NATIONAL HIV & AIDS STRATEGIC FRAMEWORK 2023 - 2027

NATIONAL HIV/AIDS/STI/TB COUNCIL

Contents

LIST OF FIGURES III

LIST OF TABLES IV

ACRONYMS VI

FOREWORD IX

PREFACE X

ACKNOWLEDGEMENTS XI

EXECUTIVE SUMMARY XII

1.0 BACKGROUND 1

1.1 Situation analysis 1
1.1.1 Country Context 1
1.2 Factors fuelling new HIV infections 4
1.3 Progress made towards the UNAIDS Target (95 95 95) 6
1.4 Morbidity and mortality trends 7
1.5 The National HIV and AIDS Response 8
1.6 Sexually transmitted infections epidemiological response profile 9
1.7 Sexually transmitted infections response profile 10
1.8 Viral hepatitis infection 11
1.9 Viral hepatitis infection response profile 11
1.10 Tuberculosis epidemiological and response profile 11
1.11 Priority Populations 13
1.12 Stigma and discrimination 15

2.0 VISION, GOAL, OBJECTIVES, KEY RESULTS AND GUIDING PRINCIPLES .. 17

3.0 STRATEGIC PRIORITIES AND INTERVENTIONS 20

3.1 HIV Prevention 21
3.2 Laboratory and Diagnostic Services 45
3.3 Procurement and Supply Chain Management 46
3.4 Critical Enablers 47
3.5 Education Sector Intervention 51
3.6 Social Protection 51
3.7 Food and Nutrition 52
3.8 Mainstreaming HIV into Capital Projects 53
3.9 Workplace Policies and Practices 53
3.10 Reinvigorate Community Responses 54
3.12 Strengthen Strategic Information 55
3.13 Surveillance and Surveys 56
3.14 Research 56
3.15 Community Led Monitoring (CLM) 56

3.16 Reporting 56
4.0 COORDINATION, MANAGEMENT AND INSTITUTIONAL ARRANGEMENT 57
4.1 Provisions for an effective multi sectoral coordination 57
4.2 Coordination of the NASF 2023-2027 implementation 59
4.3 Coordination at the National Level 59
4.4 Coordination among partners 61
4.3 Response Coordination and Management Framework at Provincial and District Level 62
5.0 FINANCING OF THE NASF 2023 - 2027 65
5.1 Resources needed for the NASF 2023-2027 65
5.2 Limitations of the cost estimates 71
5.3 Potential Impact of the NASF on New Infections and Mortality 72
5.4 Funding Landscape 74
5.5 Potential funding shortfall for the NASF 77
5.6 Sustainability of the HIV Response in Zambia 81
6.0 MONITORING AND EVALUATION OF THE NASF 2023 - 2027 86
7.0 REFERENCES 88

LIST OF FIGURES

FIGURE 1- 1: HIV INCIDENCE 2
FIGURE 1- 2: HIV NEW INFECTION TRENDS OVER TIME 3
FIGURE 1- 3: HIV PREVALENCE BY AGE 3
FIGURE 1- 4: ADULTS LIVING WITH HIV 7
FIGURE 1- 5: AIDS-RELATED DEATHS, 2000-2022 7
FIGURE 1- 6: TRENDS OF STIS CASES 2017 -2022 9
FIGURE 1- 7: ESTIMATED TB INCIDENCE 12
FIGURE 1- 8: TRENDS OF INCIDENCE RATE PER 100,000 POPULATION 2020-2021 12
FIGURE 4-1: RESPONSE COORDINATION AND MANAGEMENT FRAMEWORK AT NATIONAL LEVEL 58
FIGURE 4-2: RESPONSE COORDINATION AT DISTRICT LEVEL 63
FIGURE 4-3: RESPONSE COORDINATION AT PROVINCIAL LEVEL 64
FIGURE 5-1: ESTIMATED SHARE OF NASF 2023-2027 AVAILABLE RESOURCE (US$' MIL) 68
FIGURE 5-2: EST. TOTAL RESOURCES NEEDED FOR THE NASF 2023-2027 (US$' M) 70
FIGURE 5-3: ESTIMATED RESOURCES NEEDED FOR THE NASF 2023-2027 (US$' M) 70
FIGURE 5-4: PROJECTED IMPACT OF THE NASF 2023 - 2027 72
FIGURE 5-5: NEW HIV INFECTIONS 73
FIGURE 5-6: NEW PAEDIATRIC HIV INFECTIONS 73
FIGURE 5-7: AIDS DEATHS 74
FIGURE 5-8: ANTICIPATED FUNDING FOR THE HIV RESPONSE IN NASF 2023-2027 (US$' M) 75
FIGURE 5-9: NASF 2023-2027 AVAILABLE HIV FUNDS (TOTAL) VERSUS RESOURCES NEEDED AND POTENTIAL FUNDING GAP (US$' M), INCLUDING AND EXCLUDING NEW GF GRANT 78
FIGURE 6-1: DATA FLOW ARRANGEMENTS 87

LIST OF TABLES

TABLE 1-1: BARRIERS TO ACCESS TO HIV SERVICES BY KEY AND VULNERABLE POPULATIONS 14
TABLE 3-1: SBCC PROGRAMME OBJECTIVE AND INTERVENTIONS 22
TABLE 3-2 (A): ADOLESCENTS WITH COMPREHENSIVE HIV KNOWLEDGE 22
TABLE 3-2 (B): ADULTS WITH COMPREHENSIVE HIV KNOWLEDGE 23
TABLE 3-3 COMPREHENSIVE CONDOM PROGRAMMING & LUBRICANT PROGRAMME OBJECTIVE AND INTERVENTIONS 23
TABLE 3-4 (A): CONDOMS AND LUBRICANTS TARGETS 24
TABLE 3-4 (B): CONDOM USE TARGETS FOR ADOLESCENTS AGED 15 – 19 YEARS 24
TABLE 3-4 (C): CONDOM USE TARGETS FOR ADOLESCENTS AGED 20 – 24 YEARS 25
TABLE 3-4 (D): CONDOM USE TARGETS FOR ADULTS AGED 15 – 49 YEARS 25
TABLE 3-4 (E): CONDOM USE TARGETS FOR KEY POPULATIONS 25
TABLE 3-5: HARM REDUCTION AND OPIOID SUBSTITUTION THERAPY 26
TABLE 3-6:VMMC PROGRAMME OBJECTIVE AND INTERVENTIONS 26
TABLE 3-7: VMMC TARGETS 27
TABLE 3-7 (A): VMMC TARGETS 0 – 2 YEARS 27
TABLE 3-7 (B): VMMC TARGETS 10 – 14 YEARS 27
TABLE 3-7 (C): VMMC TARGETS 15 – 29 YEARS 28
TABLE 3-7 (D): VMMC TARGETS 30 – 49 YEARS 28
TABLE 3-8: PROGRAMME OBJECTIVES AND INTERVENTIONS 28
TABLE 3-9: ESTIMATED NUMBER AT RISK TO NEED PREP 29
TABLE 3-9 (A): PREP PROJECTED TARGETS 29
TABLE 3-10: STI PROGRAMME OBJECTIVE AND INTERVENTIONS 29
TABLE 3-11: STIS TARGETS 30
TABLE 3-11 (A): MALES AND FEMALES 20 – 24YEARS REPORTING STI 30
TABLE 3-12:VIRAL HEPATITIS INFECTION PROGRAMME OBJECTIVES AND INTERVENTIONS 31
TABLE 3-13: BLOOD SAFETY PROGRAMME OBJECTIVES AND INTERVENTIONS 31
TABLE 3-14: BLOOD SAFETY TARGETS 32
TABLE 3-15: ADOLESCENTS AND YOUNG PEOPLE PROGRAMME OBJECTIVE AND INTERVENTIONS 32
TABLE 3-16: ADOLESCENT AND YOUNG PEOPLE INDICATORS AND TARGETS 32
TABLE 3-16 (A): ADOLESCENT REACHED WITH SRHR PREVENTION SERVICES 33
TABLE 3-16 (B): HIGH-PREVALENCE DISTRICTS COVERED WITH COMPREHENSIVE PREVENTION PROGRAMMES 33
TABLE 3-17: KEY POPULATIONS PROGRAMME OBJECTIVE AND INTERVENTIONS 33
TABLE 3-18: KEY POPULATIONS INDICATORS AND TARGETS 34
TABLE 3-18 (A): KEY POPULATIONS REACHED WITH HIV PREVENTION PROGRAMMES 34
TABLE 3-18 (B): KEY POPULATIONS WHO AVOIDED HEALTH CARE 35
TABLE 3-19: HIV TESTING SERVICES PROGRAMME OBJECTIVE AND INTERVENTIONS 35
TABLE 3-20: HIV TESTING SERVICES TARGETS 36
TABLE 3-20 (A): WOMEN AND MEN AGED 15 – 19 YEARS WHO RECEIVED HIV TEST RESULTS 36
TABLE 3-20 (B): WOMEN AND MEN AGED 20 – 24 YEARS WHO RECEIVED HIV TEST RESULTS 36
TABLE 3-20 (C): WOMEN AND MEN AGED 15 – 49 YEARS WHO RECEIVED HIV TEST RESULTS 37
TABLE 3-20 (D): SPECIFIC KEY POPULATIONS WHO THEIR HIV STATUS 38
TABLE 3-21: EMTCT PROGRAMME OBJECTIVE AND INTERVENTIONS 38
TABLE 3-23: TREATMENT AND CARE PROGRAMME OBJECTIVE AND INTERVENTIONS 40
TABLE 3-24: ART TREATMENT TARGETS 41
TABLE 3-24 (A): HIV POSITIVE ADULTS 15 – 49 YEARS ON ART 42
TABLE 3-24 (B): SPECIFIC KEY POPULATIONS ON ART 42

TABLE 3-25: VIRAL LOAD SUPPRESSION TARGET 43
TABLE 3-25 (A): PLHIV 15 – 49 YEARS WHO ARE VIRALLY SUPPRESSED 43
TABLE 3-26: HIV/TB CO-INFECTIONS PROGRAMME OBJECTIVE AND INTERVENTIONS 44
TABLE 3-27: HIV/TB CO-INFECTION TARGETS 44
TABLE 3-28: PSYCHOSOCIAL SUPPORT FOR PLHIV PROGRAMME OBJECTIVE AND INTERVENTIONS 45
TABLE 3-42: MAINSTREAMING HIV INTO CAPITAL PROJECTS PROGRAMME OBJECTIVE AND INTERVENTIONS 53
TABLE 3-43: WORKPLACE POLICIES AND PRACTICES PROGRAMME OBJECTIVES AND INTERVENTIONS 53
TABLE 3-46: STRATEGIC INFORMATION 55
TABLE 5-1: ESTIMATED RESOURCES NEEDED FOR THE NASF 2023-2027 INTERVENTIONS (US$' MIL) 66
TABLE 5-2: EXTERNAL SOURCES FUNDING OF THE HIV RESPONSE (US$' M, 2023-2027) 76
TABLE 5-3: HIV FUNDING LANDSCAPE 76
TABLE 5-4: NASF 2023 – 2027 RESOURCE ALLOCATION AND RESOURCE GAP BY PROGRAMME (US$' MILLION) 80
TABLE 5-5: GOVERNMENT HEALTH EXPENDITURE AS A SHARE OF THE GRZ TOTAL BUDGET 82
TABLE 5-6: BUDGET ALLOCATIONS FOR THE HEALTH SECTOR (2023-2025) 82
TABLE 5-7: HIV FUNDING LANDSCAPE 83
TABLE 5-8: UNIT COSTS USED IN THE COSTING OF THE NASF 2023 - 2027 85

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Anti-Retroviral Drugs
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
CDC	Centres for Disease Control and Prevention
CHA	Community Health Assistants
CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
CWA	Community Welfare Assistance
DACA	District AIDS Coordination Advisor
DATF	District AIDS Task Force
DBS	Dry Blood Spot
DHS	Demographic and Health Survey
DWA	District Welfare Assistance
eMTCT	Elimination of Mother-to-Child Transmission
FBO	Faith-Based Organisation
FCDO	Foreign Commonwealth and Development Office
FDI	Foreign Direct Investment
FGD	Focus Group Discussion
FISP	Farmer Input Support Programme
FSW	Female Sex Worker
GBV	Gender-Based Violence
GFATM	The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GIDD	Gender in Development Division
GRZ	Government of the Republic of Zambia
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organization for Migration
JUNTA	Joint United Nations Team on AIDS
JMTR	Joint Mid-Term Review
KII	Key Informant Interview
LDTD	Long Distance Truck Drivers
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MARP	Most-At-Risk Populations

MCP	Multiple Concurrent Partnerships
MOH	Ministry of Health
MSM	Men Having Sex with Men
MYSA	Ministry of Youth, Sport and Arts
NAC	National HIV/AIDS/STI/TB Council
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework
NBTS	National Blood and Transfusion Services
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
NZP+	Network for Zambian People Living with HIV
OVC	Orphans and Vulnerable Children
PACA	Provincial AIDS Coordination Advisor
PATF	Provincial AIDS Task Force
PEP	Post-Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with Disabilities
PWID	People Who Inject Drugs
R-NASF	Revised National AIDS Strategic Framework
R-SNPD	Revised Sixth National Development Plan
SADC	Southern African Development Community
SBC	Social and Behaviour Change
SCT	Social Cash Transfer
SDGs	Sustainable Development Goals
SMAGs	Safe Motherhood Action Groups
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
UTH	Teaching Hospital
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
VSU	Victim Support Unit
WDC	Ward Development Committee

WHO	World Health Organisation
WILSA	Women in Law in Southern Africa
WV	World Vision
YWCA	Young Women Christian Association
ZAMPHIA	Zambia Population-Based HIV Impact Assessment
ZDHS	Zambia Demographic and Health Survey

FOREWORD

Zambia, like other countries particularly those in Sub-Saharan Africa, is faced with a high disease burden, especially the communicable types such as Malaria, AIDS, Sexually Transmitted Infections (STIs), Tuberculosis (TB), and lately COVID-19, among others. Non-communicable diseases (NCDs) are also growing alongside maternal, child and adolescent health problems.

Fortunately, Zambia has made tremendous progress in the HIV response over the years as can be seen in the reduction of both the incidence and prevalence of the virus that causes AIDS. The estimated annual new infections among adults aged 15 - 49 years dropped from 43, 000 in 2017 to 28, 000 in 2022, while those for children aged 0 - 14 years dropped from 8, 900 in 2017 to 4, 500 in 2022. Annual AIDS-related deaths also saw similar decreases from 69, 000 to 20, 000. Further, out of the estimated 1, 400, 000 People Living with HIV (PLHIV), over 1, 100, 000 of those are on life-saving Antiretroviral Therapy (ART). In addition to the achievements above, around four million Zambians receive HIV counselling and testing services and know their results annually.

However, AIDS has continued to rank highest in mortality figures, burdening households and straining national health systems.

This National AIDS Strategic Framework (NASF) 2023-2027 thus provides an opportunity for the country's national multi-sectoral HIV response to evolve towards adopting more effective socially inclusive and cost-effective interventions to prevent new HIV infections and acquire better AIDS management skills for optimal health for all.

The five-year NASF places emphasis on equitable access to HIV services without leaving anyone behind. Universal access to health especially HIV services is a priority for this Government. To achieve this goal, we will make evidence-based investments which target priority populations while ensuring that all Zambians are reached, and stigma and discrimination are reduced as barriers to health services.

Another priority area is increasing domestic and sustainable financing for HIV. This document outlines an innovative leverage funding approach based on implementation of the HIV Fund that will increase resources, increase access to universal healthcare for those living with HIV and ultimately subsidise Zambia's future liability for HIV prevention and treatment.

My Ministry makes an undertaking to facilitate the realisation of the aspirations articulated in this document while protecting and preserving the gains made this far. I urge all stakeholders to use the NASF in their respective interventions to avoid wasteful duplication of efforts and to ensure that all those in need receive a fair share of services.

The successful implementation of the NASF will undoubtedly contribute to socio-economic development of the country.

Hon. Elijah Muchima, PhD
MINISTER OF HEALTH

PREFACE

The National HIV/AIDS/STI/TB Council (NAC) is pleased with the commitment of the Government of the Republic of Zambia to prioritise provision of quality health services to all citizens and residents in the country. The development of this National AIDS Strategic Framework (NASF) 2023-2027 is an embodiment of this commitment and a pledge of continuity by the Government to deliver HIV services in a structured approach for the next five years.

The NASF is one of the three Ones principles upon which national HIV responses are anchored. The other two are one Monitoring and Evaluation Framework and One coordinating body which NAC is.

Realising the importance of the NASF as a national guiding document for high impact HIV interventions, NAC galvanised key stakeholders in developing the document to secure popular buy-in and support.

A shift has been made in this NASF to migrate from crisis management of the epidemic to a more strategic and sustainable approach.

Additionally, combination HIV interventions drawing from social, behavioural, cultural, biomedical, scientific, and technological dividends have been harnessed as inputs to make real progress in HIV prevention, care and treatment especially for the marginalised populations,

Our key strategic objectives in the next five years of the life cycle of this NASF include;

1. Reduction of new HIV infections by at least 50 per cent from the current 28, 000 to 14, 000 by 2027.
2. Reduction of AIDS related mortality by 50 per cent, that is from the current 20, 000 to 10, 000, by 2027.
3. Reduction of HIV related stigma and discrimination by 50 per cent
4. Increasing domestic financing of the HIV response from the current 13.8 per cent to 30 per cent by 2027.
5. Reduction of mother to child transmission of HIV, which stood at 3.7 per cent in 2019, to less than 3 per cent by 2027. Refer to the UNAIDS Report

I invite all stakeholders to utilise this document as their guide in their respective areas of interventions in our continued resolve to deepen and strengthen the national HIV multi-sectoral response.

NAC remains optimistic that concerted efforts will enable us to realise the vision of a nation free from the threat of HIV and AIDS.

Dr Kennedy Lishimpi
Permanent Secretary – TS
MINISTRY OF HEALTH

ACKNOWLEDGEMENTS

This National AIDS Strategic Framework (NASF) 2023–2027 benefited from the participation of different stakeholders, each playing a unique role, culminating into its successful completion in a consultative process, giving the document a truly national character and outlook.

The development of this NASF was informed by, among other things, the Revised NASF 2020 – 2023; the Eighth National Development Plan (8NDP) 2022-2026; the National Health Strategic Plan (NHSP) 2022-2026; global guidelines; as well as the African Union (AU) and Southern African Development Community (SADC) commitments. Several analytical studies investigated the epidemic and reasons for slower reduction in incidence, gaps, constraints, barriers and challenges to implementation progress.

Consultative multi-stakeholder dialogue meetings guided the NASF development. A series of consultations and reviews, by people living with HIV/AIDS (PLHIV) and/or TB; National HIV/AIDS/STI/TB Council of Zambia (NAC); Ministry of Health and other line ministries; United Nations (UN) agencies through the Joint United Nations Team on AIDS (JUNTA); PEPFAR; Global Fund; civil society organisations (CSOs); private sector and others, were undertaken. These series of consultations and reviews enabled a deep dive into programmatic and operational level specificities, while relying on available evidence to make more granular, corrective recommendations for strategies, interventions and activities. An analysis of all the above evidence by implementers and policymakers determined common reasons for lower coverage and impact.

The development process was led and coordinated by the NASF technical committee, comprising carefully selected experts, and overseen by the NASF steering committee. The steering committee comprised government; development partners; civil society organisations, including networks of People Living with HIV and representatives of Key Populations; and private sector groups.

NAC is greatly indebted to all the individuals and organisations, in the above-mentioned categories, who are too numerous to mention one by one, for their valuable support in making the task of putting this document together a success.

Lastly, I wish to thank all NAC staff who supported the development of this document at both the head office in Lusaka and at sub-national structures.

It is my hope that the aspiration of this NASF will be realised and contribute to the positive health outcomes in the Zambian HIV response.

Dr Kebby Chongwe Musokotwane
Director General
NATIONAL HIV/AIDS/STI/TB COUNCIL

EXECUTIVE SUMMARY

With the NASF 2023 - 2027, Zambia is laying emphasis on the obstacles that are in the way of ending the AIDS epidemic as a public health threat by 2030 and highlighting strategic priorities for achieving the ambitious 95-95-95 targets by 2027.

The NASF prioritises key interventions to achieve the global targets. It is premised on the realisation that significant improvement in HIV prevention, and treatment, particularly for the populations not sufficiently reached with the services, is still needed and that to keep the momentum, and further accelerate the progress to achieve the goal of ending AIDS by 2030, a forward-looking new strategic framework is needed.

The framework has been prepared through a wide range of consultations, including with Government, civil society networks, development and cooperating partners and service providers. The whole process was initiated and coordinated under the leadership of the National AIDS Council (NAC) and geared towards achieving a shared understanding across all relevant stakeholders. Inputs from these consultations served to build the foundation of the NASF.

The NASF comprises a set of evidence-informed strategies, focused on optimising equitable access to HIV services, addressing barriers, resourcing, and sustaining the HIV response while building resilient and sustainable systems for health, with a particular focus on strategic information and community responses. This is aimed at ensuring a consolidated, unified, rights-based and decentralised HIV programme, with services that are integrated into the health systems at all levels.

Furthermore, the framework builds on the significant gains already made in the national response and addresses key gaps, challenges, and priorities. It aims to provide a clear direction towards ambitious, visionary, and evidence-informed strategic outcomes. It continues the momentum generated by the universal access commitments and hence positions the health sector response to HIV as being critical to the achievement of universal health coverage – one of the key health targets of the Sustainable Development Goals (SDGs). Thus, the framework aims to serve as a road map to ensure country-led coordinated response to end AIDS as a public health threat by 2030. The NASF shapes the new landscape of HIV response in the changed context and approach.

The NASF promotes a people-centred approach, grounded in principles of human rights and health equity. It will contribute to a significant decline in new HIV infections and HIV-related deaths, while also improving the health and well-being of all people living with HIV. It will guide efforts to accelerate and focus HIV prevention, empower people to know their HIV status, provide antiretroviral therapy and comprehensive long-term care to all people living with HIV and challenge pervasive HIV-related stigma and discrimination. As such, the strategic priorities that will get Zambia on the path to achieving the NASF targets and ending AIDS as a public health threat by 2030 are to:

- Optimise equitable and equal access to HIV services through differentiated HIV combination prevention, treatment, care and support services focusing on key and vulnerable populations including children, adolescents and young people and key populations.

