37% in 2007 to 55% in 2013 and 73% by 2015</p>

<sup>121</sup> Baselines are from Zambia UNGASS National Report 2008/2009

<sup>122</sup> Baseline data for male and female condoms is derived Mode of Transmission report, while projection targets are based on the targets proposed in 6<sup>th</sup> NDP Chapter for HIV and AIDS i.e. 40% for 2013 and 50% for 2015.

<sup>123</sup> According to the MOT report (2009) in 2008, there were 15,252 condom outlets

	and 70% for male by 2015	
	<b>Medical Male Circumcision</b> <b>[OC6]</b> <i>More male are circumcised by a health professional: male aged 15-49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015</i>	<b>[OP18]</b> Male aged 15-49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015 <sup>124</sup> . <b>[OP19]</b> At least 50% of all infants born in a health facility are circumcised in the first week of life <b>[OP20]</b> Between 2011 and 2015 at least 80% of all PMTCT centres have integrated male circumcision service provision. <b>[OP21]</b> Between 2011 and 2015 100% of traditional leaders promote MC as an HIV prevention strategy as part of community mobilisation efforts.
	<b>Prevention of Mother to Child Transmission</b> <b>[OC7]</b> <i>More HIV positive pregnant female receiving ARVs to reduce risk of transmission to child: HIV positive pregnant Female who receive ART to reduce the risk of mother to child transmission is increased from 61% <sup>125</sup>(47,175) in 2009 to 85% (72,828) and to 95% (85,655) in 2015</i>	<b>[OP22]</b> Pregnant women who were counselled during the ANC for their most recent pregnancy, who were offered and accepted a HIV test and received their test results in the last twelve months increased from 67% <sup>126</sup> in 2009 to 80% in 2013 and 95% by 2015 <b>[OP23]</b> Female aged 15-49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015 <b>OP24]</b> HIV-infected pregnant females who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission increased from 61% (47175/79498) in 2009 to 85% (72828/85708) in 2013 and 95% (85655/90163) by 2015 <b>[OP25]</b> HIV positive mothers, their children and families who have received at least two categories of care at home /community increased from 40% in 2009 to 75% in 2013 and to 100% by 2015 <b>[OP26]</b> Male participation in PMTCT programming increased to 50% (equivalent of 50% of women on PMTCT) by 2013 and 80% by 2015.
	<b>[OC8]</b> <i>More infants born from HIV-positive mothers are not infected: Infants born to HIV-infected mothers who are infected has reduced from 7%<sup>127</sup> in 2009 to 5% in 2013 and to less than 2% by 2015</i>	<b>[OP27]</b> Infants born to HIV-infected females (HIV-exposed infants) receiving ARV prophylaxis to reduce the risk of MTCT has increased from 62% <sup>128</sup> (21050/36215) in 2009 to 50% (31110,39469) in 2013 and 95% 36140/38042)by 2015 <b>[OP28]</b> Infants born to HIV-infected mothers (HIV-exposed infants) started on Cotrimoxazole prophylaxis within two months of birth has increased from 34% <sup>129</sup> in 2009 to 50% by 2013 and to 100% by 2015

<sup>124</sup> The targets for MC are set out in the Zambia National Male Circumcision Strategy 2010-2020

<sup>125</sup> NDP 6 – Chapter on HIV and AIDS (draft), 2010

<sup>126</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID / not targets have been taken from the 6<sup>th</sup> NDP Chapter paper

<sup>127</sup> Zambia UNGASS National Report 2008/2009

<sup>128</sup> SNDP chapter on HIV and AIDS, June 2010

<sup>129</sup> Zambia UNGASS National Report 2008/2009

	<p><b>[OC09]</b> PLHIV aged 15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased to X% by 2015</p>	<p><b>[OP29]</b> PLWHIV reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards</p>
	<p><b>[OC10]</b> PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015</p>	<p><b>[OP30]</b> Females and males who received counseling and testing services for HIV and received their test results</p>
	<p><b>Post Exposure Prophylaxis</b>  <b>[OC11]</b> <i>All persons who have been accidentally or forcibly exposed to HIV are given drugs to reduce the risk of primary infection:</i> People in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)</p>	<p><b>[OP31]</b> Health facilities with PEP services available on site and being provided according to the national guidelines has increased from 43% in 2008 to 100% by 2015</p> <p><b>[OP32]</b> Health Workers with reported needle prick injuries in health facilities has reduced from 6.7%<sup>130</sup> in 2008 to 4% by 2013 and to less than 2 % by 2015</p>
	<p><b>Sexually Transmitted Infections</b>  <b>[OC12]</b> <i>Fewer Females and males have STIs:</i> Female and Male who report having STI in the past 12 months has reduced for Female from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for Male from 26% 2007 to 13% in 2013 and 5% in 2015</p>	<p><b>[OP34]</b> MOH Primary Health facilities offers comprehensive STI treatment maintains its current 100% of STI services by 2013 and remains at the same level by 2015</p>
	<p><b>Blood Safety</b>  <b>[OC13]</b> <i>Donated blood units are screened for HIV and other TTIs in a quality assured manner:</i> Donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100%<sup>131</sup> between 2010 and 2015</p>	<p><b>[OP35]</b> MOH meet national demand of 100% of need using the national blood transfusion of centrally collected blood screened for transfusion transmissible infections .</p>