- Address barriers to achieving HIV outcomes in all populations through reduction of stigma and discrimination and other human rights and gender related barriers to services while enhancing critical social enablers and developing synergies with relevant sectors.
- Resource and sustain the HIV response through increased domestic financing for HIV, prioritised investments to scale-up innovative interventions targeted at key and vulnerable populations, with a particular focus on adolescents and youth and key populations, strengthened public and private partnerships for comprehensive HIV services and focus on well-coordinated and harmonised integrated HIV services in the health system at all levels, leveraging the decentralisation policy.
- Strengthen strategic information for achieving and sustaining HIV epidemic control through investments and support for integrated systems for generation of quality data for evidence informed programming and sustainability.
- Reinvigorate community responses for a quality, efficient, effective, and sustainable HIV response, including through community-led monitoring and effective feedback mechanism for continuous quality improvement in HIV service provision.
- Alignment of treatment targets from 90-90-90 to 95-95-95.
- Focus on addressing barriers to HIV service access by key and vulnerable populations in contribution to the global 10 10 10 targets on inequalities.
- Attention to domestic financing and sustainability of the HIV response through a strengthened multisectoral coordination leveraging the decentralisation policy.
- A strengthened strategic information system for achieving and sustaining the HIV response.
- Expansion of community responses including scale up of community-led service delivery and community-led monitoring (CLM) towards the global 30 80 60 targets
- A shift from intervention-focus to a people-centred response. Examples include Differentiated Service Delivery (DSD) for ART such as Community ART Groups (CAGs), HTS, and other prevention programmes.
- Differentiated Service Delivery (DSD) for ART such as Community ART Groups (CAGs) and ART Refills Groups.
- Adoption of results-based planning and accountability framework (Strategic Results, or Goals; Programme Results; Result Areas and Outcome Results cascading into output level results at the operational planning level).
- Strengthened and rolled out adolescent-focused interventions to reduce new infections and maintain those on treatment to achieve the last 95 among the target groups.

- Consideration of “leave no one behind” principles to ensure equitable access to treatment, care and support for all key and vulnerable populations such as persons with disabilities, refugees, migrants and inmates to the largest extent possible.
- Focus on finding men and boys who have been left out in the response to HIV and AIDS.
- Strengthening the focus on pregnant and breastfeeding women, including adolescent girls and young women (AGYW);
- Key population definition list streamlined to only five (5), namely sex workers, transgender people, men who have sex with men (MSM), people in closed settings and people who inject drugs (PWID), while categorising others as vulnerable populations.
- Review of service delivery models and response allocation prioritisation criteria especially for commodities such as condoms and lubricants - from geography to sources and drivers of the epidemic); and
- Strengthened focus on gender mainstreaming and considering different needs and aspirations of men, women, boys, and girls.

This strategy is fully aligned with the Eighth National Development Plan (8NDP); Vision 2030; and the United Nations (UN) Sustainable Development Cooperation Framework for Zambia. It takes into consideration the HIV and broader health strategies of key development partners, including the Global Fund to fight AIDS, Tuberculosis and Malaria; and the United States President’s Emergency Plan for AIDS Relief.[1]

The goal of ending the AIDS epidemic requires rapid acceleration of the response over the next five years and then sustained action through to 2030 and beyond. This can only be achieved through political commitment; additional resources; and technical and programmatic innovations.

[1] For more information on the United States President’s Emergency Plan for AIDS Relief, see http://www.pepfar.gov/about/strategy/ (accessed 15 March 2016).

1.0 BACKGROUND

The National HIV/AIDS Strategic Framework (NASF) 2023 - 2027 is the seventh (7th) in a series of national HIV/AIDS strategic frameworks and is a five-year strategy. It is aligned with the Vision 2030; Eighth National Development Plan (8NDP); National Health Sector Strategic Plan; Zambia United Nations Sustainable Development Cooperation Framework 2023 – 2027; National HIV/AIDS Policy; and International and regional commitments. Specifically, it is aligned with Global AIDS Strategy 2021-2025; Global Fund Strategy 2023-2028; and PEPFAR's five-year strategy.

The priority focus for the NASF is to intensify combination HIV prevention in the national multi-sectoral HIV response This is with a view of reducing new HIV infections among children (0 - 14 years), currently standing at 5, 000 (Spectrum, 2022), and adults (15+), currently standing at 28, 000 (ZAMPHIA, 2021). This will be done by focusing on addressing the barriers to optimal access to HIV services, particularly by key and vulnerable populations.

This NASF recognises the HIV and AIDS epidemic as a socio-developmental challenge. It incorporates emerging issues in the epidemic, including the application of multi-sectoral strategies to address the barriers to HIV service access. It focuses on key and vulnerable populations aiming to achieve the 95-95-95 targets by 2025, ultimately putting Zambia on the path to eliminating new HIV infections and ending AIDS by 2030.

The purpose of the NASF is to reposition prevention of new HIV infections as the focus of the national multi-sectoral HIV and AIDS response, highlighting national strategic priorities, expected outcomes and targets. The frame provides transparency for reaching an agreement with cooperating partners on their technical and financial support as well as the management and coordination of the response.

1.1 Situation analysis

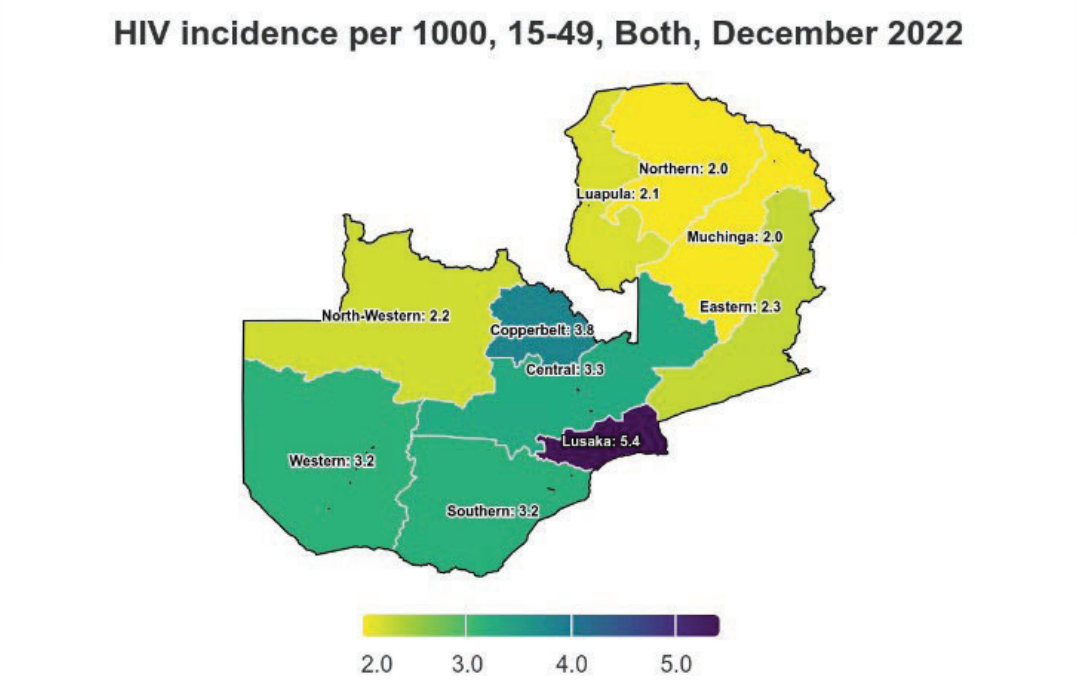
1.1.1 Country Context

Zambia is classified as a low-income country following poor economic growth in the recent past. Zambia's economy is, however, showing encouraging signs of stabilising after a period of macroeconomic imbalances that weakened economic performance.

The population of Zambia stands at 19, 610, 769 as of 2022. The male population is 9, 603, 056 and the female population is 10, 007, 713. Lusaka province has the largest population size at 3, 079, 964 with the smallest population size being Muchinga province with 918, 296 (Zamstats, 2022). The life expectancy at birth is 63.9 years.

1.1.2 HIV Incidence and Prevalence

Figure 1- 1: HIV Incidence



According to the ZAMPHIA 2021 report, the annual incidence of HIV among adults aged 15 and above was 0.3 per cent, higher at 0.6 per cent among women than 0.1 per cent among men. The annual incidence of HIV among young people aged 15-24 years was 0.4 per cent with young women having a higher incidence at 0.8 per cent.

The ZAMPHIA 2021 report estimated HIV prevalence among adults aged 15 years and above at 11.0 per cent, 13.9 per cent among women and 8.0 per cent among men. HIV prevalence was higher among women compared to men from the 20-24 age group to the 35-39 age group and the 45-49 age group. The largest difference was seen in the 30-34 age group with a prevalence of 19.4 per cent in women and 7.0 per cent in men. The figure below shows the prevalence rates by age and sex.

Figure 1- 2: HIV new infection trends over time

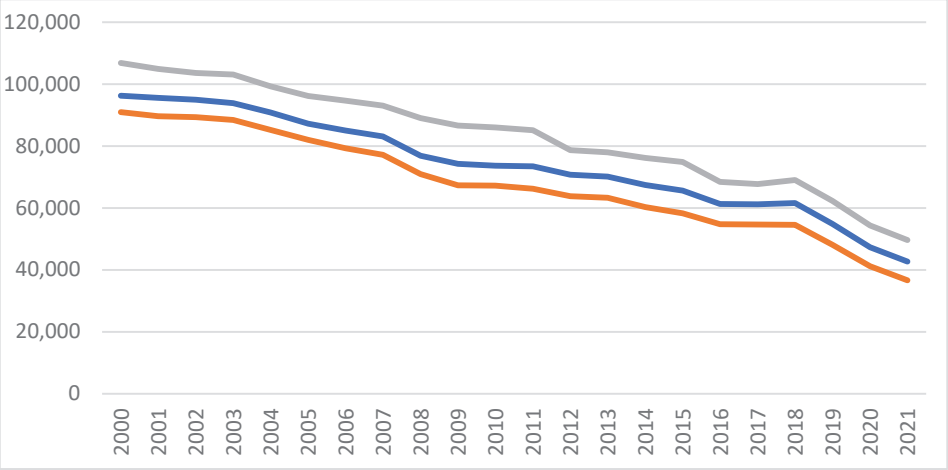
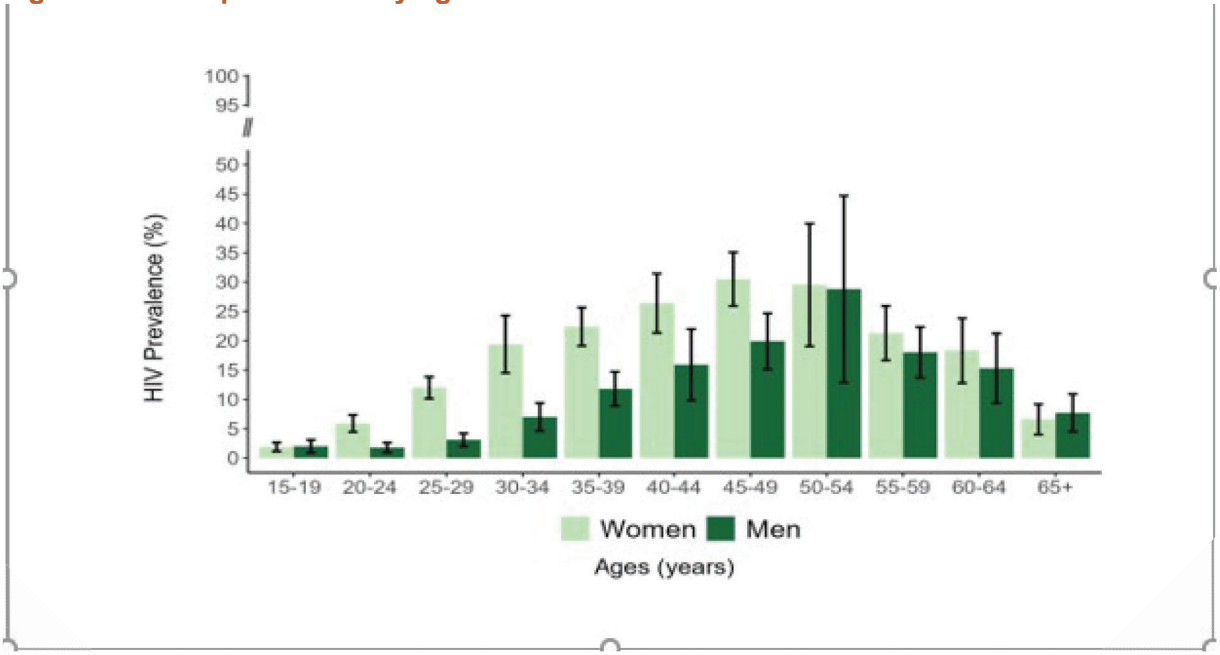


Figure 1- 3: HIV prevalence by age



1.2 Factors fuelling new HIV infections

1.2.1 Early sexual debut

The term "early sexual debut" describes the start of sexual activity when a person is young. This is frequently in their adolescence. Increased risk factors for poor health outcomes, such as STIs, unplanned pregnancies and detrimental psychological effects, are linked to this phenomenon. Numerous factors, including peer pressure; a lack of sexual education; and socioeconomic circumstances, can have an impact on an early sexual debut. Comprehensive sexual education programmes that teach youth about consent; safe sexual practices; and the emotional components of relationships with others, are necessary to address this issue. Policies and communities that support healthy adolescent development must also be in place.

1.2.2 Number of lifetime sexual partners

Understanding sexual behaviour and its effects on public health requires an understanding of the number of lifetime sexual partners. As a result of more opportunities for exposure, having more lifetime sexual partners is frequently linked to an increased risk of STIs, including HIV. Insights into relationship dynamics, sexual activity patterns, and the efficacy of sexual health education can all be gained from this metric. The risks associated with having multiple sexual partners can be reduced, leading to healthier communities, through public health interventions that support safe sex practises; frequent STI testing; and open communication about sexual health.

1.2.3 Widespread abuse of alcohol and other substances

There are serious social and public health issues associated with the widespread misuse of alcohol and other drugs. Numerous negative effects result from it, such as an increase in the prevalence of mental health issues, accidents, violence and chronic diseases. In addition to putting a strain on families, communities and healthcare systems, substance abuse also increases healthcare costs and reduces productivity. This adds to the burden on the economy. Comprehensive approaches are needed to address this problem, such as public awareness campaigns; treatment and rehabilitation service accessibility; prevention programmes; and laws that control and limit the supply of addictive substances.

1.2.4 Sub-optimal uptake of other biomedical prevention interventions

The sub-optimal uptake of other biomedical prevention interventions, such as pre-exposure prophylaxis (PrEP); male circumcision; and post-exposure prophylaxis (PEP), undermines efforts to control the spread of HIV and other sexually transmitted infections. Barriers such as lack of awareness, stigma, limited access to healthcare services and insufficient healthcare provider training contribute to the low adoption rates of these effective measures. Enhancing the uptake of biomedical prevention requires targeted public health campaigns; improved education and outreach efforts; streamlined access to services; and robust support systems to address the social and structural obstacles that hinder utilisation.

1.2.5 Vertical transmission especially during the breastfeeding period

The attempt to eradicate paediatric HIV continues to face a significant obstacle in the form of vertical transmission of HIV, particularly during the breastfeeding period. In spite of great progress in prevention of mother-to-child transmission (PMTCT) during pregnancy and delivery, HIV transmission through breastfeeding remains possible if the mother is not receiving effective antiretroviral therapy (ART). It is crucial to guarantee that mothers living with HIV/AIDS have ongoing access to ART and appropriate guidance on safe breastfeeding techniques. The risk of vertical transmission during breastfeeding can be greatly decreased by bolstering healthcare systems to support ART adherence and offering substitute feeding options when needed. This will ultimately improve health outcomes for mothers and their babies.

1.2.6 Transactional and intergenerational sex

Sexual relationships involving the exchange of goods, money or other benefits are referred to as transactional or intergenerational sex. These relationships typically involve older individuals and younger partners. These relationships have the potential to worsen power disparities; make people more susceptible to exploitation; and raise the risk of sexually transmitted diseases (STDs) like HIV. Younger people in these relationships, particularly women, frequently have less negotiating power for safer sex practises. This puts them at risk of negative health consequences. To address this issue, strong legal frameworks; economic empowerment initiatives; and comprehensive sexual education are needed to safeguard vulnerable populations; advance gender equality; and foster positive relationship dynamics.

1.2.7 Low levels of comprehensive knowledge of HIV

Inadequate comprehension of HIV considerably impedes attempts to stop and manage the virus's spread. A lot of people do not fully comprehend how HIV spreads; how to prevent it; or how important it is to get tested frequently and follow treatment recommendations. This knowledge gap may give rise to harmful behaviours, stigma and misconceptions that raise the risk of infection. Targeted education campaigns; neighbourhood outreach initiatives; and the inclusion of HIV education in school curricula, are crucial in the fight against this phenomenon. Increasing public knowledge about HIV enables people to make more informed decisions about their health and backs larger public health campaigns aimed at lowering the prevalence of HIV.

1.2.8 Gender inequality including GBV

Gender inequality, encompassing gender-based violence (GBV), presents noteworthy obstacles to socioeconomic development, well-being and health. GBV, which includes emotional abuse; sexual and physical abuse; disproportionately impacts women and girls and restricts their access to healthcare, work opportunities and education. As a result of victims of this inequality frequently lacking the power to negotiate safe sex practises or seek necessary medical care, it exacerbates their vulnerability to HIV and other health issues. Comprehensive strategies, such as legal protections; public awareness campaigns; and support services for survivors, are needed to address gender inequality

and GBV. Building healthier and more equitable societies requires empowering women and girls and promoting gender equality.

1.2.9 Low and inconsistent use of condoms

A serious public health issue that jeopardises attempts to prevent HIV and other STIs as well as unwanted pregnancies is the low and inconsistent use of condoms. Many things can contribute to this problem. These include barriers to accessing condoms; stigma in the community; inadequate information about how to use condoms properly; and false beliefs about their efficacy. The spread of STIs is facilitated by inconsistent condom use, which raises the risk of transmission during sexual activity. Improving condom accessibility; offering thorough sexual education; and encouraging condom use, through focused public health campaigns are crucial in addressing this situation. Improving these initiatives could result in more widespread and regular condom use, which would improve the state of people's sexual health in general.

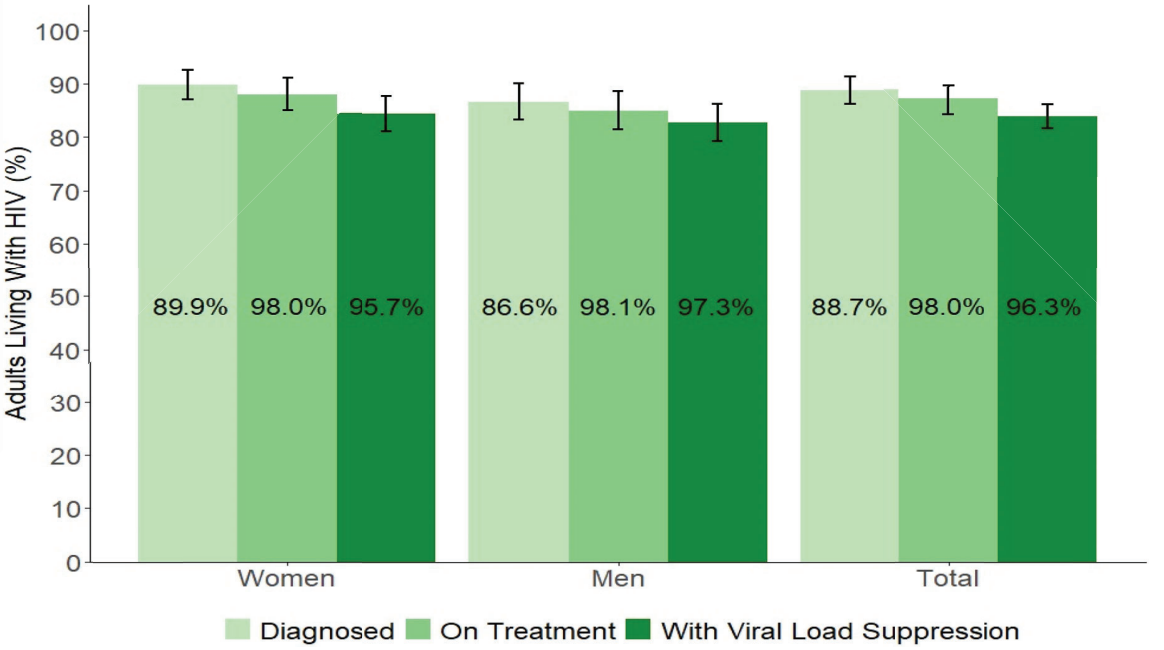
1.2.10 Multiple and concurrent sexual partnerships

The risk of STIs, including HIV, is greatly increased by multiple and concurrent sexual partnerships because of the increased likelihood of exposure and transmission within interconnected sexual networks. These actions can hasten the spread of infections, especially in cases where condom use is sporadic or non-existent. To address this issue, comprehensive sexual health education, which supports frequent STI testing; encourages consistent condom use; and fosters awareness of the risks associated with such practises, is needed. Reducing the stigma attached to seeking sexual health services and promoting safer sexual behaviours are the two main goals of public health campaigns and community-based interventions.

1.3 Progress made towards the UNAIDS Target (95 95 95)

ZAMPHIA 2021 revealed that 88.7 per cent of adults (15+ years) living with HIV were aware of their HIV status, 89.9 per cent among women and 86.6 per cent among men. Among those unaware of their HIV status, 27.2 per cent were young people aged 15-24 years. Among adults living with HIV who were aware of their status, 98 per cent were on ART, 98 per cent among women and 98.1 per cent among men. Among those aware of their HIV-positive status and on treatment, 96.3 per cent had viral load suppression (VLS): 95.7 per cent of women living with HIV and 97.3 per cent of men living with HIV. The prevalence of VLS among adults aged 15 years and above living with HIV in Zambia stands at 86.2 per cent: 86.6 per cent among women and 85.5 per cent among men as shown in Figure 1-4 below.

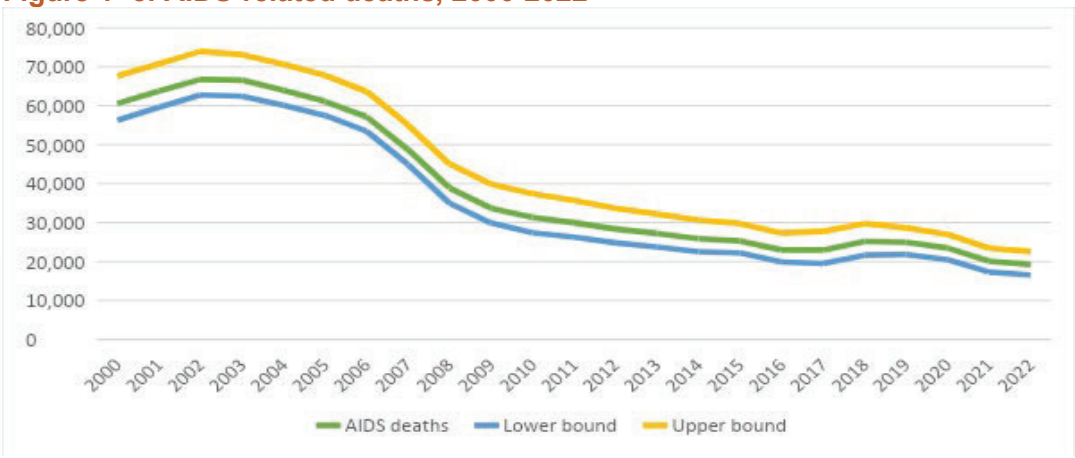
Figure 1- 4: Adults living with HIV



1.4 Morbidity and mortality trends

Spectrum estimates that mortality rate from AIDS-related deaths had reduced to less than 20, 000 in 2021.

Figure 1- 5: AIDS-related deaths, 2000-2022



Source: Spectrum, 2023

1.5 The National HIV and AIDS Response

Zambia has made significant progress in moving towards HIV epidemic control. Results from the second Zambia Population-based HIV and AIDS Impact Assessment (ZAMPHIA) survey conducted in 2021 showed the following key achievements:

1. **Awareness of HIV Status**: 89 per cent of Zambian adults aged 15 years and older living with HIV are aware of their status.
2. **Treatment Coverage**: 98 per cent of those aware of their status are on treatment.
3. **Viral Suppression**: 96 per cent of those on treatment are virally suppressed, meaning a reduction of HIV in the body to low levels where transmission is less likely to occur.

Zambia is close to achieving the first 95 target. There are, however, still HIV awareness gaps within the population, with higher disproportions among adolescent girls and young women (AGYW) and men. Nonetheless, the country remains on track to attain and sustain all three UNAIDS 95-95-95 targets by the year 2025. Additionally, HIV incidence has reduced from 0.6 per cent in 2016 to 0.3 per cent in 2021 among the population aged 15 years and above.

In an effort to achieve the first 95 target, Zambia has put in place strategies targeted at reaching key and vulnerable populations, especially AGYW and mobile and hard-to-reach populations, who are disproportionately affected by HIV. This is being done through addressing the legal, policy and social-cultural barriers and sustainable financing in order to increase access to health care and reduce further transmission of HIV.

Furthermore, in sustaining the gains made towards the HIV response, the country has put in place measures in prevention and treatment of HIV. Under prevention, there has been routinised voluntary male medical circumcision (VMMC) provision; increased condom access, through last mile condom distribution strategies and differentiated service delivery (DSD) for HIV testing; and ART-based prevention methods. In the treatment response, the country has used DSD models; expanded viral load testing points; and transitioned to effective ART regimen. Zambia is aligned with all global health response strategies and has adopted WHO guidance on prevention and treatment of HIV, including the introduction of PrEP methods i.e. injectable and vaginal ring; HIV testing strategies; and current treatment regimens. The country has innovated condom dispensation and expanded information dissemination modes to include social media to reach targeted audiences. Other interventions are in school behavioural change communication and enforcement of by-laws to control alcohol and substance abuse.

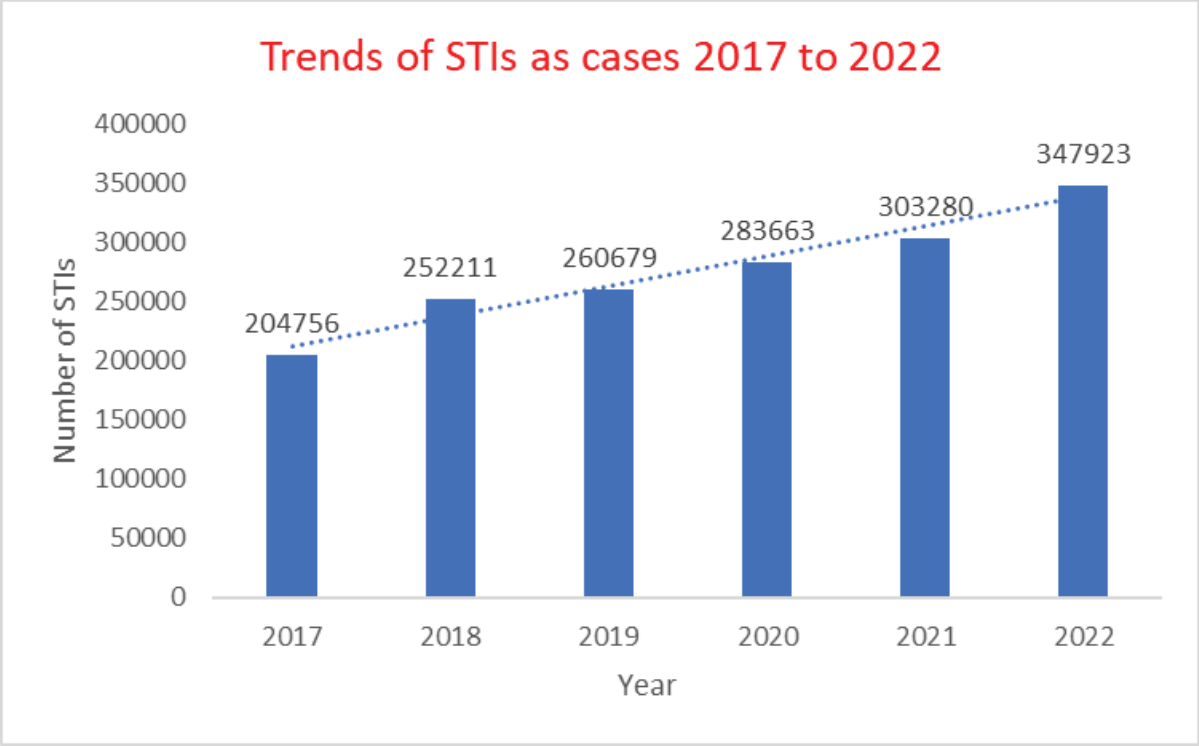
1.6 Sexually transmitted infections epidemiological response profile

Epidemiological profile

In Zambia, Sexually Transmitted Infections (STIs) have continued to be among the major causes of outpatient attendance both in public and private health institutions. The most affected age group is the sexually active population of between 15 - 25 years.

According to HMIS (2017-2021), the number of new sexually transmitted infections has been rising from 204,756 cases in 2017 to 347,923 cases in 2022.

Figure 1- 6: Trends of STIs cases 2017 -2022



The most common STI syndromes recorded by frequency from 2017 were lower abdominal pain syndrome; genital ulcers syndrome; vaginal discharge syndrome (VDS); and urethral discharge syndrome (UDS). The frequently affected age range was 15 to 49 years (HMIS, 2022). According to the 2016 ZAMPHIA Study, three per cent of pregnant women had active syphilis infections. Each year, without screening and treatment, this would result in 4, 300 stillbirths; 1, 800 neonatal deaths; 3,250 cases of disability due to congenital syphilis; and 1, 200 cases of low-birth-weight new-borns. The burden of STIs is partly due to low condom use.

Among the 15 to 49-year-old respondents of the 2018 Zambia Demographic and Health Survey (ZDHS), only 35 per cent of females and 54 per cent of males reported using a

condom when having sex with a person who was neither their spouse nor lived with them in the 12 months preceding the survey. The proportions were even lower among young people. Only 34 per cent of females and 49 per cent of males aged 15 to 24 years used a condom at the last high-risk sex with a non-regular partner.

1.7 Sexually transmitted infections response profile

1.7.1 Status of the national STI control programme

Over the years, government has implemented the following STI prevention and control measures as part of the HIV response:

- Comprehensive condom programming;
- STI screening as part of VMMC provision;
- Coordination between partners and across programmes, such as testing and sexual reproductive health (SRH);
- Integration of STI into the HIV programme; and
- Integration into SRH services including adolescent, maternal and child health (MCH) and key population (KP) health programmes.

1.7.2 Challenges in the STI control programme

Despite the implementation of the interventions described above, the cases of STIs continued to rise due to the following challenges:

- Inadequate community awareness campaigns on STIs to enhance early treatment-seeking behaviour;
- Inadequate partner notification and referral including cross-border patient information sharing;
- Stockouts of diagnostic and treatment commodities;
- Inadequate countrywide condom promotion and distribution mechanisms; and
- Inadequate approaches to ensure the adolescents, pregnant women and KPs are reached with STI prevention and treatment messages (e.g. anti-stigma messages).

Other challenges:

- Inadequate STIs programmes/information on social media;
- Poor data collection, documentation, management and reporting in the health management information system (HMIS); and
- Syndromic reporting of STIs and not as diagnosis.

1.8 Viral hepatitis infection

1.8.1 Epidemiological profile

Of the various types of viruses that can cause hepatitis, Hepatitis B virus is of major public health concern as it is more prevalent and can cause chronic liver disease infection and liver damage. This predisposes individuals to developing cirrhosis and liver cancer, and thus, increases the risk of death.

According to the 2016 ZAMPHIA report, the prevalence of infection with Hepatitis B virus (HBV) among adults aged 15 to 59 years was higher among people living with HIV (PLHIV) (7.1%) than HIV-negative individuals (5.4%). It was also noted that the prevalence of HBV was especially high among HIV-positive males of the said age group, at 10.2 per cent. similarly, among children under the age of 14, HBV infection was more prevalent among those living with HIV, at 5.2 per cent, than among those living without HIV (1.3%).

1.9 Viral hepatitis infection response profile

1.9.1 Status of the national viral hepatitis infection control programme

Zambia has made significant strides in responding to viral Hepatitis B infection. This has been done through various measures and programmes, such as the generation and provision of information for decision-making and for informing programming, through conducting of specialised studies such as the ZAMPHIA. Other efforts include developing and operationalising policy documents such as the implementation framework and guidelines for treating and preventing viral hepatitis. In addition, the country has joined global efforts to eliminate vertical transmission of HBV. This has been done through the adoption of triple eMTCT of HIV, HBV and Syphilis Strategy.

Zambia has implemented strategies to prevent and reduce the spread of viral hepatitis as a public health threat by 2030. These strategies aim to reduce maternal transmission; scale up interventions and enhance knowledge and skills of health care providers in screening high-risk populations; and ensure adequate follow-up and management of viral hepatitis.

1.9.2 Challenges to viral hepatitis infection programming

- Low testing among pregnant women;
- Stockouts of testing commodities;
- Inadequate awareness about hepatitis; and
- Lack of routine Hepatitis B birth dose.

1.10 Tuberculosis epidemiological and response profile

1.10.1 Tuberculosis epidemiology

In 2021, the estimated tuberculosis (TB) incidence was 307 (195-445) per 100,000 population, translating to 60, 000 (38,000-86,000) inhabitants falling ill with TB, with 20,000 (13,000-29,000) of the TB burden in HIV positive individuals; 8, 400 in children; and 18,000 in women aged 15 years and above. In 2015 the estimated incidence was

391 per 100,000 population, giving a 22 per cent reduction in TB mortality between 2015 and 2021. Since 2019, the burden of TB has been greater in the HIV-negative population than in HIV-positive individuals, a departure from the situation observed between 2000 and 2018 (Figure 1-7). HIV/TB mortality has decreased from 41 per 100,000 population to 14 per 100,000 (equivalent to 7, 900 estimated TB deaths) between 2020 and 2022. (Figure 1-8).

Figure 1- 7: Estimated TB incidence

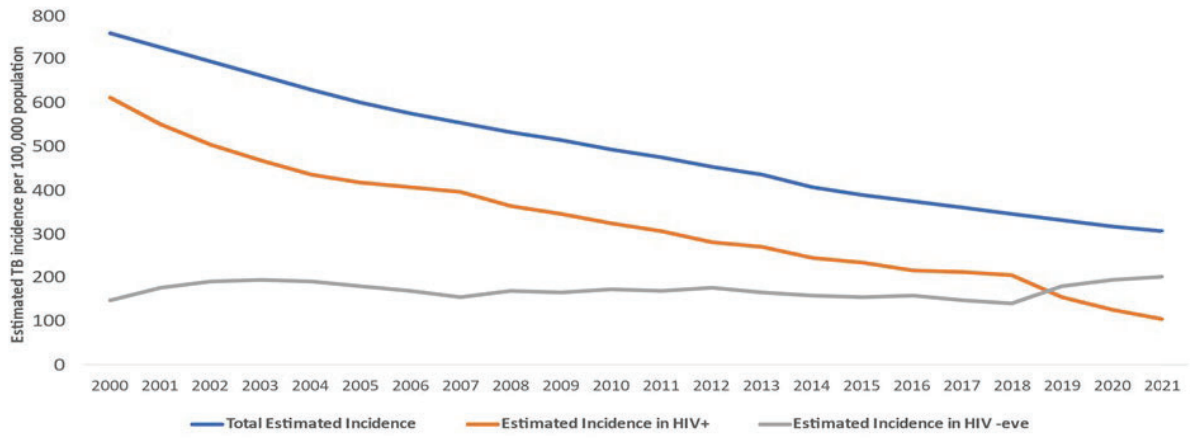
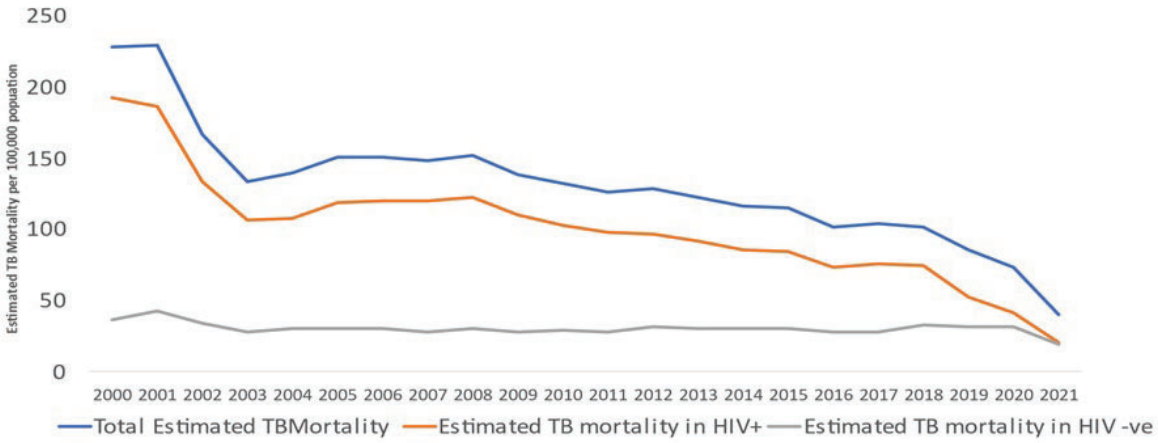


Figure 1- 8: Trends of incidence rate per 100,000 population 2020-2021



1.10.2 Tuberculosis Response

Over time, several strides and gains have been noted in the country's response to Tuberculosis. As such, there has been a decrease in the number of cases in the general population as well as among those related to HIV infection. According to the Global TB Report 2022, TB treatment coverage in 2022 was 92 per cent, a remarkable improvement

from 59 per cent in 2019, while the treatment success rate for HIV-positive TB cases was 90 per cent in 2021 from 88 per cent in 2019.

These successes can be attributed to shorter, and more potent, but less toxic regimens for treating TB; and improved methods of diagnosing TB by use of innovative methods for molecular tests such as X-pert, TB-LAMP and TB-LAM, which have led to better and more accurate case-finding. Further, evidence from the TB Diagnostic Network Assessment Report of 2020-2021 shows that 67 per cent of the population access X-pert services within 35 kilometres. These have also been complemented by mobile service provision contributing to increased case-finding and reduced timeline for overall service provision and acquisition.

Additionally, the decentralisation of treatment for multidrug resistance (MDR) TB has contributed to an increase in the number served and reducing the case load. Furthermore, capacity has been built among service providers in TB diagnosis and treatment.

Regarding the prevention of TB, the country has focused on the provision of TB preventive therapy (TPT) to PLHIV, under-five children and among contacts of bacteriologically confirmed cases. However, the coverage of TPT among under five contacts of bacteriologically confirmed TB patients was only 35 per cent in 2021[1]. In response to the sub-optimal coverage, there is a thrust in TPT coverage resulting in high political commitment; stakeholders buy-in and support; and effective commodity security.

There has been an increase in the uptake of TPT among PLHIV since 2018. Over 90 per cent coverage has been linked to a reduction of TB-HIV co-infection from 60 per cent in 2018 to 34 per cent in 2021.

1.10.3 Challenges in the Tuberculosis/HIV Response

Despite the strides made in the prevention and control of TB/HIV through a robust countrywide approach, the response still faces challenges such as:

- Perceived and experienced stigma and discrimination;
- Low TB Screening among PLHIV;
- Inadequate awareness of TB/HIV co-infection;
- Low TB case-finding;
- Low coverage of TB preventive therapy;
- Weak coordination mechanisms between TB and HIV programmes;
- Myths and Misconceptions on acquisition and transmission of TB;
- Inadequate infrastructure for TB screening; and
- Insufficient Latent TB infection testing kits.

1.11 Priority Populations

Priority populations include the following: -

1. Adolescent and Young People:
    - Adolescent girls and young women; and
    - Young men;
2. Men;
3. Underserved Populations:
    - inmates;
    - People who inject drugs;
    - Female sex workers;
    - Gay men and other men who have sex with men;
    - Transgender people; and
    - Refugees and Migrants;
4. Persons with disabilities; and
5. Children and pregnant women living with HIV.

Table 1-1: Barriers to Access to HIV Services by Key and Vulnerable Populations

POPULATION	BARRIERS
Adolescent and Young People	• Current age of access to health services • Gender-based discrimination • Gender-based violence • Inadequate knowledge of HIV prevention • Low perceived risk to HIV infection • Lack of confidentiality and privacy • Limited number of adolescent friendly spaces • Negative and judgemental attitudes from healthcare providers • Distance to health facilities • Low social economic status/poverty
Men 25 years and above	• Hours of service delivery, facility congestion and long waiting times limit access to services • Perceived stigma and need for privacy • Insufficient information on HIV and low treatment literacy • Non-existence of Male-specific problem services • Non-existence of Male-specific mobilization activities
Underserved Population	• Perceived and experienced stigma and discrimination • Prohibitive legal environment • Limited capacity of healthcare workers to provide KP-friendly services • Lack of privacy and confidentiality • Perceived fear of being reported to law enforcement • Unavailability of services for people who inject drugs (PWIDs)
Inmates	• Perceived and experienced stigma and discrimination • Limited capacity of healthcare workers to provide in-mate friendly HIV prevention services • lack of comprehensive prevention packages within prisons and places of detention

Refugees and Migrants	• Challenges in accessing healthcare services due to their transient nature • Limited awareness of where to seek health services • Refugees may have limited financial resources and face language and cultural barriers • Defence and security forces may be exposed to higher-risk environments due to their work • Restriction of movement resulting into poor health seeking behaviours • Lack of confidentiality from healthcare workers
Persons with disabilities	• Limited knowledge and skills by the health providers to provide services to people living with disabilities e.g. sign language interpretation • Physical accessibility issues such as lack of rumps • Stigma and discrimination • Limited awareness about prevention methods tailored to their specific needs
Children and pregnant women living with HIV	• Cultural, religious and social norms related to pregnancy disclosure • Poor access to early infant diagnosis (EID) services due to inadequate and centralised laboratory capacity and services • Limited integration of ART in maternal and child health (RAMNCAH) • Gendered power inequalities • Low levels of comprehensive knowledge on HIV • Long distance to health facilities

1.12 Stigma and discrimination

Stigma and discrimination have been identified as barriers to HIV prevention and uptake of care and treatment services. The Zambia Demographic and Health Survey (ZDHS, 2018) reports that differences in discriminatory attitudes towards PLHIV were observed between urban and rural areas: 20 per cent of women and 17 per cent of men in urban areas have discriminatory attitudes compared to 33 per cent of women and 28 per cent of men in rural areas. The report further indicates that discriminatory attitudes are highest in Luapula (47% for women and 39% for men) and lowest in Copperbelt for women (17%) and Lusaka for men (16%).

The recent National Stigma Index 2.0 (2023) provides valuable insights into the experiences of people living with HIV across 25 districts. Although there has been a decrease in stigma since the last index in 2012, there are still areas of significant concern that need to be addressed. The data reveals that about 12.4 per cent of women reported instances of stigma manifesting as in exclusion from social activities. Among men, this percentage was slightly higher at 14 per cent. Additionally, a slightly larger proportion of individuals, both men and women, mentioned experiencing discriminatory remarks or gossip related to their HIV status.

About 14.5 per cent of women reported such experiences in the past 12 months, while 16 per cent had experienced such gossip but not in the immediate past 12 months of that period. Similarly, the proportions were 14.2 per cent and 17.8 per cent among men, respectively. While the prevalence of external forms of stigma and discrimination affecting

the population has decreased, the report highlights a concerning trend of internal stigma. Although the overall levels of internal stigma are lower than those observed in 2012, a significant number of participants still reported experiencing it.

2.0 VISION, GOAL, OBJECTIVES, KEY RESULTS AND GUIDING PRINCIPLES

2.1 Vision

A nation free from the threat of HIV by 2030.

2.2 Goal

To contribute to ending AIDS by 2030.