<sup>130</sup> Joint MID TERM Review of NASF report- Technical Report, January 2009, NAC

<sup>131</sup> Joint Mid – Term Review of NASF report- Technical Report, January 2009, NAC



**(c) Treatment, Care and Support**

Impact Result	Outcome Result	Output Result
<p>PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased from 65% in 2009 to 85% by 2015</p>	<p><b>Antiretroviral Therapy</b>  <b>[OC14] More PLHIV survive longer on ART:</b> Adults (15 and older, and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015</p>	<p><b>[OP36]</b> Adults enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis remains at 100% up to 2015</p>
		<p><b>[OP37]</b> Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis increased from 34% to 60% in 2013 and 100% up to 2015</p>
		<p><b>[OP38]</b> Female and Male with advanced HIV infection receiving ART has increased from 68%<sup>132</sup> in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015</p>
		<p><b>[OP39]</b> Children (aged 0-14) eligible for HIV receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015</p>
	<p><b>TB/HIV co-infection:</b>  <b>[OC15]</b> <i>More PLHIV with TB/HIV co-infection are successfully treated:</i> PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 and 60 % in 2013 and to 75% by 2015</p>	<p><b>[OP40]</b> Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015</p>
	<p><b>Community Home Based Care and Palliative Care</b>  <b>[OC16]</b> Male and Female children 0-17 yrs orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and to 50% by 2015</p>	<p><b>[OP41]</b> The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 40.6 %<sup>133</sup> in 2007 to 60% 2013 and to 80% by 2015.</p>
	<p><b>[OP42]</b> HIV-positive TB patients who are started on ART has increased from 41% (6595) in 2007 to 60% in 2013 and to 75% in 2015.</p>	
	<p><b>[OP43]</b> People receiving palliative care increased from 157,712 in 2007 to 200,000 in 2013 and 250,000 in 2015</p>	

<sup>132</sup> Zambia UNGASS National Report 2008/2009 / and NDP 6<sup>th</sup> Chapter on HIV and AIDS, 2010 (draft) paper

<sup>133</sup> Joint Mid Term Review of NASF report- Technical Report, January 2009, NAC

## (d) Impact Mitigation

Impact Result	Outcome Result	Output result
<b>Fewer households are vulnerable:</b> The number of vulnerable households <sup>134</sup> is reduced by 50% by 2015	<b>Vulnerable Households and Food Security</b> <b>[OC17]</b> <i>More people receive comprehensive and quality care at home and in the community:</i> Female and male aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41% <sup>135</sup> in 2009 to 50% in 2013 and 60% by 2015..	<b>[OP44]</b> Households <sup>136</sup> with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015
		<b>[OP45]</b> Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from X% in 2010 to X% in 2013 and to X% in 2015.
	<b>Orphans and Vulnerable Children</b> <b>[OC18]</b> <i>More OVC receive free external basic support:</i> OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16% <sup>137</sup> in 2009 to 25% in 2013 and to 40% by 2015	<b>[OP46]</b> A national framework for the protection, care and support of OVC developed
		<b>[OP47]</b> Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28% <sup>138</sup> in 2009 to 40% in 2013 and 60% by 2015
		<b>[OP48]</b> Orphans and vulnerable children under age 18 years whose household had not received any basic external support to care for the child in the last 12 months has decreased from 84% in 2007, to 50% in 2013 and 25% by 2015
		<b>[OP49]</b> OVC aged 5-17 possessing three minimum basic material needs <sup>139</sup> increased from 49% <sup>140</sup> in 2007 to 60% in 2013 and to 85% in 2015
		<b>[OP50]</b> The ratio of OVC and non-OVC currently attending school is increased from 0.93 <sup>141</sup> in 2009 to 1:1 in 2013 and remains that way by 2015.