2.3 Strategic Objectives of the NASF 2023-2027

- To optimise equitable and equal access to HIV and co-morbidity services for key and vulnerable populations;
- To address social and structural barriers to achieving HIV outcomes in all populations;
- To mobilise domestic and external resources to sustain the HIV response beyond 2030;
- To strengthen strategic information for achieving and sustaining HIV epidemic control; and
- To reinvigorate community responses for a quality, efficient, effective and sustainable HIV response.

2.4 Summary of Programme Results of the NASF 2023-2027

i. Intensified Test and Treat to attain 95-95-95 targets for all population groups by 2027.

ii. 95 percent of women and girls access integrated HIV and SRH services.

iii. Vertical transmission of HIV, syphilis and Hepatitis B virus eliminated.

iv. 95 per cent of children and adolescents living with HIV on treatment by 2027.

v. 95 per cent of people aged 15 and above at risk for HIV have accessed combination prevention services.

vi. 90 per cent of people living with HIV are protected from contracting TB.

vii. 90 per cent of people living with HIV and people at risk are linked to other integrated health services.

viii. Increased comprehensive HIV and AIDS knowledge among the adolescents and young people by 2027.

ix. Gender and Human Rights related barriers to service delivery, accessibility and utilisation by key and vulnerable populations reduced by 2027.

x. Reduce HIV-related stigma and discrimination by 50 per cent.

xi. People-centred systems for health that sustainably integrates HIV, AIDS and TB and other infections by 2027.

xii. 45 per cent of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.

xiii. 95 per cent of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics including COVID-19.

xiv. Increased efficiencies and financial investments in HIV programme to 90 per cent of the national strategic plan (NSP) budget by 2027.

xv. Increase domestic financing of the HIV response to 30 per cent by 2027 from 13.8 per cent in 2017.

xvi. Inter-operable electronic/ digital community and health information systems for planning and decision making.

xvii. Enhanced national and community access to and utilisation of information on HIV, AIDS, STIs and TB.

xviii. Expanded community-led HIV testing and treatment, prevention and societal enabler programmes towards the 30 80 60 global targets respectively.

2.5 Guiding Principles

The following principles will guide the NASF 2023-2027:

1. **Partner Coordination:** To avoid duplication and overlap of responsibilities.
2. **Gender and Age Sensitive:** Given the gender bias or feminisation of the HIV epidemic, gender dimensions will be proactively addressed in all programme areas and mainstreamed into all aspects of the responses.
3. **Greater Involvement of PLHIV (GIPA), Key Populations and Young People:** To strengthen and expand the involvement of PLHIV at all levels of the national response. This principle will be extended to include the greater involvement of most-at-risk populations including adolescents and young people (AYP) particularly adolescent girls and young women.
4. **Human Rights-Based:** To consistently ensure that as we implement a public health approach the individual human rights are not violated but respected regardless of one's ethnic, racial, religious, economic and social status.
5. **Affordability**: To ensure affordability of healthcare services to all, considering the socio-economic status of the people.
6. **Cost-effectiveness:** To ensure efficient and cost-effective delivery of healthcare services, always ensuring 'Value for Money.
7. **Leadership:** To ensure appropriate, visionary, efficient and effective leadership in the management and control of the responses at all levels.
8. **Transparency and Accountability:** To ensure the highest standards of transparency in the management of the health services; and accountability for the actions taken and resources utilised, to the communities served at all levels of health service delivery.

9. **Decentralisation:** To implement decentralisation of the health system, according to the objectives and implementation framework of the National Decentralisation Policy of 2002.
10. **Partnerships:** A continuous review and strengthening of partnerships with all the main stakeholders through stronger and effective coordination and harmonisation.
11. **Gender Responsive/Sensitivity:** To ensure gender sensitivity in the management and delivery of health services at all levels following the National Gender Policy.
12. **Evidence-Based:** To ensure that every decision made is evidence-based.
13. **Investing for impact and maximising efficiencies:** Zambia will use the adapted investment thinking approach, with a 95-95-95 overlay, to achieve maximum leverage on investments in HIV and AIDS.
14. **Equality and non-discrimination:** The current Global AIDS Strategy is about ending inequalities. Therefore, it will be amiss not to adhere to a principle that ensures equality and non-discrimination.

3.0 STRATEGIC PRIORITIES AND INTERVENTIONS

The NASF prioritisation considers the following dimensions:

i. Optimising access to HIV services through prioritisation of adolescents, young people and key populations interventions based on evidence.

ii. Addressing barriers to HIV service access through a multi-sectoral response that leverages the decentralisation policy.

iii. Stimulating increased domestic financing and the development of a sustainability roadmap for the national responses.

iv. Focus on strategic information for positioning of high impact interventions based on efficiency of approach, scope and scale in reducing new annual HIV infections.

v. Balancing between biological and structural drivers of the epidemic in Zambia while invigorating community responses.

vi. Differentiation of approaches in diverse geographical locations based on impact and value for money considerations.

The NASF has prioritised the following key interventions classified into five strategic priorities as detailed in sections 4.1 to 4.5 below:

i. Scaling up combination HIV prevention interventions in key and vulnerable populations.

ii. Expanding quality assured HIV testing with access to comprehensive HIV treatment, care and support services, including viral load testing and adherence to and retention to treatment.

iii. Triple elimination of mother-to-child transmission of HIV, Hepatitis B and congenital syphilis.

iv. Strengthening strategic information systems for evidence-informed HIV programming.

v. Addressing barriers to HIV service access, including stigma and discrimination, gender and human rights related barriers while enhancing critical enablers and developing synergies with relevant sectors.

vi. Strengthening Resilient and Sustainable Systems for Health (RSSH) including Community Systems Strengthening (CSS).

vii. Strengthening local health systems for pandemic preparedness and response to ensure HIV services are not disrupted during the health emergencies or other disasters.

viii. Enabling policy environment at all levels.

3.1 HIV Prevention

3.1.1 Strategic Objective: To optimise equitable and equal access to HIV services.

3.1.2 Programme Results

- Intensified Test and Treat to attain 95-95-95 targets for all population groups and geographical settings by 2027.
- 95 per cent of women and girls access integrated HIV and SRH services.
- Vertical transmission of HIV, syphilis and hepatitis B virus eliminated.
- 95 per cent of children and adolescents living with HIV on treatment by 2027.
- 95 per cent of people aged 15 and above at risk of HIV have accessed combination Prevention.
- 90 per cent of people living with HIV are protected from contracting TB.
- 90 per cent of people living with HIV and people at risk are linked to other integrated health services.

3.1.3 Programme Areas

- Social and Behaviour Change Communication
- Comprehensive Condom Programming and Lubricants
- Harm reduction and Opioid Substitution ***T***herapy
- Voluntary Medical Male Circumcision (VMMC)
- Pre-Exposure Prophylaxis (PrEP)
- Post Exposure Prophylaxis (PEP)
- Sexually Transmitted Infections (STIs)
- Viral Hepatitis Infection
- Blood Safety
- Adolescents and Young People (status neutral approach to HIV service delivery)
- HIV Testing Service

3.1.4 Social and Behaviour Change Communication

To promote and reinforce safer and protective sexual behaviours by addressing knowledge, attitudes, skills and social norms using a combination of strategic approaches and methods.

Table 3-1: SBCC Programme Objective and Interventions

Strategic Interventions
1. Use innovative approaches to reach adolescents and young people to enhance their comprehensive knowledge on HIV/STI. 2. Build capacity of implementers at national, district and community levels to implement targeted activities to reach adolescents and young people. 3. Develop culturally appropriate interventions anchored in positive traditional beliefs. 4. Implement tailored social and behaviour change communication and advocacy, ensuring that children of different ages and young adults are appropriately reached with knowledge and skills for safer sex (including risk perception, protective sexual behaviours and integrated service uptake), with AGYW and male counterparts actively involved in SBC design, implementation, monitoring and evaluation. 5. Use innovative community approaches and low-tech approaches to better target men that focus on reaching men in their places of leisure, using specialised SBC techniques and men peer educators, and ensure that messages are attractive for this population sub-group. 6. Strengthen implementation of age-appropriate Life Skills and Health Education (LSHE) - and information for learners in school settings and out-of-school youth using innovative approaches. 7. Use inclusive, innovative ways to promote prevention, management/treatment and care that target migrants and mobile populations, especially in the migration corridors of the country where mobility of vulnerable populations is high. 8. Establish youth friendly spaces in communities, churches, and schools. 9. Deliver SBCC through edutainment and digital spaces through low-tech to captivate young people. 10. Use innovative approaches targeting older well-to-do men that target young girls, especially those in tertiary institutions and boarding houses. 11. Update SBCC messages that address current situations.

Table 3-2 (a): Adolescents with comprehensive HIV knowledge

Indicator 1: Percentage and projection of Adolescents aged 15-19 years with Comprehensive HIV Knowledge

		2022	2023	2024	2025	2026	2027
Estimated population in need	Female	1, 055, 550	1, 090, 550	1, 094, 050	1, 097, 600	1, 101, 050	1, 104, 440
	Male	1, 060, 928	1, 064, 428	1, 067, 930	1, 071, 432	1, 074, 929	1, 078, 433
Percent Target	Female	40.5%	50%	65%	72%	85%	95%
	Male	38.6%	40%	55%	64%	75%	85%

Source: ZDHS, 2018

Table 3-3 (b): Adults with comprehensive HIV knowledge

Indicator 2: Percentage and projection of young adults aged 20-24 years with Comprehensive HIV Knowledge							
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	Female	835, 039	851, 421	866, 159	879, 861	894, 332	908, 803
	Male	814, 881	833, 604	851, 902	869, 925	888, 929	903, 400
Percent Target	Female	44.9%	67.2%	75.4%	82.7%	90%	95%
	Male	43.2%	65.0%	75.7%	82.5%	90%	95%

Source: ZDHS, 2018

3.1.5 Comprehensive Condom Programming and Lubricants

To ensure sustainable and equitable access to high-quality male and female condoms as well as lubricants to sexually active persons, thereby contributing to the prevention of new HIV infections, STIs and unintended pregnancies in the country.

Table 3-4 Comprehensive Condom Programming & Lubricant Programme Objective and Interventions

Interventions
1. Strengthen the national leadership, coordination and partnerships for sustainable condom and lubricant financing and programming. 2. Increase demand, access to and use of male and female condoms and condom-compatible commodities and lubricants through a total market approach. 3. Strengthen condom and lubricant strategic information and social and behavioural sciences for effective condom programming. 4. Build capacity and strengthen community distribution points such as community information hubs where vulnerable population can easily access commodities and information addressing myths and misconceptions on condoms without fear, as some may not access health facilities. 5. Strengthen the supply chain management system of comprehensive condoms and lubricant programming. 6. Strengthen the Last Mile Distribution (LMD) creating a community-based condom distribution mechanism beyond health facilities. 7. Use innovative community-led distribution approaches to reach different categories of people. 8. Use peer-led approaches for condom literacy and support that ensures sustained access.

Table 3-5 (a): Condoms and Lubricants Targets

Indicator 3: Number and projection of condoms and lubricants distributed.							
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated Condom & Lubricant need	Female	574, 513	751, 039	811, 423	843, 495	951, 452	1, 413, 203
	Male	98, 542, 452	148, 326, 869	170, 931, 997	193, 537, 125	216, 537, 321	238, 533, 740
	Lubricants	550, 321	632, 291	843, 495	965, 376	1, 000, 429	1, 550, 321
Condom & Lubricant Target	Female	574, 513	751, 039	811, 423	843, 495	951, 452	1, 413, 203
	Male	98, 542, 452	148, 326, 869	170, 931, 997	193, 537, 125	216, 537, 321	238, 533, 740
	Lubricants	550, 321	632, 291	843, 495	965, 376	1, 000, 429	1, 550, 321

Source: CNET, 2022

Table 3-6 (b): Condom use targets for adolescents aged 15 – 19 years

Indicator 4: Percentage and projection of adolescents aged 15-19 years, who had sex in the past 12 months with non-regular partner, reporting condom use at last sex							
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated Condom & Lubricant need	Female	1, 055, 550	1, 090, 550	1, 094, 050	1, 097, 600	1, 010, 500	1, 104, 440
	Male	1, 060, 928	1, 064, 428	1, 067, 930	1, 071, 432	1, 074, 929	1, 078, 433
Condom & Lubricant Target	Female	19%	50.1%	68.6%	73.1%	85%	95%
	Male	33%	59.6%	66.7%	77.6%	87.3%	95%

Source: ZDHS, 2018

Table 3-7 (c): Condom use targets for adolescents aged 20 – 24 years

Indicator 5: Percentage and projection of adolescents aged 20-24 years, who had sex in the past 12 months with non-regular partner, reporting condom use at last sex							
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated Condom & Lubricant need	Female	835,039	851,421	866,159	879,861	894,332	908,803
	Male	814,881	833,604	851,902	869,925	888,929	903,400
Condom & Lubricant Target	Female	33.7%	59.9%	66.6%	75.4%	85.4%	95%
	Male	49.1%	62.8%	73.5%	79.3%	84.8%	95%

Source: ZDHS, 2018

Table 3-8 (d): Condom use targets for adults aged 15 – 49 years

Indicator 6: Percentage and projection of adults aged 15-49 years, who had sex in the past 12 months with a non-regular partner, reporting condom at last sex						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
% Targeted	**F**: 35% **M:** 54%	F: 55% M:65%	F:65% M:78%	F: 75% M:88%	F: 85% M:89.3%	F: 95% M: 95%

Source: ZDHS,2018

Table 3-9 (e): Condom use targets for key populations

Indicator 7: Percentage and projection of specific key populations reporting using condoms and lubricants							
KP Type	**Size Estimate**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**
Sex Workers	148,077	58.4%	60.8%	65%	73.4%	84%	95%
MSM	137,587	42.%	59.2%	67%	74.6%	87%	95%
PWID	91,141	ND	56%	65%	73.1%	83.9%	95%
Transgender	23,110	50.8%	60%	69%	77.8%	85%	95%
Inmates	22,000	ND	ND	ND	ND	ND	ND

Source: ICAP, 2022 (IBBS)
NB: In Zambia, condom distribution in correctional facilities is not allowed.

3.1.6 Harm reduction and opioid substitution therapy

Mitigate the increased risk to new HIV infections and poor access to HIV prevention services by PWIDs

Table 3-10: Harm reduction and opioid substitution therapy

Strategic Interventions
1. Opioid Substitution Therapy and rehabilitation services with integrated combination HIV prevention. 2. Removing human rights related barriers and violence prevention. 3. Sexual and reproductive health services, including STIs, hepatitis, post-violence care. 4. Community empowerment. 5. HIV prevention communication, information and demand creation. 6. PrEP and PEP programming.

3.1.7 Voluntary Medical Male Circumcision (VMMC)

Contribute to the reduction of new HIV infections among men by providing integrated, safe and accessible voluntary male circumcision services.

Table 3-11:VMMC Programme Objective and Interventions

Strategic Interventions
1. Intensified sustainable service delivery model. 2. Human Centred Design Approach for demand generation. 3. Scaling up ShangRing device method. 4. Build VMMC technical and strategic capacity, provide effective oversight and ensure collaboration and multi-sectoral engagement at national and sub-national levels. 5. Provide high quality VMMC services as part of a sustained, comprehensive, integrated, appropriate and effective health services package. 6. Scaling up innovations such as implementation and use of ShangRing devices, blended learning and market-oriented demand generation. 7. Conduct operational research on HIV prevalence in circumcised men in Zambia. 8. Achieve an integrated VMMC commodity supply chain management system that ensures VMMC commodity availability and security. 9. Strengthen community led interventions for demand creation.

Table 3-12: VMMC Targets

Indicator 8: Achieve 85 per cent VMMC coverage among men aged 15-49 years by 2027.							
		2022	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	Male	3,954,716	4,074,632	4,198,597	4,327,405	4,462,342	4,621,213
Targeted	Male	32%	57%	68%	75%	80%	95%

Source: ZDHS, 2018

Table 3-13 (a): VMMC targets 0 – 2 years

Indicator 9: Number and projection of voluntary medical male circumcisions performed among males aged 0-2 years						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Population in need*	978,470	987,712	1,001,635	1,020,571	1,039,614	1,102,221
Target number	2, 044	1, 752	1, 802	1, 852	1, 889	1, 927

Source: MoH, 2022

Table 3-14 (b): VMMC targets 10 – 14 years

Indicator 10: Number and projection of voluntary medical male circumcisions performed among males aged 10-14 years						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Population in need*	1, 119, 107	1, 160, 256	1, 200, 517	1, 238, 296	1, 272, 970	1, 301, 113
Target number	83,207	85,604	73,392	70,312	66,142	60,732

Source: MoH, 2022

Table 3-15 (c): VMMC targets 15 – 29 years

Indicator 11: Number and projection of voluntary medical male circumcisions performed among males aged 15-29 years						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Population in need*	2, 407, 838	2, 485, 341	2, 561, 696	2, 637, 903	2, 715, 867	2,851,221
Target number	45,321	46,913	38,8301	37,361	36,732	35,227

Source: MoH, 2019

Table 3-16 (d): VMMC targets 30 – 49 years

Indicator 12: Number and projection of voluntary medical male circumcisions performed among males aged 30-49 years						
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Population in need*	1, 646,778	1, 689, 892	1, 731, 901	1, 812,100	1 846 475	2,153,414
Target number	77,392	79,616	70,145	69,192	68,781	67,774

Source: MoH, 2022

3.1.8 Pre-Exposure Prophylaxis (PrEP)

1 To reduce new HIV infections among people who are at risk of exposure to HIV.
2 To improve retention among those already accessing PrEP.

Table 3-17: Programme Objectives and Interventions

Strategic Interventions
3 Introduce injectable PrEP to ensure retention and adherence. 4 De-medicalise PrEP by expanding community-based follow-ups. 5 Address the challenge of retention on PrEP especially for key and vulnerable populations. 6 Establish cohort monitoring for individuals receiving pre-exposure prophylaxis (PrEP). 7 Promote PrEP as an additional option in the context of combination prevention of HIV. 8 Address stigma and discrimination associated with PrEP uptake through appropriate media platforms.

Table 3-18: Estimated number at risk to need PrEP

Indicator 13: Estimated number at risk who need PrEP						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Target Number	1,104,431	1,321,112	1,454,484	2,646,621	3,941,284	4,162,721

Source: PrEP TWG, 2022

Table 3-19 (a): PrEP projected targets

Indicator 14: Number of people at risk enrolled and projected to be enrolled on PrEP						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Target Number	131,573	188,455,	275,777	347,629	506,570	671,570

Source: PrEP Quantification Report, 2023

3.1.9 Sexually Transmitted Infections (STIs)

Promote accessible, acceptable and effective case management of persons with STIs through public and private health care systems, including first-level health care, using simple algorithms based on syndromic diagnosis.

Table 3-20: STI Programme Objective and Interventions

	Strategic Interventions
1	Promote community awareness campaigns on STIs to enhance early treatment seeking behaviour, partner notification and referral including cross border patient information sharing.
2	Prioritise the availability of Health Centre Kits since they contain most of the basic supplies needed in STI treatment.
3	Develop an innovative and workable system for tracking and provide treatment of the contact to index cases.
4	Develop a robust countrywide condom promotion and distribution mechanism that targets all, including migrants and mobile populations such as sex workers, truck drivers, fishermen and cross border traders.
5	Need to build capacity of newly recruited staff in both private and public health facilities to track STI-related indicators and report in the health management information system (HMIS).
6	Devise approaches to ensure the KPs are reached with STI prevention and treatment messages.
7	Provide essential data collection tools.
8	Promote awareness programme on STIs through social media

Table 3-21: STIs Targets

		2022	2023	2024	2025	2026	2027
Estimated population in need	F	932,473	954,923	983,185	1,016,917	1,055,550	1,105,223
	M	933,078	958,687	988,683	1,022,817	1,060,928	1,076,552
Percent Target	F	0.5%	0.475%	0.45%	0.425%	0.4%	0.3%
	M	2.7%	2.45%	2.2%	1.95%	1.7%	1.5%

Source: MoH, 2022

Table 3-22 (a): Males and females 20 – 24years reporting STI

Indicator 15: Percentages of Males and Females 20-24 years who reported an STI in the past 12 months							
		2019	**2020**	**2021**	**2022**	**2023**	**2024**
Estimated population in need	F	835,039	851,421	866,159	879,861	894,332	910,132
	M	814,881	833,604	851,902	869,925	888,929	892,112
Percent Target	F	2%	1.625%	1.25%	0.875%	0.5%	0.4%
	M	6.2%	5.675%	5.15%	4.625%	4.1%	3.5%

3.1.10 Viral Hepatitis Infection

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

Table 3-23:Viral Hepatitis Infection Programme Objectives and Interventions

Strategic Interventions
• Reduce new viral hepatitis infections through enhanced eMTCT. • Reach more susceptible people in communities and prevent health care related transmission. • Strengthen strategies for enhanced knowledge and skills of health care providers in screening high risk populations. • Support the health sector response by conducting estimation of the national burden of Viral Hepatitis and to monitor trends over time. • Screen and manage HPV among sex workers, MSM and people who inject drugs. • Scale up awareness of Viral Hepatitis to increase knowledge of the general population and key populations on risks and protection from viral hepatitis. • Support improved efforts for reducing stigma and discrimination associated with hepatitis in the community. • Decrease HCV incidence among injection drug users. • Ensure adequate follow-up of and management of people diagnosed with viral hepatitis.

3.1.11 Blood Safety

Ensure availability of adequate supplies of safe blood and blood products to all patients in Zambia.

Table 3-24: Blood Safety Programme Objectives and Interventions

Strategic Interventions
1. Ensure availability of adequate blood transfusion Infrastructure, equipment and commodities. 2. Increase the annual blood collection to meet the national blood and blood products requirements. 3. Operate an effective, nation-wide quality assurance programme that ensures security of the entire blood transfusion process. 4. Develop a national apheresis, tissue and organ transplantation centre. 5. Develop and implement ICT Solutions to improve the management of the blood transfusion processes. 6. Improve the clinical interphase in the blood transfusion chain. 7. Strengthen monitoring and evaluation function of the Zambia National Blood Transfusion Service (ZNBTS).

Table 3-25: Blood Safety Targets

Indicator: Number and projection of safe blood units available for transfusion					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
110,000	180,000	230,000	300,000	360,000	400,000

Source: ZNBTS,2022

3.1.12 Adolescents and Young People

Table 3-26: Adolescents and Young People Programme Objective and Interventions

Strategic Interventions
1 Scale up and strengthen peer-to-peer education and support networks at school, health facility and community.
2 Use community-based and community-led outreach services to reach out to AYP.
3 Lobby and engage key stakeholders such as traditional and civic leaders, Members of Parliament, and other policy makers to address harmful social and cultural norms that promote intergenerational sex and early marriages.
4 Promote equal rights and access to education, skills development training, legal services for both male and female adolescents and young adults including those differently abled and other key populations.
5 Use technology to standardise the content of CSE and facilitate interactive engagement of students.
6 Increase access of support services and legal protection of adolescents and young adults from physical and sexual violence, sexual exploitation and sex work, human trafficking, and illicit substance.

Table 3-27: Adolescent and Young People Indicators and Targets

Indicator: Number and projection of new annual HIV infections among adolescent girls and young women and boys					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
11,000	6,500	5,050	4,500	4,000	3,000

Source: Spectrum, 2022

Table 3-28 (a): Adolescent reached with SRHR prevention services

Indicator: Number and projection of adolescents reached with SRHR prevention services					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
305,395	632,215	734,424	921,761	1,512,310	2,021,811

Source: NAC, 2022

Table 3-29 (b): High-prevalence districts covered with comprehensive prevention programmes

Indicator: Percentage and projection of high-prevalence districts covered with comprehensive prevention programmes					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
69%	78%	86%	89.8%	93%	95%

Source: NACMIS,2022

3.1.13 Underserved Populations

Table 3-30: Key Populations Programme Objective and Interventions

Strategic Interventions
1 Apply human rights approach to assist programmes to pursue zero tolerance to stigma and discrimination.
2 Improve national and council legal and policy environment for protection of priority and key populations and people living with HIV.
3 Remove barriers to access to HIV, SRH and rights information and services in public and private entities.
4 Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector.
5 Implement programmes that increase coverage and access to prevention, treatment and care for key populations including through micro planning approaches.

Table 3-31: Key Populations Indicators and Targets

Indicator: Number and projection of key population surveillance activities conducted.						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Female Sex Workers	1	2	1	2	2	2
Inmates (Prisoners)	0	0	0	2	2	2
MSM	0	1	1	2	2	2
PWID	0	1	1	2	2	2
Transgender	1	1	1	2	2	2

Source: NAC, 2022

Table 3-32 (a): Key Populations reached with HIV prevention programmes

Indicator: Percentage and projection of key populations reached with HIV prevention programmes - defined package of services						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Female Sex Workers	26%	48.4%	68.8%	72%	83.4%	95%
Inmates	67%	73.7%	59.2%	67%	78.6%	95%
MSM	22%	40%	56%	65%	78.1%	95%
PWID	21%	40%	55%	61%	77.8%	95%
Transgender	56%	68.4%	70.8%	75%	83.4%	95%

Source: NAC, 2022

Table 3-33 (b): Key Populations who avoided health care

Indicator: Percentage and projection of key populations who avoided health care because of stigma and discrimination.					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Female Sex Workers	40%	32%	30%	25%	15%
Inmates (Prisoners)	35%	25%	20%	15%	10%
MSM	65%	45%	35%	30%	20%
PWID	50%	35%	30%	25%	20%
Transgender	60%	41%	30%	20%	10%

Source: NAC, 2022

3.1.14 HIV Testing Services (HTS)

To identify PLHIV in a timely manner and increase knowledge of HIV status, there is need to provide quality differentiated testing services for all and effectively link them to appropriate prevention, care, treatment and support services.

Table 3-34: HIV Testing Services Programme Objective and Interventions

	Strategic Interventions
1	Scale-up innovative ways of distributing HIV self-testing kits especially for vulnerable populations such as adolescent girls, boys, SWs, migrants and mobile populations.
2	Sustain and expand index testing and partner notification and social network testing in all provinces targeting male and females 15 – 24 years of age, key populations, children of positive mothers, under-five years old children and adolescents.
3	Develop an innovative and robust way of tracking self-test positive results across the country and tracking linkages to the nearest health facility.
4	Develop new and innovative testing approaches for both facilities-based and community-based testing.
5	Sustain targeted community-based testing including outreach HIV testing services (HTS), home-based and targeted campaigns to reach first-time testers and clients with poor access to other testing services including groups of men 15-24 years, key populations, persons with disabilities, the under-five years old children, adolescents and people loss to follow up (LTFU) for HIV related opportunistic Infections.
6	Establish the unique identifier to facilitate longitudinal tracking of clients from the point of diagnosis along the care cascade.
7	Promote public private partnerships.
8	Utilise innovative testing approaches to improve HIV positivity yield in alignment with the Standard Service Package, with a focus on case finding.
9	Expand Community Led Testing (CLT), HIV self-testing, Index testing, create online to offline and social risk network referral testing.

10 Use of recency testing in surveillance settings to inform targeted HIV testing in identified hot spots.
11 Promote provider-initiated testing and counselling (PITC) among ANC, TB, Hep C, Hep B, STI services.

Table 3-35: HIV Testing Services Targets

Indicator 16: Percentage and projection of women and men aged 15-49 years who received an HIV test and know their results.

		2022	2023	2024	2025	2026	2027
Estimated population in need		10,163,262	10,440,886	10,767,644	11,087,201	10,712,545	11,761,202
% Target	F	15.5%	15.1%	14.6%	14.2%	14.7%	13.4%
	M	6.9%	6.7%	6.5%	6.3%	6.5%	5.9%
Cumulative number of HIV Tests per Year – Population Target	F	1,571,827	1,576,574	1,572,076	1,574,383	1,574,744	1,576,001
	M	699,425	699,540	699,897	698,494	696,315	693,911

Source: ZDHS 2018, Zambia Pop Census Projections, HMIS, 2022 ART F&Q Assumptions.

Table 3-36 (a): Women and men aged 15 – 19 years who received HIV test results

Indicator 17: Percentage and projection of women and men aged 15-19 years who received an HIV test and know their results

		2022	2023	2024	2025	2026	2027
Estimated population in need	F	934,673	962,926	983,185	1,016,917	1,055,450	1,065,371
	M	933,079	958,688	988,693	1,022,817	1,060,930	1,077,712
Percent Target	F	65.3%	69.2%	73.1%	77%	80.9%	95%
	M	40.4%	47.7%	55.%	62.4%	69.7%	95%

Source: MoH, 2022

Table 3-37 (b): Women and men aged 20 – 24 years who received HIV test results

Indicator 18: Percentage and projection of women and men aged 20-24 years who received an HIV test and know their results

		2022	2023	2024	2025	2026	2027
Estimated population in need	F	74,749	80,489	82,068	84,096	86,639	89,666
	M	165,395	201,787	206,669	212,428	219,164	226,820
Percent Target	F	91%	91%	91%	91%	91%	91%
	M	77.3%	77.3%	77.3%	77.3%	77.3%	77.3%

Source: ZDHS, 2018

Table 3-38 (c): Women and men aged 15 – 49 years who received HIV test results

Indicator 19: Percentage and projection of women and men aged 15-49 years who received an HIV test and know their results

		2022	2023	2024	2025	2026	2027
Estimated population in need		10,163,262	10,440,886	10,767,644	11,087,201	10,712,545	11,761,202
Percent Target	F	64%	64%	64%	64%	64%	64%
	M	52%	52%	52%	52%	52%	52%

Source: ZDHS, 2018, 2022 F&Q Assumptions, Zambia Census, Populations Projections

Table 3-39 (d): Specific key populations who their HIV status

Indicator 20: Percentage and projection of specific key populations living with HIV who know their HIV status						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Sex Workers	51%	70.8%	75%	80%	87.4%	95%
MSM	ND	69.2%	77%	81.1%	88.6%	95%
PWID	ND	66%	75%	79.2%	88.1%	95%
Transgender	ND	60%	73%	77%	87.8%	95%
Inmates	ND	71%	78%	83%	85%	95%

Source: ICAP, 2022 (IBBS)

3.1.15 Triple elimination of vertical transmission of HIV, Syphilis and Hepatitis B virus

To eliminate new paediatric HIV, Syphilis and Hepatitis B virus infections and improve the survival of children and their mothers, the following interventions will be implemented:

Table 3-40: eMTCT Programme Objective and Interventions

	Strategic Interventions
1	Early infant diagnosis of HIV in all eMTCT sites should be scaled up and expanded and have routine opt-out testing in all the facilities.
2	Procure Point of Care (PoC) machines to address the turnaround time of Dried Blood Spots (DBS) samples.
3	PrEP for pregnant and breastfeeding women.
4	Introduce improved drugs for paediatrics and provide appropriate regimen and formulations with rapid switch to dolutegravir.
5	Expansion of family index testing for older undiagnosed children.
6	eMTCT of HIV, Syphilis and Hepatitis B Virus (HBV) – Triple eMTCT
7	Intensify viral load monitoring in HIV infected pregnant and breastfeeding women (every three months).
8	Introduce key population-focused messages for pregnant and breastfeeding mothers.
9	Strengthen community involvement and male participation.
10	Provide routine testing and PrEP to HIV negative pregnant women.

11 Consider retaining children and adolescents on treatment with youth-friendly services.

12 Address post-natal care challenges that make mothers in rural areas not to return for visits as prescribed.

13 Ensure all pregnant women get HIV testing and retesting from ANC clinics, including ANC clinics at private health facilities.

14 Ensure that all pregnant women who are living with HIV are on ART.

15 Screen for syphilis along with HIV and viral Hepatitis B for all pregnant women.

16 Increase case finding efforts through a strategic mix of additional child testing modalities and further scale up of maternal re-testing of negative pregnant and breastfeeding women (PBFW) beyond the first antenatal care visit (ANC1).

17 Integrate provider-initiated testing and counselling in the Expanded Programme on Immunisation (EPI) and Integrated Management of Childhood Illness (IMCI) programmes.

Table 3-1(a): Elimination of Mother-to-Child Transmission (eMTCT) Targets

Indicator 21: Percentage and projection of HIV positive pregnant women who receive antiretroviral therapy to reduce the risk of mother-to-child transmission.						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	50,730	48,613	46,106	43,608	40,268	37,730
All other ages: % Target	92.6%	94%	95%	96%	97%	100%

Source: Spectrum, 2022

Table 3-1(b): Children born with HIV

Indicator 22: Percentage and projection of children born with HIV from mother living with HIV						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	52,366	51,179	50,310	49,382	47,621	45,112
All other ages: % Target	3.45%	3.3%	3.%	2.5%	2%	1.5%

Source: Spectrum, 2022

3.1.16 Treatment of HIV and AIDS

To improve the health of people living with HIV and AIDS (PLHIV) there is need to provide them with improved and better life-saving antiretroviral therapy.

Strategic actions:

Table 3-41: Treatment and Care Programme Objective and Interventions

	Strategic Interventions
1	Promote Differentiated Service Delivery (DSD) models for stable patients on ART.
2	Scale up viral load literacy among PLHIV on ART using community-based structures.
3	Improve timely identification, linkage and retention in care for persons diagnosed with HIV.
4	Adopt the multi-month dispensation (MMD) approach.
5	Provide Long-Acting Treatment (LAT) options and interventions for the adult population.
6	Strengthen community systems to ensure maximum support to the PLHIV.
7	Develop and pilot differentiated service delivery models for the in-school HIV positive adolescents.
8	Scale up the Dolutegravir (DTG) based regimen as standard First-Line in all adult populations.
9	Eliminate any inequities in access to treatment to reach those left behind: infants, children, adolescent girls and boys, men, persons with disabilities and other key populations and strengthen targeted approach to retain them in treatment services.
10	Develop community-based intervention that will address the loss to follow up (LTFU). Working together with the Ministry of Community Development and Social Services (MCDSS), track and encourage the LTFU clients.
11	Working with the Ministry of Youth, Sport and Arts (MYSA) and MCDSS develop and disseminate treatment literacy messages using community-based structures and platforms.

12 Reduce interruptions in treatment by strengthening and promoting community led approaches.

13 Continue with systematic implementation of multi-month dispensing of ARVs.

14 Provide gender-responsive services to support access to treatment and adherence.

15 Increase access to viral load testing by ensuring availability of reagents for testing.

16 Strengthen public private partnership to ensure quality HIV-related services.

17 Identify ARV peer champions to motivate individuals for ARV medicines intake and follow-up in the community.

18 Strengthen reporting mechanism for HIV related gender-based violence, stigma and discrimination in the community and clinics.

19 Scale up training on the provision of psychosocial support and ensure incorporation into the curriculum for various cadres of health care providers including training of community health workers.

20 Support formation of community level groups to provide for the needs of PLHIV and affected family members and ensure psychosocial support services that address the specific needs of different groups.

21 Ensure that tailored strategies for providing psychosocial support are developed for specific groups (e.g. women, youth, men, vulnerable and other key populations).

Table 3-42: ART Treatment Targets

Indicator 23: Percentage of HIV positive children 0-14 years currently receiving, and projected to receive, Antiretroviral Therapy (ART)						
	022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	57,922	54,230	52,130	48,807	45,766	40,632
All other ages: % Target	72%	75%	80%	85%	90%	95%
Population Target	57,922	54,230	52,130	48,807	45,766	40,632
Female	28,772	29,128	28,406	27,376	26,160	28,772
Male	29,220	25,102	23,724	21,431	19,606	11,860

Source: MoH, 2022

Table 3-43 (a): HIV Positive Adults 15 – 49 years on ART

Indicator 23: Percent of HIV positive adults 15-49 years currently receiving, and projected to receive, Anti-Retroviral Therapy (ART)						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	1,276,731	1,253,553	1,287,564	1,291,896	1,296,467	1,309,672
All other ages: % Target	95%	95.4%	95.6%	95.8%	95.9%	100%
Population Target	1,276,731	1,253,553	1,287,564	1,291,896	1,296,467	1,309,672
Female	731,580	771,419	790,998	798,307	812,165	831,580
Male	545,151	482,134	496,566	493,589	484,302	478,092

Source: MoH, 2022

Table 3-44 (b): Specific Key Populations on ART

Indicator 24: Percentage of specific key populations living with HIV receiving, and projected to receive, ART						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Sex Workers	51%	70.8%	77.8%	85%	89.7%	95%
MSM	ND	69.2%	68.1%	79%	87.6%	95%
PWID	ND	66%	69%	76.4%	88.3%	95%
Transgender	ND	60%	70%	83%	89.8%	95%
Inmates	ND	71%	75%	79%	87.9%	95%

Source: ICAP, 2022 (IBBS)

.

Table 3-45: Viral Load Suppression Target

Indicator 25: Percent of PLHIV who are virally suppressed aged 0 – 14 years						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	58,927	56,201	54,807	52,820	50,474	48,421
Percent Target (%)	64%	70%	75%	85%	90%	95%
Female	34,470	29,985	28,921	28,648	27,376	26,098
Male	24,457	26,986	25,886	24,172	23,098	22,323

Table 3-46 (a): PLHIV 15 – 49 years who are virally suppressed

Indicator 26: Percent of PLHIV who are virally suppressed aged 15 – 49 years.						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	1,155,081	1,167,035	1,171,312	1,173,141	1,186,134	1,251,220
Percent Target (%)	96.44%	97%	98%	99%	100%	100%
Female	708,865	671,110	648,860	640,537	642,961	698,047
Male	446,216	495,925	522,452	532,604	543,173	553,173

3.1.17 TB/HIV programme Collaboration

To strengthen and integrate HIV/TB services including high quality and patients centred TB services and address multi drug resistant (MDR) TB.

Table 3-47: HIV/TB Co-infections Programme Objective and Interventions

Strategic Interventions
1. Intensified TB Screening among PLHIV. 2. Increased awareness and concerted action to reduce TB/HIV co-infection. 3. Scaled up interventions such as intensified TB case-finding, TB preventive therapy and TB infection control as well as routine HIV testing and improved access to antiretroviral treatment. 4. Strengthened coordination mechanisms between TB and HIV programmes.

Table 3-48: HIV/TB Co-Infection Targets

Indicator 27: Proportion of TB/HIV co-infected patients on ART						
	2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
Estimated population in need	20,737	19,832	18,549	17,026	16,703	15.362
All other ages: % Target	96.2%	97%	100%	100%	100%	100%

Source: NTP, 2019

3.1.18 Mental Health

One-third of HIV-positive individuals experience a mood disorder or clinically significant depressive symptoms; and another 20 per cent experience an anxiety disorder (UNAIDS, 2020). Mental health challenges may lead to alcohol or drug abuse, which can lead to risky sexual behaviours, HIV etc. HIV also may lead to depression and mood disorders, therefore, there is a bi-direction linkage between HIV and mental health.

These mental health struggles negatively affect quality of life while simultaneously contributing to poor medication adherence for antiretroviral therapy and stressing the immune system. This can lead to an increased viral load, reduced CD4 counts and worse health outcomes.

Table 3-49: Psychosocial Support for PLHIV Programme Objective and Interventions

Strategic Interventions
1 Institutionalise linkages with the health and other sectors to increase access to HTS, ART and condoms for teachers, non-teaching staff and students in all learning institutions.
2 Scale up the implementation of a comprehensive Ministry of Education HIV workplace programme for teachers and non-teaching staff.
3 Address stigma and discrimination against PLHIV in schools and tertiary educational institutions.
4 Strengthen the design and delivery of comprehensive sexuality education.
5 Ensure all interventions targeted at adolescents are at full scale to have an impact at national level.
6 Strengthen targeted guidance and counselling support for at-risk adolescents in secondary schools and psychosocial support for adolescents living with HIV.
7 Strengthen life skills education for both male and female students to include information on HIV, STIs and risks of early teenage pregnancy.
8 Support a national dialogue on condom availability in schools with youth, parents, teachers and other stakeholders.
9 Increase the resource envelope for bursaries and food supplements for orphans and vulnerable pupils and students.

3.2 Laboratory and Diagnostic Services

Objective: *To ensure quality laboratory and diagnostic services are expanded and available at all levels.*

Strategic actions:

Table 3-29: Viral Load Testing Programme Objective and Interventions

Strategic Interventions
1. Scale up the viral load coverage especially in areas with low viral load suppression.
2. Establish and strengthen the electronic viral load monitoring system through improved interoperability of systems.
3. Strengthen laboratory systems to scale up viral load monitoring of all individuals on ART.
4. Scale up sample transportation system, tracking and e-reporting.
5. Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics and supplies) at provincial and local level.
6. Optimised use of GeneXpert and PCR machines for VL test.
7. Utilisation of alternative specimens such as Development of Dried Blood Spots (DBS) and Dried Plasma Spots (DPS) samples collection from remote areas and

transportation to National Public Health Laboratory (NPHL) or nearest VL testing sites. At provincial level, strengthen the capacity of Provincial Public Health Laboratories (PPHLs) by ensuring good infrastructure, human resource, equipment and testing kits.

8. Ensure quality control of HIV testing through quality assurance from national reference laboratory.
9. Coordinate with private health facilities and labs to scale up laboratory services and quality assurance of the labs.

3.3 Procurement and Supply Chain Management

Objective: *To ensure robust and efficient national procurement and supply chain management system.*

Strategic actions:

Table 3-30: Procurement and supply chain management system

Strategic Interventions
• Ensure adequate budget to purchase Antiretroviral therapy (ART) medicines and HIV related commodities. • Establish appropriate timely procurement mechanism for HIV commodities. • Ensure adequate availability of HIV commodities at all levels. • Strengthen capacity of provinces to prepare detailed specifications, quantification and forecasting and supply planning for procurement of HIV-related commodities. • Establish multi-year procurement plans. • Strengthen last mile distribution for HIV commodities to all service delivery points. • Strengthen logistics management information system including Monitoring and Evaluation for HIV commodities.

3.4 Critical Enablers

3.4.1: Addressing social and structural barriers

Strategic Objective 2: To address social and structural barriers to achieving HIV outcomes in all populations.

Programme Results:

- Gender and Human Rights related barriers to service delivery, accessibility and utilisation by key and vulnerable populations reduced by 2027.
- Reduce HIV-related stigma and discrimination by 50 per cent.
- People-centred systems for health that sustainably integrates HIV, AIDS and TB and other infections by 2027.
- 45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.
- 95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics including COVID-19.

Stigma and discrimination, gender inequality, violence, lack of community empowerment, violations of human rights and laws and policies criminalising drug use and diverse forms of gender identity and sexuality fuel the spread of HIV. These factors limit access to HIV and AIDS services, constrain how these services are delivered and diminish their effectiveness.

(a) Leadership Commitment and Good Governance

Objective: To strengthen leadership, accountability and governance of the national multi-sectoral HIV and AIDS response at national and sub-national level.

Table 3-31: Leadership Commitment and Good Governance Programme Objective and Interventions

	Strategic Interventions
1	Promote political commitment to the national HIV response.
2	Strengthen leadership and governance at national level.
3	Build leadership and governance systems at sub-national levels.

Table 3-32: Leadership Commitment and Good Governance Targets

Indicator: Percentage and projection of local authorities whose plans have been resourced/implemented by locally mobilised resources.					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
60%	73%	78%	84%	88%	95%

(b) Gender Equality, Equity and Empowerment

Objective: To reduce the incidence of SGBV and improve access to SGBV care and support to survivors of SGBV.

Table 3-33: Gender Equality and Empowerment Programme Objectives and Interventions

Strategic Interventions
4 Strengthen availability and delivery of comprehensive SGBV health services. 5 Increase community awareness and utilisation of comprehensive SGBV services. 6 Strengthen coordination and referrals among partners delivering gender-related services.

Table 3-34: Gender Equality and Empowerment Targets

Indicator: Number of GBV cases reported and projected to reported annually					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
10,241	7,323	5,372	3,212	2,211	1,415
Indicator: Number of GBV survivors receiving post GBV Care					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
7,0451	6,873	4,031	2,571	1,765	978

Source: Zambia Police Service, 2022

(c) Policies, Laws and Human Rights

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

Table 3-35: Policies, Law and Human Right Programme Objectives and Interventions

	Strategic Interventions
1	Advocate and promote legal reform against laws and policies that hinder access to HIV services, especially for key and other vulnerable populations.
2	Harmonise policies to align the age of consent and access to SRHR and other services for young people.
3	Support communities to harmonise their customary law with statutory law, national policies and human rights principles.
4	Sensitise individual healthcare workers and administrators to their own human rights and skills and tools necessary to ensure patient rights are upheld.