<sup>134</sup> It is estimated that there are 8000 vulnerable households (2010) - Source: A Supplement to NASF 2006-2010 Based on the Joint MTR held in 2008, NAC

<sup>135</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>136</sup> Households will be disaggregated by type, Child, Female and or male headed, rural and urban

<sup>137</sup> Zambia Demographic and Health Survey 2007

<sup>138</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>139</sup> These needs are defined as a pair of shoes, two sets of clothing and a blanket.

<sup>140</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>141</sup> Zambia UNGASS Report 2010

**(e) Response Coordination and Management of the National Multi-sectoral HIV and AIDS Response**

Impact Result	Outcome Result	Output result
<p><b>4. The national response is effectively and efficiently managed and coordinated:</b> The total NASF service coverage targets (output level results) that have been met in all four pillars has increased to 50% by 2013 and 90% by 2015</p>	<p><b>Enabling Policy and Legal Environment</b> [OC19] <i>The enabling policy and legal environment is improved:</i> Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened</p>	<p>[OP51] <b>Social and legal protection of vulnerable people and most at risk populations is strengthened:</b> % of national policies and legal instruments reviewed and incorporated human and legal rights.</p>
	<p><b>Coordination and Management:</b> [OC20] Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework</p>	<p>[OP52] <b>Reduction stigma and discrimination:</b> Female and Male aged 15-49 expressing accepting attitudes towards people living with HIV and AIDS increased from 34%<sup>142</sup> in 2009 to 45% by 2013 and by 60% by 2015</p>
	<p><b>HIV and AIDS, Gender and Human Rights Mainstreaming</b> [OC21] Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015</p>	<p>[OP53] National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response.</p>
		<p>[OP54] 75% of sectors and private sector institutions by 2013 and 100% by 2015 have reviewed their policies and programmes, and mainstreamed HIV and AIDS, gender and human rights in their internal (HIV workplace) and external (development) programmes</p>
		<p>[OP55] Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015</p>
		<p>[OP56] Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 2015.</p>
		<p>[OP57] Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015<sup>143</sup></p>

<sup>142</sup> Zambia Sexual behaviour Survey 2009 – MOH/ CSO/UOZ and Measure/USAID

<sup>143</sup> The baseline and the targets are set out in the 6<sup>th</sup> NDP Chapter paper,

		<b>[OP58]</b> The national action plan on Gender and HIV is fully implemented, monitored and periodically reviewed
	<b>Capacity Development and Systems Strengthening</b> <b>[OC22]</b> Stakeholders capacity to implement NASF strengthened by 2013 and remains the same by 2015	<b>[OP59]</b> HIV and AIDS implementing partners capacity developed / strengthened in the areas of programme planning, resource mobilisation, service delivery, community mobilisation, monitoring, evaluation and reporting for 75% by 2015 <b>[OP60]</b> Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013 <b>[OP61]</b> Communities systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013 <b>[OP62]</b> Capacity of all local Authorities' strengthened in Good governance and leadership of HIV and AIDS programmes at district level by 2013 <b>[OP63]</b> Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes increased from 20 in 2009 to 73 by 2013 and remain at that level by 2015
	<b>Resource Mobilisation and Management</b> <b>[OC23]</b> By 2015, NASF financial resource needs that have been mobilised, and used efficiently increased to 100% by 2015	<b>[OP64]</b> Public <sup>144</sup> and private sectors that have developed annual HIV and AIDS operational plans that are aligned and harmonised with the national operational plan has increased to 100% for public and 75% for private sectors. <b>[OP65]</b> Government funding spent on health has increased from 13% in 2010 to 15% in 2015
	<b>Monitoring and Evaluation, and HIV Research</b> <b>[OC24]</b> The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NSF results framework by 2013 and 100% by 2015.	<b>[OP66]</b> Key planned research <sup>145</sup> studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015 <b>[OP67]</b> NAC has a framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011. <b>[OP68]</b> The key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015 <b>[OP69]</b> NAC coordinate the implementation of 80% of the planned research studies and surveys and results disseminated.
	<b>[OCC25]</b> The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the	<b>[OP70]</b> Stakeholders capacity for applied research is assessed and strengthened

<sup>144</sup> Including Parastatals

<sup>145</sup> This will include DHS, AIDS Indicator Survey (AIS), Quality of Impact Mitigations Services (QUIMS), Sentinel Surveillance, Behavioural Surveys and Studies (various), TB and STI prevalence surveys among others

	performance of the NASF The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF	
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## Annex 2: Glossary of terms uses in the NASF