(d) Stigma and Discrimination Elimination

Objective: To reduce stigma and discrimination to advance health rights and access to health services for all.

Table 3-36: Stigma and Discrimination Elimination Programme Objective and Interventions

	Strategic Interventions
1	Scale up campaigns to reduce stigma and discrimination, particularly targeting key populations.
2	Conduct periodic HIV-related stigma assessments to inform programming.
3	Advocate for people-centred, inclusive, non-judgmental and non-discriminatory delivery of health services.
4	Strengthen community- and facility-based social support networks and structures, particularly those led by PLHIV and key populations civil society organisations and scale up the capacitation of community-based social support networks and structures on stigma and discrimination.

3.4.2 Resource and Sustain the HIV Response

Strategic Objective 3: To secure sufficient and reliable financing from public, private and other sources to ensure a prompt and effective response.

Programme Result

- Increased efficiencies and financial investments in the HIV programme to 90 per cent of the NSP budget by 2027.
- Increase domestic financing of the HIV response to 30 per cent by 2027 from 13.8 percent in 2017.

Programme Area

Sustainable HIV Financing

Objective: To increase domestic financing for the HIV response from 10 per cent to 30 per cent by 2027.

Table 3-37: Programme Objectives and Intervention

Strategic Interventions
1. Coordinate sufficient and complementary investments from government departments, development partners and the private sector to achieve the NASF goals, guided by a national resource mobilisation strategy for the NASF (Create an HIV and AIDS Fund). 2. Enhanced focus on domestic resource mobilisation to localise the major share of the AIDS budget by 2027. 3. Improved private sector engagement and coordination (NAC - Private Sector Forum). 4. Advocate for needed legislation to broaden the net of domestic resource mobilisation from both State and non-state sources. 5. Strengthen donor confidence through enhanced efficiencies in resource utilisation coupled with increased transparency and accountability. 6. Advance integrated health services for HIV. 7. Develop and implement an HIV sustainability roadmap to integrate HIV services seamlessly into existing health systems at all levels, ensuring comprehensive and accessible care. 8. Align HIV strategies with TB and malaria plans to reinforce health system strengthening, fostering synergies for increased impact. 9. Establish uniformity in ART sites, encompassing human resources, health infrastructure, and the availability of essential healthcare services. 10. Strengthen collaborative monitoring and evaluation of HIV services, involving civil society organisations (CSOs) for comprehensive assessments. 11. Create provincial and district-level coordination platforms to localise the HIV response effectively, aligning with the government's decentralisation policy. 12. Build the capacity of CSOs to scale up outreach services, community-involved monitoring, documentation and advocacy for domestic resource mobilisation. 13. Foster partnerships between the public and private sectors to enhance the overall HIV response, leveraging diverse resources and expertise. 14. Develop and adopt mitigation plans for health emergencies, including the COVID-19 pandemic and various natural or human-made disasters. 15. Develop a comprehensive HIV sustainability roadmap to plan for long-term success, considering financial, systemic and service-related aspects. 16. Institute social contracting mechanisms to empower and involve communities in leading HIV responses, ensuring inclusivity and effectiveness. 17. Develop and implement mitigation plans for various emergencies, including health crises like the COVID-19 pandemic and other natural or human-made disasters.

3.5 Education Sector Intervention

Table 3-38: Education Sector Indicators and Targets

Indicator: Percentage and projection of schools implementing Life Skills and Health Education (LSHE)					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
70%	75%	80%	85%	90%	100%

Indicator: Proportion of teachers trained in Life Skills and Health Education (LSHE) and are delivering and projected to be delivering lessons to learners.					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
70%	75%	80%	85%	90%	100%

3.6 Social Protection

Table 3-39: Social Protection Programme Objectives and Interventions

Strategic Interventions
1. Scale up innovative social protection delivery mechanisms that are responsive to the needs of vulnerable groups. 2. Advocate full enforcement of the 2022 Children's Code Act. 3. Provide social cash transfer to vulnerable households, people affected by and living with HIV to enhance cash and care interventions. 4. Strengthen outreach and linkages between social welfare and protection services and HIV services, as well as cost effective delivery systems. 5. Ensure that appropriate legal redress mechanisms exist to improve access to social protection services free from stigma and discrimination. 6. Advocate for inclusive, enabling and HIV-sensitive social protection policies and regulatory environments. 7. Improve collaboration among major players in social protection programmes, including ministries of community development and social services, agriculture and livestock, and local government. 8. Strengthen the coordination, monitoring and evaluation of social protection measures to ensure the inclusion of all vulnerable groups, including those vulnerable to HIV. 9. Improve linkages between social protection programmes and other poverty alleviation strategies. 10. Promote economic empowerment of women using various economic and financial mechanisms and strategies. 11. Integration of HIV and gender into poverty alleviation and livelihood policies, strategies and interventions.

12. Enhance knowledge on HIV-livelihood linkages.
13. Promote the integration of PLHIV networks in sustainable business development and livelihood empowerment initiatives focusing on adolescent girls and boys and young and vulnerable women and men.
14. Working with TEVETA to promote entrepreneurship and vocational training targeting the young people and other vulnerable populations.

Table 3-40: Social Protection Targets

Indicator: Percentage of formal and informal employees with comprehensive health insurance cover					
2022 Baseline	**2023**	**2024**	**2025**	**2026**	**2027**
20%	40%	50%	65%	70%	85%

Source: NHIMA, 2022

3.7 Food and Nutrition

Table 3-41: Food and Nutrition Security Programme Objective and Interventions

Strategic Interventions
1. Standardise and harmonise specifications for appropriate therapeutic and supplementary foods for malnourished PLHIV on treatment, pregnant/lactating women in eMTCT programme and infants of HIV positive women. 2. Integrate nutrition assessments into high impact interventions such as ART and eMTCT. 3. Increase access to and coverage of high impact community-based nutrition interventions and integration of food and nutrition in the overall HIV management for PLHIV, pregnant mothers and those on ART. 4. Strengthen breastfeeding counselling messages for HIV exposed infants. 5. Reinforce the importance of nutrition for treatment adherence. 6. Collaborate to support agricultural productivity and incomes of small-scale farmers, in particular women, including through secure and equal access to land and other productive resources. 7. Ensure food security and sufficient nutritional supplies, including adequate harmonisation of nutrition messages disseminated by government and other partners. 8. Strengthen district level and community level planning and coordination on nutrition and HIV services and enhance district financing.

3.8 Mainstreaming HIV into Capital Projects

Table 3-42: Mainstreaming HIV into Capital Projects Programme Objective and Interventions

Strategic Interventions
1. Integrate HIV, gender and human rights aspects into capital projects eligible for Environmental Assessments. 2. Promote south to south and cross border cooperation on integration of HIV, related gender and human rights aspects in joint regional development initiatives. 3. Use public transport systems for prevention messages and condom distribution, targeting the general and key populations around capital project sites. 4. Develop an effective and efficient tracking system on utilisation of funds allocated to HIV and AIDS mitigation for higher impact interventions during all phases of mega capital projects. 5. Promote a bold mass media HIV prevention campaign around capital project sites and surrounding communities.

3.9 Workplace Policies and Practices

Table 3-43: Workplace Policies and Practices Programme Objectives and Interventions

Strategic Interventions
1. Develop relevant and effective legislation, policies and programmes on HIV and ADS related to the world of work. 2. Routine monitoring and provision of positive incentives (i.e., annual awards, recognition of champions) for innovative programming, implementation capacity and outcomes of HIV and AIDS wellness –policies and programmes for all workplaces, both formal and informal. 3. Establish a coordinating forum for the world of work, inclusive of government, employers, and workers. 4. Generate strategic information that highlights investment choices and efficient use of resources earmarked for HIV and related gender responses in the public sector. 5. Development of a strategic information system linked to the national system, either collectively or by individual companies. 6. Encourage and allow for dialogue between government and cellular network providers and forge strategic partnerships that will enable easy flow of information and knowledge sharing through technology. 7. Develop the national HIV/AIDS/TB and wellness policy and private sector engagement strategy. 8. Support informal sectors such as cross-border, bus drivers and truck drivers' associations to have some HIV policies included in their constitutions or strategic plans.

3.10 Reinvigorate Community Responses

Strategic Objective 4:

- To reinvigorate community responses for a quality, efficient, effective and sustainable HIV response.
- To facilitate increased participation of communities, community-based organisations and civil society in the national multi-sectoral HIV and AIDS response ensuring accountability, implementation, advocacy and coordination at all levels.

Programme Results

Expanded community-led HIV testing and treatment, prevention and societal enabler programmes towards the 30 80 60 global targets, respectively.

Programme Areas

- Community Led - Advocacy
- Coordination
- Community Participation and Engagement

Table 3-44 Community responses programme objectives and strategic interventions

Strategic Interventions
1. Enhance community led monitoring in all HIV services through consultations with affected communities. 2. Create demand for HIV/STI/TB services in communities. 3. Increase community participation in the HIV/AIDS dialogues to promote community-driven solutions. 4. Amplify affected communities' voices in advocating for improved HIV services. 5. Improve accountability mechanisms through community dialogues with all stakeholders in the HIV response. 6. Facilitate CSO dialogue to strengthen coordination, collaboration and effective engagement in national response to HIV. 7. Promote community-based and civil society coordination to respond at all levels for easy information sharing on HIV. 8. Facilitate dialogues for increased funding for HIV. 9. Identify CSO technical support needs, build the capacity of the CSOs based on their needs and coordinate CSOs, including key populations and vulnerable groups, to strengthen their participation in the multi-sectoral national response to HIV and AIDS.

3.12 Strengthen Strategic Information

Strategic Objective 5:

- To strengthen strategic information for achieving and sustaining HIV epidemic control.
- National consolidated strategic information system is strengthened for tracking and measuring the progress in HIV response.

The framework will be centred on creating one M&E system in realising the multisectoral HIV response. In achieving this, developing one national health information system (NHIS) that will comprise other health information systems (HMIS, DATIM, NACMIS, EMIS, and ELMIS), including community systems and all partner systems, will be cardinal. The one system will enhance data accessibility, availability and utilisation for a coordinated multisectoral HIV response.

Programme Results

- Inter-operable electronic/ digital community and health information systems for planning and decision making.
- Enhanced national and community access to and utilisation of information on HIV, AIDS, STIs and TB.

Programme Areas

Monitoring and evaluation (M&E)

Table 3-50: Strategic Information

Strategic Interventions
1. Develop one comprehensive strategic information system. 2. Strengthen data comprehensive strategic information system to provide real-time quality and timely data. 3. Strengthen data quality to inform decision making at all levels. 4. Strengthen national strategic information as well as monitoring and evaluation guidelines to harmonise existing reporting systems, including HIMS for alignment and coherence. 5. Strengthen one national HIV information system. 6. Enhance the use of digital technologies to increase access to HIV and health services. 7. Build the capacity of CSOs for monitoring, evaluation and documentation. 8. Strengthen data analysis, reporting and use.

3.13 Surveillance and Surveys

Strategic Interventions
1. Strengthen sentinel surveillance for HIV/STI/TB and Key Populations. 2. Conduct systematic surveys to inform decision-making. 3. Strengthen HIV surveillance systems. 4. Strengthen capacity of national and sub-national officers in survey data analysis. 5. Enhance survey data dissemination and utilisation.

3.14 Research

Strategic Interventions
1. Promote HIV research and surveys. 2. Strengthen HIV surveillance systems. 3. Enhance the use of digital technologies to increase access to HIV and health services. 4. Build the capacity of CSOs for monitoring, evaluation and documentation. 5. Strengthen data analysis, reporting and use.

3.15 Community Led Monitoring (CLM)

Strategic Interventions
1. Promote community led monitoring implementation. 2. Establish mechanisms for community led monitoring data dissemination at sub-national levels. 3. Enhance the use of digital technologies in reporting community led monitoring data. 4. Strengthen community led monitoring data utilisation, reporting and use in communities.

3.16 Reporting

Strategic Interventions
1. Strengthen real-time data reporting. 2. Conduct routine data analysis and reporting. 3. Strengthen data analysis, reporting and use. 4. Increase the “granularity” of data, appropriately disaggregated to the district, community and facility levels by age, sex, population and location to better understand sub-national epidemics and assess performance along the continuum of HIV services.

4.0 COORDINATION, MANAGEMENT AND INSTITUTIONAL ARRANGEMENT

4.1 Provisions for an effective multi sectoral coordination

The National HIV/AIDS/STI/TB Council (NAC) will be the government institution mandated to coordinate the multisectoral response to HIV and AIDS envisaged in this NASF. The identified functions are conceptualised in line with the national HIV and AIDS policy of 2005 NAC continues to operate under the overall supervision and guidance of the Ministry of Health (MoH).

Cabinet Committee on Health under Policy Analysis and Coordination (PAC) will be the link structure for HIV and health issues in parliament charged to coordinate policy formulation, determining strategic direction and providing oversight on the overall national response.

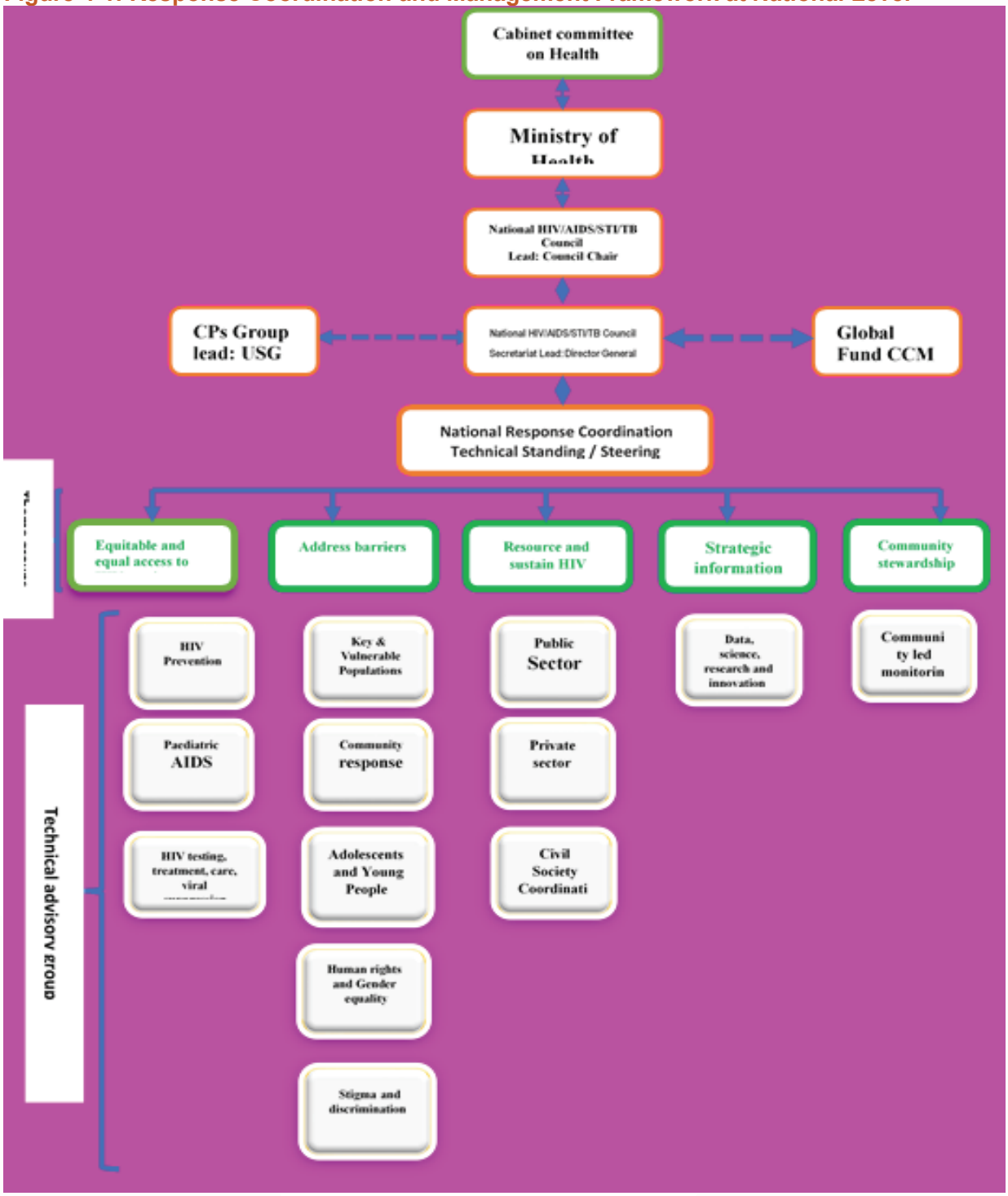
NAC council, appointed by the Minister of Health, will be the apex body for coordinating the HIV response in Zambia. The council advises the Government through the Minister responsible for Health. The National Response Coordination Committee (NRCC), convened by the NAC Director General (DG), will be the technical oversight structure operating under the Council providing overall leadership for stakeholder and partner coordination.

The NAC secretariat will ensure seamless coordination of stakeholders and partners operations through facilitating programme design, implementation and monitoring and evaluation of the multisectoral HIV response. Apart from convening Technical Advisory Groups (TAGs) at all levels, the secretariat will also work closely with the appropriate Cluster Advisory Group (CAG) in coordinating implementation of mainstreaming programmes for HIV in social economic development programming espoused in the 8th National Development Plan (8NDP).

Accordingly, the NAC subnational coordination structures namely Provincial and District HIV and AIDS Coordination Committees (PHAC and DHAC) under the office of the Provincial AIDS Coordination Advisors (PACAs) at provincial level and the District AIDS Coordination Advisors (DACAs) under the local authorities at district level will collaborate and support the Provincial Development Coordination Committees (PDCCs) and the District Development Coordination Committees (DDCCs) operating as subcommittees respectively.

In addition, the community response at the local level will be coordinated by the Community HIV and AIDS Committees (CHACs) under the auspices of the Ward Development Committees (WDCs).

Figure 4-1: Response Coordination and Management Framework at National Level



Coordination of the NASF 2023-2027 implementation

The National HIV/AIDS/STI/TB Council (NAC) established by Act No. 10 of 2002 will exercise the overall legal mandate to coordinate the national response to HIV and AIDS, through the implementation of this framework and informed by an updated HIV policy. This will be done in partnership with other stakeholders, through a multi-sectoral and decentralised response framework. The stakeholders include the Ministry of Health, Ministry of Education, Ministry of Local Government and Rural Development, Gender Division of Cabinet Office, Ministry of Youth, Sport and Arts, among other Government Ministries, Civil Society Organisations (CSOs) and Cooperating Partners (CPs).

It is envisaged that both coordination and management will be conducted in a participatory manner, within the existing national coordination framework which defines the roles of each stakeholder, sector and coordinating entity at national, provincial, district and health facility or community levels premised on the three ones' principle.

Coordination at the National Level

4.3.1 Public Sector Coordination and Roles of Government Ministries

Government institutions involved in the response include line ministries, parastatal organisations, and other semi-autonomous government agencies. This category also includes Cabinet, Parliament and local authorities. The Ministry of Health has the mandate to coordinate and manage the health sector response to HIV and AIDS, particularly the biomedical interventions, as part of the national multi-sectoral response. While NAC will continue its overall coordination role.

For the public sector, the Public Service Management Division (PSMD) will play a critical role in ensuring mainstreaming of HIV interventions in all the planned government Ministries activities. This will be important considering that the Government is one of the largest employers and funder of key developmental programmes.

4.3.2 Ministry of Health

The Ministry of Health will continue to be the lead health sector agency for implementation of prevention, treatment and care interventions. Its roles will include regulation, formulation and review of health sector policies and guidelines on HIV prevention, treatment and care; strengthening, availing and quality assuring the health system including infrastructure and equipment, human resources at and linked to health facilities; pharmaceuticals, vaccines, health equipment and other technologies procurement and supply chain management; adequate budget allocation for HIV within the health sector; ensuring strong laboratory systems; managing the health information management system; and ensuring access to services by the general population, PLHIV, people affected by TB, key and vulnerable populations.

4.3.4 The Ministry of Education

The Ministry of Education will facilitate HIV and AIDS mainstreaming in schools; prevention among children and young people, including through Life Skills Health Education (LSHE) delivery; promotion of HIV prevention and treatment services and

product uptake; social protection for example through the school feeding programme and provision of menstrual hygiene kits; and identification of sexual GBV survivors and other children in need of legal protection; among others.

4.3.5 The Ministry of Community Development and Social Services

As per its mandate, the Ministry of Community Development and Social Services (MCDSS) will coordinate social assistance across the life-course stages. In addition, the Ministry will identify individuals that qualify for other forms of social protection being provided by other ministries or sectors to alleviate the social and economic impacts of HIV and AIDS for people living with HIV and those affected, such as orphans and vulnerable children (OVC). MCDSS will collaborate with NAC to coordinate identification and targeting of different levels of vulnerable individuals through Public Welfare Assistance Scheme (PWAS) and other means.

4.3.6 The Ministry of Labour and Social Security

The Ministry of Labour and Social Security (MLSS) will be responsible for integrating all HIV programme results and policies in the world of work and surrounding communities, including in the formal and informal sectors and among migrant, seasonal workers and the provision of social security to vulnerable individuals in collaboration with MCDSS and other implementers.

4.3.7 Ministry of Finance and National Planning

The Ministry of Finance and National Planning will be responsible for resource mobilisation to ensure a sustainable financing of the HIV response in Zambia.

4.3.8 The Ministry of Justice and Ministry of Home Affairs and Internal Security

The two Ministries will be responsible for ensuring that the legal environment is conducive for all the people, regardless of one's sexual orientation, political affiliation or social status in society.

4.3.9 Ministry of Agriculture

The Ministry will be responsible for training PLHIV, through their support groups, AGYW and other vulnerable groups and communities to promote food security; providing nutritional counselling, measuring nutritional status; and linking severely acute malnourished PLHIV and TB patients to relevant implementers.

4.3.10 The Ministry of Local Government and Rural Development (MLGRD)

The Ministry will be responsible for coordinating district and community-based HIV and AIDS interventions in collaboration with NAC while working through Ward Development Committees (WDCs). The Ministry will work towards strengthening District and Community HIV and AIDS Committees (DHACs) to more efficiently coordinate the response on behalf of government and other sectors. MLGRD will coordinate and monitor the multi-sectoral HIV response at the local level. It will also provide leadership in mainstreaming of cross-cutting social issues of HIV, Gender and Human Rights in local development plans, programmes and projects.

4.3.11 The Ministry of Youth, Sport and Arts

The Ministry of Youth, Sport and Arts, formerly known as the Ministry of Sport, Youth and Child Development, will be responsible for reaching out to the out-of-school adolescents and young people, through their established Youth Resource Centres across the country. The Ministry will also be responsible for information dissemination using Arts.

Below is the response coordination and management framework at National level:

Coordination among partners

4.4.1 Cooperating Partners

Cooperating partners (CPs) are coordinated through various fora, including the Cooperating Partners Mechanism which meets quarterly. Currently, the mechanism is co-chaired by PEPFAR and UNAIDS.

4.4.2 Civil Society and Private Sector

Civil society organisations and the private sector are coordinated through umbrella organisations. Coordination between umbrella organisations will be strengthened under this framework.

Civil society organisations include NGOs, faith-based organisations (FBOs), organisations of people living with HIV and AIDS (including support groups) and community-based organisations (CBOs).

4.2.3 Theme Groups

This NASF is anchored on five themes identified as key result areas which include equitable and equal access to HIV services, address barriers, resource and sustain the HIV response, strategic information, and community stewardship. Each theme provides a platform for stakeholders to engage, exchange ideas, share experiences and provide updates on the status of the HIV response focusing on the theme.

The purpose of Theme Group (TG) meetings is to provide oversight, leadership and monitor the implementation of the National HIV and AIDS Strategic Framework (NASF) 2023 – 2027. This is done by way of following laid down national guidelines. The theme group meetings are apex meetings that are informed by specific Technical Advisory Groups (TAGs) and feed into the meetings of the national response coordination committee of NAC.

4.2.4 Technical Advisory Groups (TAGs)

At the interventions level, technical coordination, advisory and progress reviews are performed through the technical advisory groups (TAGs). These TAGs are coordinated under NAC, specific specialised themes will be chaired by the appropriate responsible ministry. For instance, the health system-specific groups will be chaired by MoH but still be convened under NAC coordination.

These groups will be critical in guiding NASF 2023-2027 operationalisation and will be strengthened to reflect the desired programme results and results areas of the framework.

4.3 Response Coordination and Management Framework at Provincial and District Level

The Provincial HIV and AIDS Committee (PHAC) will form the apex platform for coordination of multiple stakeholders and partners involved in the HIV response at provincial level. The PHAC is anchored by the office of the Provincial AIDS Coordination Advisors (PACAs) placed under the Provincial Administration office. In collaboration with the Provincial Health Office, the PACA supervises the implementation of HIV services focusing on mainstreaming of HIV, gender and human rights in all socio-economic development programming.

District HIV and AIDS Committees (DHACs), under the auspices of the District AIDS Coordination Advisors (DACAs) within the Ministry of Local Government and Rural Development coordinate the response at district level. The District Health Offices (DHOs), under the Ministry of Health, are responsible for coordinating the decentralised health sector response. They work in collaboration with the DHACs that ensure the planning, implementation, monitoring and evaluation of programmes at the local level.

Coordination at community level is facilitated by Community HIV and AIDS Committees (CHACs). CHACs will operate as sub-committees of Ward Development Committees (WDCs).

Figure 4-2: Response Coordination at District Level

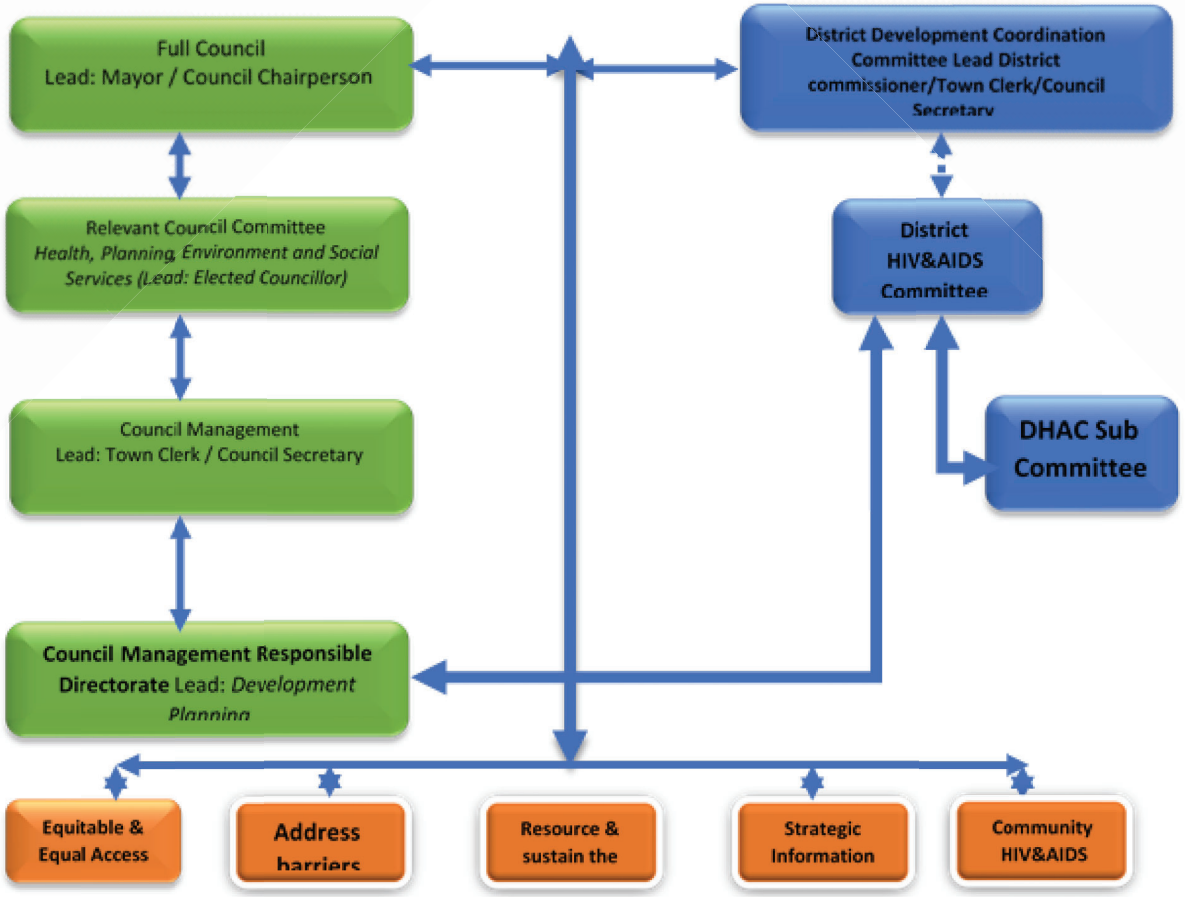
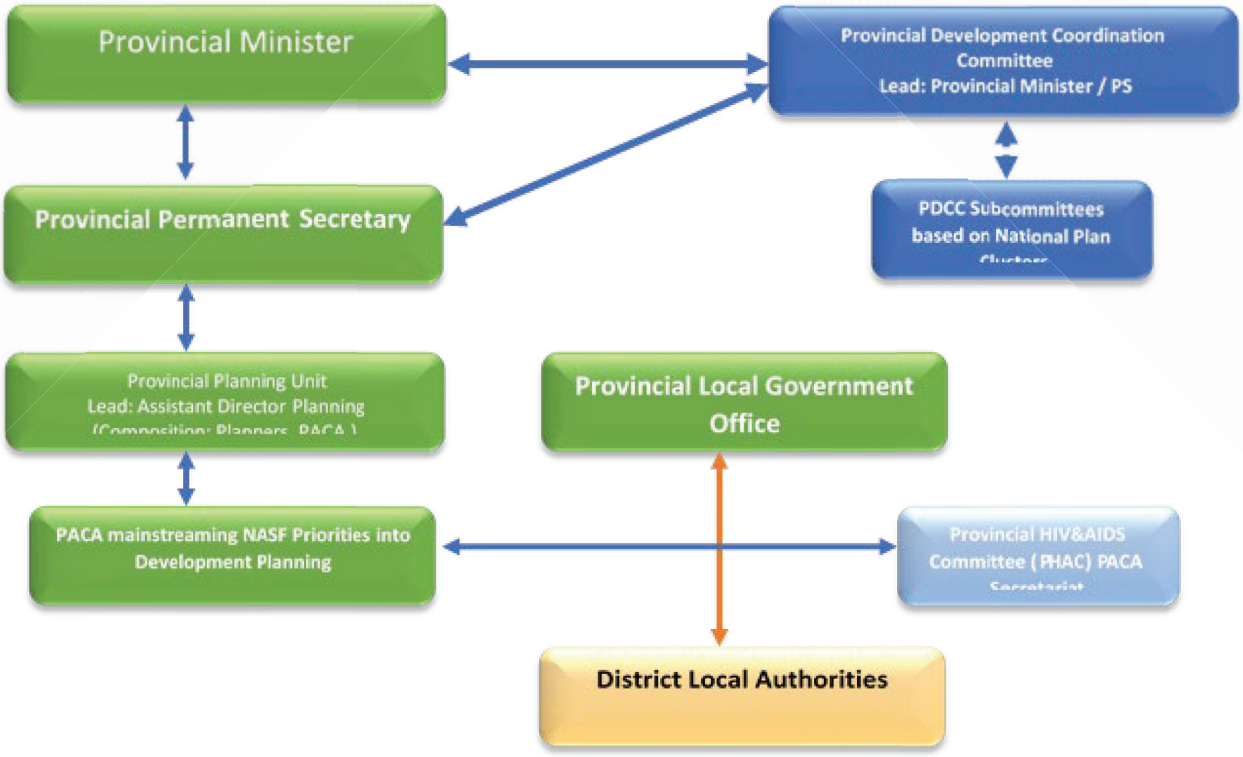


Figure 4-3: Response Coordination at Provincial Level



5.0 FINANCING OF THE NASF 2023 - 2027

5.1 Resources needed for the NASF 2023-2027

The key goal of the NASF 2023-2027 is to contribute to ending AIDS by 2030 through universal access to comprehensive HIV prevention, treatment, care and support. It aims to achieve this by, among others, reducing new HIV infections from 28,000 in 2022 to lower than 15,000 by 2027; and increasing domestic financing of the HIV response from 13.8 per cent in 2017 to 30 per cent by 2027.

This is an ambitious programme that will require significant resources. The costing of the NASF 2023 – 2027 has taken this into account. Additionally, it recognises the need to increase allocative and technical efficiencies, with targeted spending towards high impact interventions, as well as key interest groups (e.g. Priorities and AGYW), for the optimal use of available resources, to achieve the country's targets in a sustainable manner and to reach HIV epidemic control.

Estimating resource needs examined and identified potential efficiencies by improving targeting and coverage for the high impact interventions. For example, the resource needs for AGYW programmes were estimated utilising the *"Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women,"*[2] which led to estimating the coverage of AGWY programmes and the package of interventions based on incidence threshold, optimising package of interventions and the resource allocations. This led to targeting investments to high impact interventions and efficient allocations, reducing the estimated budget by about 69 per cent or by more than US$190 million compared to a non-targeted budgeting approach. Similar approach in the costing of condoms resulted in reducing the estimated budget by more than US$80 million. Additional efficiencies shall be planned and examined during the NSP implementation.

To estimate the resources required to achieve this, the costing of the NASF 2023 – 2027 was done using the GOALS Resource Needs Model. This is a tool that was calibrated to the proposed and agreed NASF interventions and targets and unit costs (based on country prices, implementing partners' budget data or, where none is available, literature from surrounding countries or global unit costs). Unit costs and populations reached are provided in the appendices. Details of costing assumptions are available upon request.

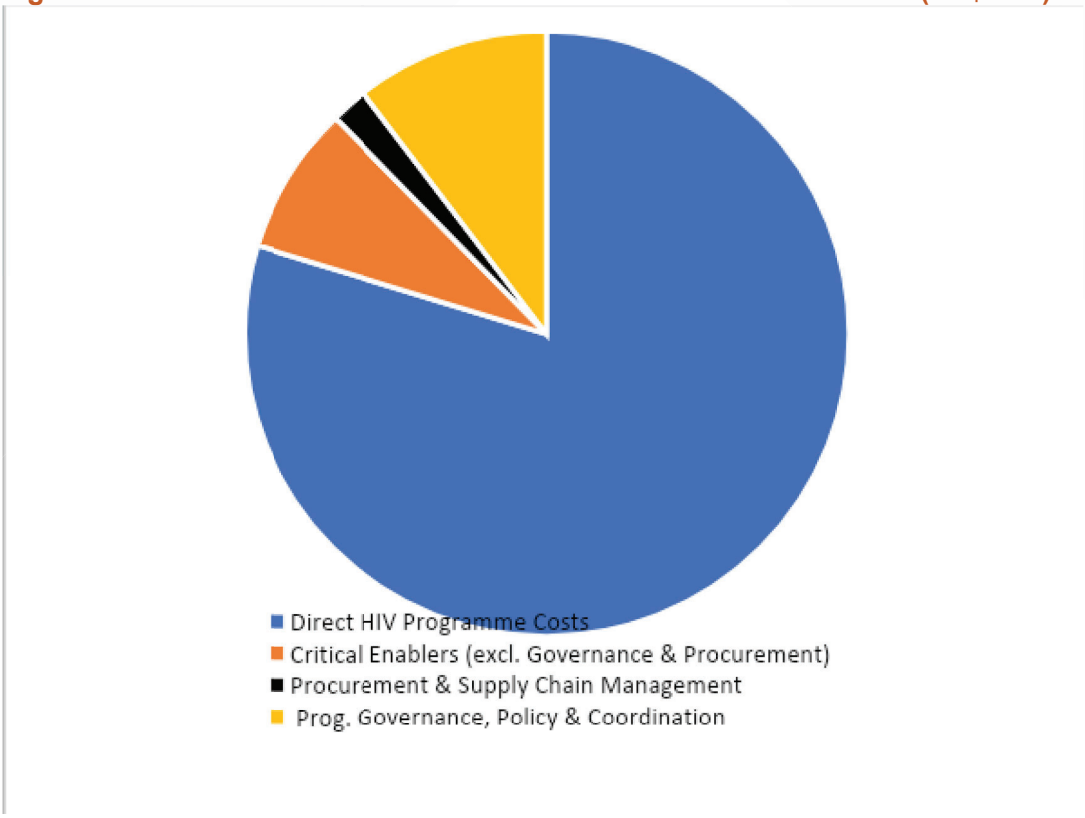
Table 5-1: Estimated resources needed for the NASF 2023-2027 Interventions (US$' mil)

NASF 2023 - 2027 Interventions	2023	2024	2025	2026	2027	Total	%
HIV Testing	9.38	9.59	9.82	10.05	10.28	**49.11**	1.6%
Treatment (ART, TB Prophylaxis)	309.48	318.84	320.80	322.17	337.81	**1,609.09**	51.5%
Prevention: (eMTCT, PrEP, Blood Safety)	24.56	34.12	41.68	48.25	55.04	**203.65**	6.5%
Prevention: (Condoms, STIs, SBC & VMMC adult)	16.80	19.08	22.37	25.49	30.46	**114.20**	3.7%
Prevention: (AGYW/ABYM)	9.79	12.70	12.91	16.03	18.00	**69.44**	2.2%
VMMC for ABYM	0.18	0.13	0.12	0.11	0.09	**0.63**	0.0%
Other Interventions for AGYW/ABYM (LSHE)	0.57	0.69	0.81	0.95	1.07	**4.09**	0.1%
Prevention: Key Populations	35.13	40.05	43.34	48.71	53.84	**221.06**	7.1%
SBC for Priorityes	0.00	0.00	0.00	0.00	0.00	**-**	0.0%
Social Protection (OVC Support & Econ Empowm)	42.61	43.68	43.68	43.69	43.69	**217.35**	7.0%
Critical Enablers	**114.36**	**122.11**	**126.36**	**131.43**	**140.32**	**634.60**	20.3%
CE: Human Rights & Gender Related barriers to Access, Utilisation and Delivery	2.24	2.39	2.48	2.58	2.75	**12.44**	0.4%
CE: CSS	8.97	9.58	9.91	10.31	11.01	**49.77**	1.6%
CE: HMIS & Research	17.94	19.16	19.82	20.62	22.01	**99.54**	3.2%
CE: Procurement & Supply Chain Management	11.21	11.97	12.39	12.89	13.76	**62.22**	2.0%

CE: Laboratory Systems and Equipment	13.45	14.37	14.87	15.46	16.51	**74.66**	2.4%
CE: Programme Governance, Policy & Coordination	58.30	62.25	64.42	67.01	71.54	**323.52**	10.4%
CE: Finance and Sustainability	2.24	2.39	2.48	2.58	2.75	**12.44**	0.4%
Total NASF Costs (US$'m)	**562.85**	**600.99**	**621.90**	**646.86**	**690.62**	**3,123.22**	100.0%
Summary of NASF Costs	**2023**	**2024**	**2025**	**2026**	**2027**	**Total**	**%**
Direct HIV Programme Costs	448.49	478.88	495.54	515.43	550.29	2,488.62	79.7%
Critical Enablers (excl. Governance & Procurement)	44.85	47.89	49.55	51.54	55.03	248.86	8.0%
Procurement & Supply Chain Management	11.21	11.97	12.39	12.89	13.76	62.22	2.0%
Prog. Governance, Policy & Coordination	58.30	62.25	64.42	67.01	71.54	323.52	10.4%
Total NASF 2023 - 2027 Resource Need (US$'m)	**562.85**	**600.99**	**621.90**	**646.86**	**690.62**	**3,123.22**	100.0%

The total resource needs envelope for the NASF 2023 – 2027 is estimated at about US$ 3.12 billion for the five-year period. Direct HIV programmes costs account for 79.7 per cent of total costs at about US$2.49 billion. Critical enablers (excluding governance and procurement) are estimated at around US$248.86 million (8.0%), procurement and supply chain management at US$62.22 million (2.0%) and programme governance, policy and coordination at US$323.53 million (10.4%).

Figure 5-1: Estimated share of NASF 2023-2027 Available Resource (US$' mil)



The NASF 2023 estimated cost of US$562.85 million compares with the RNASF 2020 – 2023 estimate of 638.73 million for the same year. The difference could partly be attributed to the revised assumptions in the NASF. The total resource needed for the NASF 2023 – 2027 increases to US$600.99 million in 2024 and is estimated to reach US690.62 million by 2027, in nominal terms. This represents increases of 6.8 per cent between 2024 and 2023 and 4.0 per cent between 2026 and 2025 and 6.8 per cent between 2027 and 2026. On average, the NASF cost estimates rise by 5.3 per cent annually over the five-year period.

Adolescents and young people have disproportionately high HIV incidence rates (0.56 per cent for AGYW and 0.06 per cent for ABYM)[3] and thus, investment in impactful programmes to prevent, identify and treat HIV among this group is a key priority of the NASF 2023-2027. To contribute to the goal of ending AIDS by 2030, the NASF recognises that behaviour change packages must target young people, particularly those between 0 to 14 years old who account for 46 per cent of all Zambians. It is envisaged that the introduction of HIV education in the national school curriculum is the best strategy that will help to tackle the HIV epidemic effectively.

The total cost of interventions for the AGYW/ABYM, as an interest group, is US$69.44 million or 2.2 per cent of the total NASF 2023-2027 estimates. It rises from US$9.79

[3] Zambia Population-based HIV/AIDS Impact Assessment (ZAMPHA 21), Summary Sheet, December 2022.

million in 2023 to US$18 million in 2027. If packages for adolescents and young people from SBC and VMMC are included (but excluding condoms whose cost is not disaggregated), its share into total cost rises slightly to 2.3 per cent. As a share of the prevention budget, AGYW/ABYM account for about 11 per cent.

It is expected that the bulk of interventions aimed at adolescents (AGYW/ABYM), including SBC, VMMC and CSE is earmarked for social behaviour change communication and advocacy, ensuring that adolescent boys and girls are appropriately reached with knowledge and skills for safer sex, with AGYW and male counterparts actively involved in SBC design, implementation, monitoring and evaluation.

The NASF 2023-2027 also prioritises investing in interventions for key populations, that is, MSMs, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people who are at most risk of contracting HIV, TB and STIs. Consequently, the cost of interventions for key populations rises from US$35.1 million in 2023 to US$53.8 million in 2027. As a proportion of total NASF cost, Prioritys account for 6.0 per cent - rising from 5.8 per cent in 2023 to 7.1 per cent in 2027. Key interventions include removing barriers to accessing HIV, SRH and rights information and services; and improving access to legal and social justice and protection from stigma and discrimination, both in the public and private sectors.

HIV treatment, which includes ART, laboratory monitoring, services delivery (SD) and other treatment service enablers account for 51.3 percent of the total NASF 2023 – 2027 cost for the five-year period. This compares to 47 per cent in the RNASF 2020 – 2023.

Figure 11 below shows how the total NASF 2023 – 2027 resource needs will be allocated to programmes or interventions. Figure 12 on the other hand shows the allocations by programme or intervention year by year.