Term	Definition
<b>Act</b>	The legislation that established the NAC in 2002
<b>Assumption</b>	The necessary conditions for the achievement of results (impact, outcome and output) or implementation of an activity at different levels. Helps to determine that the probability that identified negative conditions will not be present. Describe conditions (external factors) that must exist if the project is to succeed, but are beyond the control of project management
<b>Civil Society Organisations</b>	The term is used in the NASF to refer to organisations that are established to provide services and are not profit oriented. These include NGOs, Faith Based Organisations, Community Based Organisations, and trade unions.
<b>Coordination:</b>	The process of bringing together stakeholders to undertake plan or arrive at consensus on to manage planning and implementation process
<b>Decentralised response</b>	HIV and AIDS implementation at sub-national levels, e.g. provincial, district and community
<b>Duty bearer</b>	A person or institutions that have a legal obligation to provide services to another person.
<b>Evidence Based:</b>	The application of qualitative or quantitative evidence to inform choices and decisions on interventions and strategies to achieve specific desired results.
<b>Gender</b>	: “ <i>Gender</i> ” refers to differences in social roles and relations between men and women whereas “ <i>sex</i> ” refers to biologically determined difference. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity and religion, as well as by geographical, economic and political environments.
<b>Health Sector</b>	Refer to all institutions offering health services. In Zambia this include public and private health systems, traditional health practitioners and those offering alternative medicine
<b>Household</b>	A unit of residence comprised of one family
<b>Impact result:</b>	Long term positive changes in the lives of people, condition or organization arising from an intervention.
<b>Impact Mitigation:</b>	A strategy used to alleviate negative social and economic impacts
<b>Informal Sector</b>	Refer to people who are self-employed and their operations are not necessarily classified in a legal framework. It is comprised of small scale enterprises
<b>Input:</b>	Refer to resources such as human, information, finance or material that are required to support activity implementation to produce outputs.
<b>Multiple and concurrent sexual partners:</b>	<p>This is a composite term, made up of those with multiple sexual partners and those with concurrent sexual partners. The term ‘<b>multiple sexual partners</b>’ refers to when a person has sex with more than one person over a period of time. These partnerships could be overlapping or not. The prevalence of the population with multiple sexual partners is referred to as ‘multiple partner prevalence’.</p> <p>The term ‘<b>concurrent sexual partners</b>’ refers to when a person has “overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner” (UNAIDS Reference Group on Estimates, Modelling, and Projections, 2009). The prevalence of the population with concurrent sexual partners is referred to as ‘concurrency prevalence’, and this can be measured in two ways – point prevalence of concurrency, and cumulative prevalence of concurrency</p>
<b>Outcome:</b>	A change in behaviour (values, attitudes, practices etc) of, or the use of new capacities (laws, policies etc) by target group (people and institutions).
<b>Output:</b>	Operational changes or new capacities (knowledge, skills and equipment, products

	and services) which result from the completion of activities within a specified intervention in a given time.
<b>Private Sector</b>	. Private sector institutions include privately owned companies and organisations whose primary motive is making money through the sale of services and products. In the context of NASF the term private sector does not include parastatals or civil society organisations
<b>Result:</b>	. A measurable or describable change in the lives of people or organizations resulting from a cause and effect relationship or programme intervention.
<b>Results Based Management:</b>	. A Planning and management strategy that focuses on the achievement of results (impact, outcome and output) at all levels through a systematic and evidence-based strategic and results-based planning.
<b>Results based planning:</b>	. Part of the results-based management approach: it involves using evidence to understand the current situation and weaknesses, and then to plan based on the current situation and other evidence of what is most cost effective to address the weaknesses in the program.
<b>Results Framework:</b>	. A diagrammatic illustration of the logical chain of actions that contribute to higher results
<b>Sector</b>	A segment of society that has common characteristics or interest, or a segment of the economic with distinct mandate (i.e. health, agriculture etc).
<b>Social Protection</b>	Social Protection is a set of interventions whose objective is to reduce social and economic risk and vulnerability, and to alleviate extreme poverty and deprivation. A comprehensive social protection system should include preventing, promotive and transformative programmes
<b>Thematic area</b>	An operational area or broad topic with a common central theme or focus. NASF has four thematic areas i.e. prevention, treatment, care and support, impact mitigation and response management.
<b>Three Ones principle</b>	. Refer to one national coordinating authority, one national strategic framework and one national M&E framework.
<b>vulnerability</b>	Vulnerability is defined as the extent to which a unit of interest i.e. homestead, household, individual is able to protect itself from unwanted exposure to negative impacts, whether these impacts come from outside or inside.



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