Figure 5-2: Est. total resources needed for the NASF 2023-2027 (US$' m)

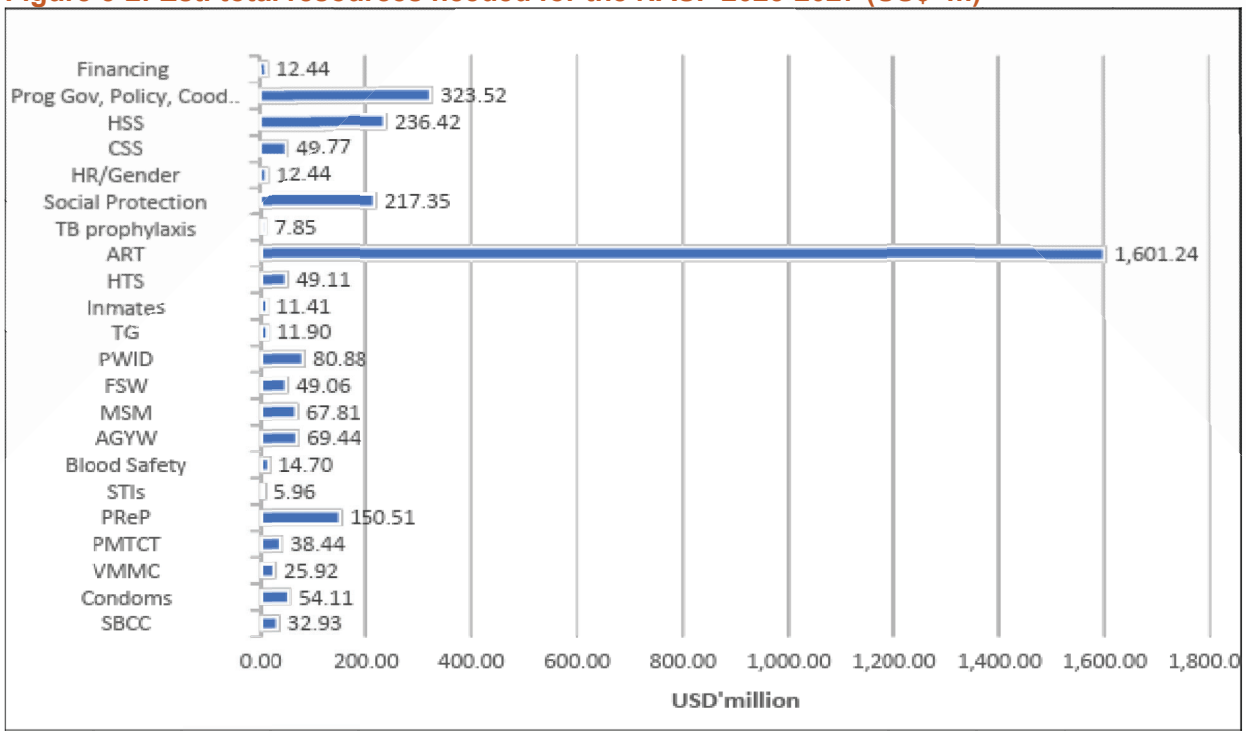
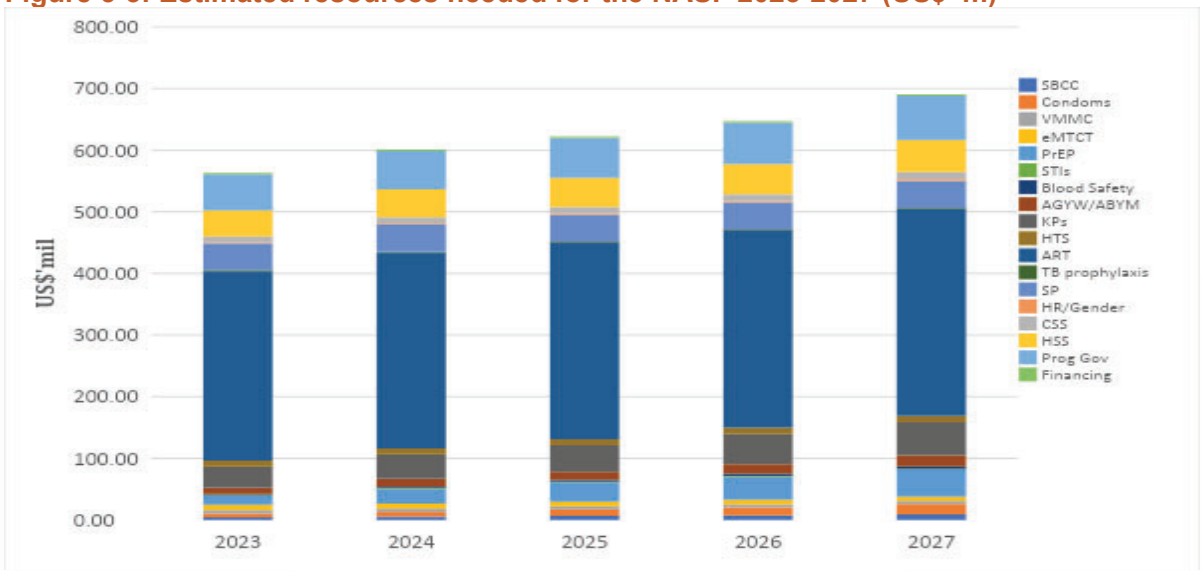


Figure 5-3: Estimated resources needed for the NASF 2023-2027 (US$' m)



***Abbreviations**: SBC: Social and Behaviour Change Communication; VMMC: Voluntary Medical Male Circumcision; eMTCT: Elimination of Mother to Child Transmission; PrEP: Pre-Exposure Prophylaxis; STIs: Sexually Transmitted Infections; AGYW/ABYM: Adult Girls and Young Women/ Adult Boys and Young Boys; Prioritys: Key Populations; HTS:*

HIV Testing Services; ART: Anti-Retroviral Therapy; SP: Social Protection; HR/Gender: Human Rights and Gender Related Barriers to Access, Utilisation and Delivery; CSS: Community Systems Strengthening; HSS: Health Supply Systems; Prog Gov: Programme Governance, Policy and Coordination.

HIV testing, which aims to scale up innovative ways of distributing HIV self-testing kits especially for vulnerable populations such as adolescent girls and boys, increases from US$9.4 million in 2023 to US$10.3 million in 2027. For the five-year period, resources for HIV testing could account for 1.6 per cent of total resource needs. Interventions here will target community-based testing, including Outreach HTS, home-based and targeted campaigns to reach first-time testers and clients with poor access to other testing services, including groups of men 15-24 years, key populations, persons with disabilities, the under-five years old children, adolescents and people living with HIV related opportunistic infections. Social protection, mostly OVC support, is expected to cost around $34 million per year (5.4 per cent of total costs). Economic empowerment on the other hand, largely national insurance coverage and social cash transfer to the vulnerable groups, particularly those households with a member or members who are chronically ill on palliative care. This category is expected to cost around US$8.6 million in 2023 rising to US$9.7 million in 2027, accounting for 1.5 per cent of total costs. Critical enablers (social, system and service enablers) could require around $127.0 million per annum, on average – rising from US$114.4 million in 2023 to US$140.3 million in 2027 and account for 26 per cent of the total programme costs. These include community systems strengthening, health systems strengthening (PSM, labs, human resources), policies, human rights, stigma reduction, gender empowerment, reduction of gender-based violence, improving access to SRH services, as well as coordination, and programme management, leadership and governance. These investments are considered essential to enhance and support the achievement of the NASF goals.

5.2 Limitations of the cost estimates

In the costing of the NASF 2023 – 2027, obtaining up-to-date Zambian unit costs for the various costing interventions and commodities was a big challenge. Owing to limited time for the costing exercise, other sources of unit costs were sought (see Table 49 for the unit costs). The bulk of the unit costs came from the background paper by Avenir Health[4]. These included unit costs for paediatric ART treatment, STIs, Prioritys and PMTCT. A few interventions' unit costs were obtained through literature review – these were computed using data from COP22 Investment Profile, NASA expenditure data and AIDSinfo/UNAIDS for target populations. These included adult ART treatment, condoms, VMMC, PrEP, AGYW/ABYM, HIV testing and OVC packages. Unit costs for SBC adults 25 – 49 years and for blood screening were based on the regional unit costs, particularly from Namibia. The unit cost for TB Prophylaxis was obtained from the TB Strategic Plan. Local unit costs were used for the economic empowerment interventions. One such intervention is the National Health Insurance Scheme (NHIS) managed by the National

[4] Lori Bollinger, Steven Forsythe, and John Stover. Avenir Health. November 2020. *Costing Assumptions for 2021-2030 Resource Needs Estimates:* Background paper

Health Insurance Management Authority (NHIMA). The unit cost for the insurance package is based on the Zambian Kwacha amount set aside and the number of beneficiaries earmarked for this package. Another was the Social Cash Transfer (SCT), which was derived from a monthly payment of K400 per household. The critical enablers (CE) were equally difficult to cost – due to a lack of existing unit costs and expenditure data as well as their poor definition, making it impossible to anticipate what might be required. Therefore, each CE indicated in Table 44 was assumed to be a proportion of the total cost. In total, critical enablers were assumed to be 26 per cent of total programme expenditures. It is, however, difficult to say whether they have been over or under-estimated.

Missing from the cost estimates: Although important programmes, post-exposure prophylaxis (PEP) and viral hepatitis infection and psychosocial support for PLHIV, synergies within the health sector, are missing from the NASF 2023-2027 cost estimates. This is because no targets have been provided for the same.

5.3 Potential Impact of the NASF on New Infections and Mortality

If the NASF is implemented as planned and the targets are achieved, the resulting impact on HIV will be significant. Modelling results by Avenir Health show that new HIV infections are expected to be reduced in the order of 31, 000 in the general population and 2, 900 in children over the period. This translates to huge savings because of cost per infection averted. This may imply that NASF 2023 - 2027 will be targeting high impact interventions with some cost efficiencies. Additionally, around 8, 700 more HIV-related deaths could be averted over the NASF period. Figures 13 to 16 below shows the modelled impact of the successful implementation of the NASF, depicting the positive impact of implementing the NASF.

Figure 5-4: Projected impact of the NASF 2023 - 2027

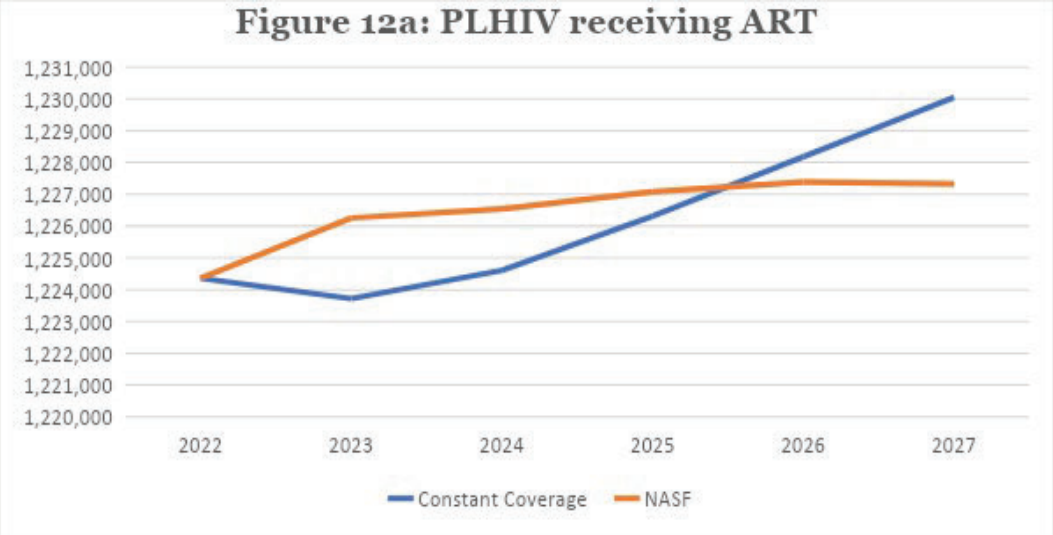


Figure 5-5: New HIV Infections

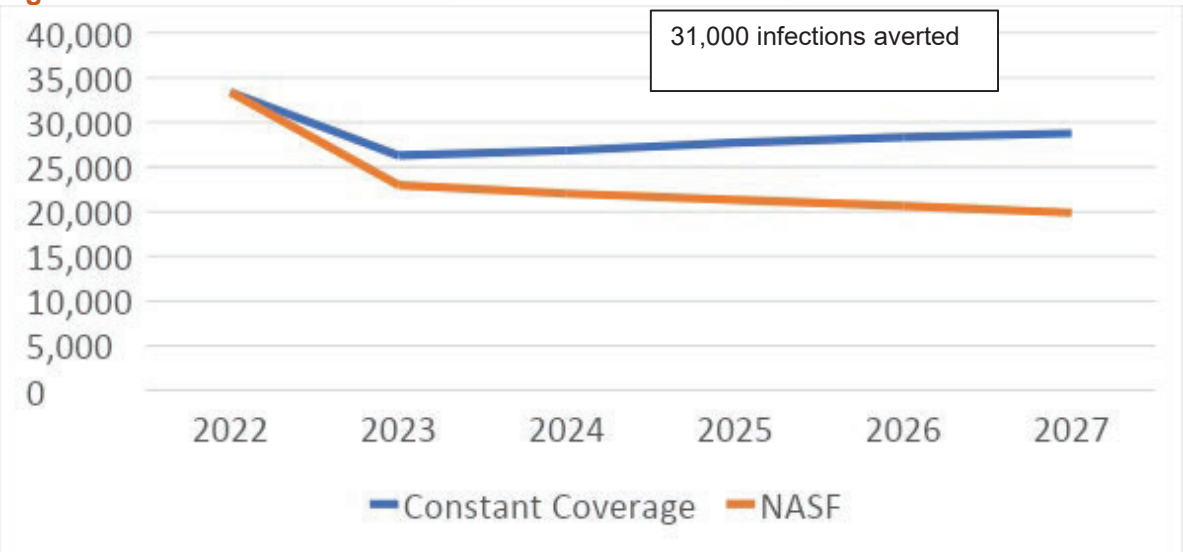


Figure 5-6: New Paediatric HIV Infections

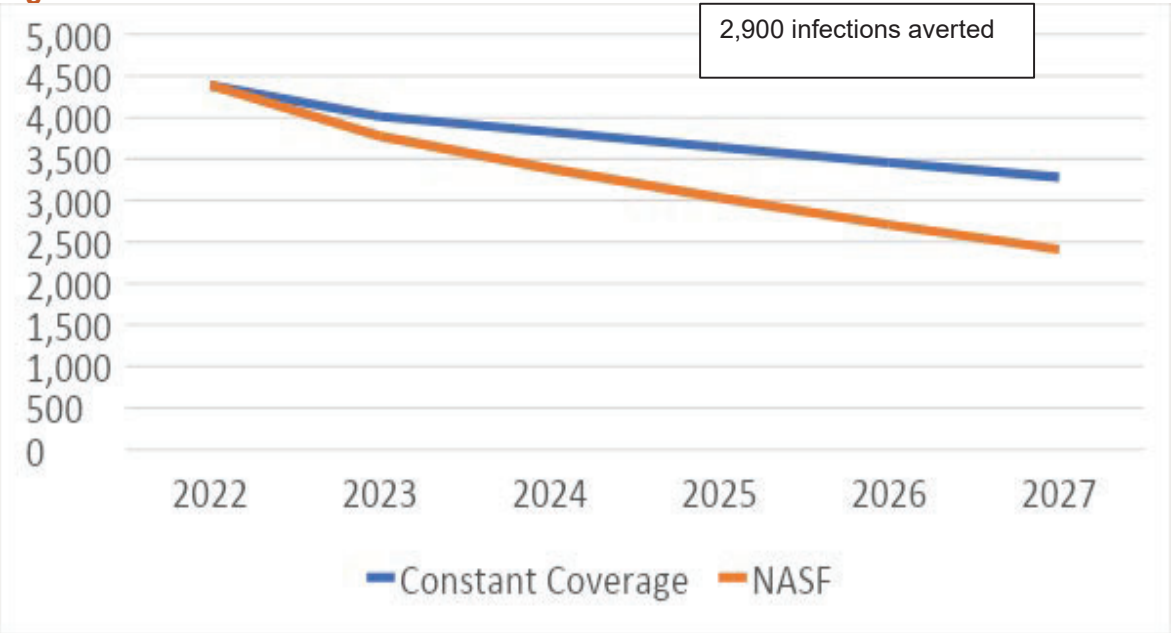
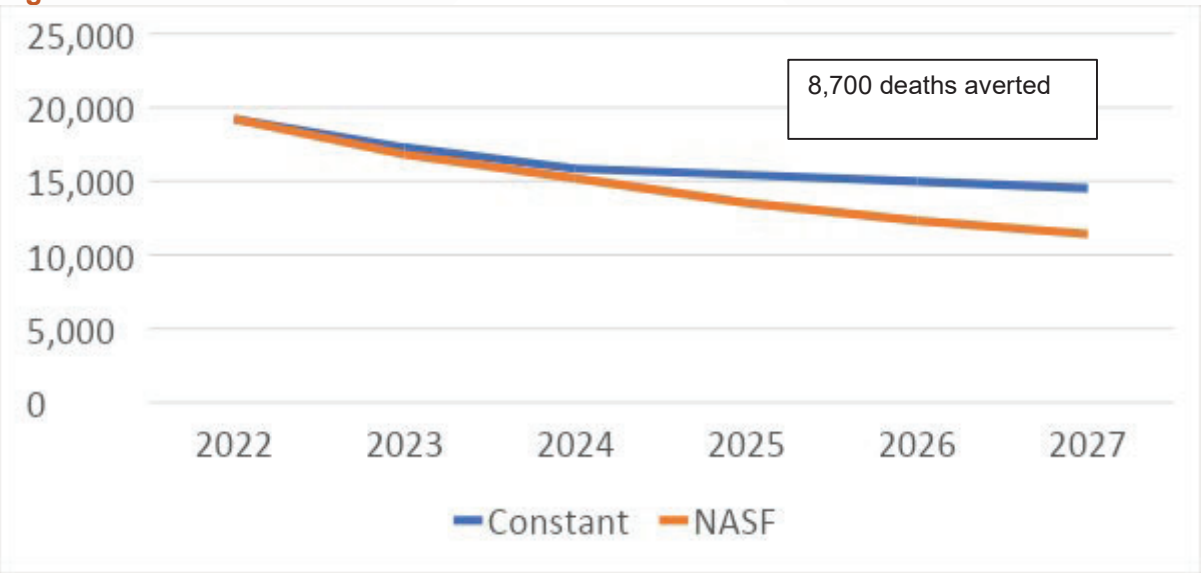


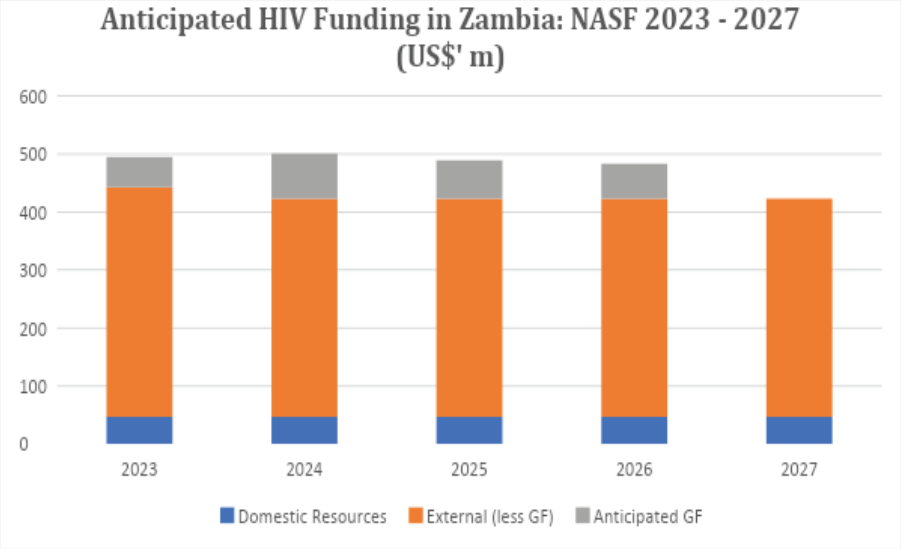
Figure 5-7: AIDS deaths



5.4 Funding Landscape

Other than the resource needs derived from the costing of the NASF 2023 – 2027, the funding landscape is largely derived from the Zambia National AIDS Spending Assessment (NASA) 2019 – 2021 Final Draft Report. From the NASA data, available HIV resources from the key stakeholders in Zambia could amount to US$454.0 million in 2024 and is projected to decline to around US$376.2 million by 2027 (Figure 17). This funding is largely from the United States Government (PEPFAR), Germany, the UN agencies (i.e. UNFPA, UNHCR, UNICEF and UNAIDS) and other undisclosed foreign sources. PEPFAR remains the largest funder for HIV and AIDS programmes in Zambia, accounting for about 85 per cent of total external funding for HIV. As indicated in the two-year Country Operational Plan (COP 2023), PEPFAR funding will begin to decrease incrementally beginning in 2024. COP23 Year 1 (2024) funding is estimated at $390.5 million; COP23 Year 2 (2025) is $371.0 million. Thereafter, PEPFAR anticipates an annual reduction of five per cent.

Figure 5-8: Anticipated funding for the HIV response in NASF 2023-2027 (US$' m)



Notes:

- The anticipated Global Fund amounts (2023-2027) were based on the NASA projection and assumed successful outcomes from the recent Global Fund (GF) funding request (2024-2026). These exclude TB allocations.
- PEPFAR funds: Based on COP22 budget and are assumed to decrease by five per cent yearly.
- UN Agencies funds: includes UNFPA, UNICEF, UNHCR and UNAIDS and are based on flatlining 2021 expenditure.
- Germany funds, just like those of other external sources, are equally based on flatlining 2021 expenditure.

Domestic resources will account for around 9.4 per cent in 2023 of the total available HIV funding and are expected to rise steadily to 9.6 per cent in 2025, 9.7 per cent in 2026 and to 11.1 per cent by 2027. The higher 2027 rate is largely because there is no provision for the Global Fund grant in that year. There is, therefore, a need for the Government to increase domestic funding for the HIV response to maintain the momentum in the response to HIV and AIDS.

Table 49 below provides some pictures on the projected external sources available for the funding of the HIV response in Zambia, by source, including the anticipated new GF grant. On the other hand, Table 50 shows the funding landscape of the NASF 2023 – 2027.

Table 5-2: External sources funding of the HIV response (US$' m, 2023-2027)

	2023	2024	2025	2026	2027	% of Total (2024)
Germany	1.37	1.37	1.37	1.37	1.37	0.3%
US Gov't (Excl. TB)	390.52	371.00	371.00	371.00	371.00	80.2%
UNFPA	-	1.45	1.45	1.45	1.45	0.3%
UNICEF	-	1.43	1.43	1.43	1.43	0.3%
UNAIDS	0.51	0.51	0.51	0.51	0.51	0.1%
UNHCR	0.05	0.05	0.05	0.05	0.05	0.0%
Global Fund	52.69	77.80	66.14	59.99		18.7%
Other Ext. Sources		0.41	0.41	0.41	0.41	0.1%
Total Ext. Funding	**448.03**	**462.70**	**462.70**	**462.70**	**376.22**	**100.0%**

Table 5-3: HIV Funding Landscape

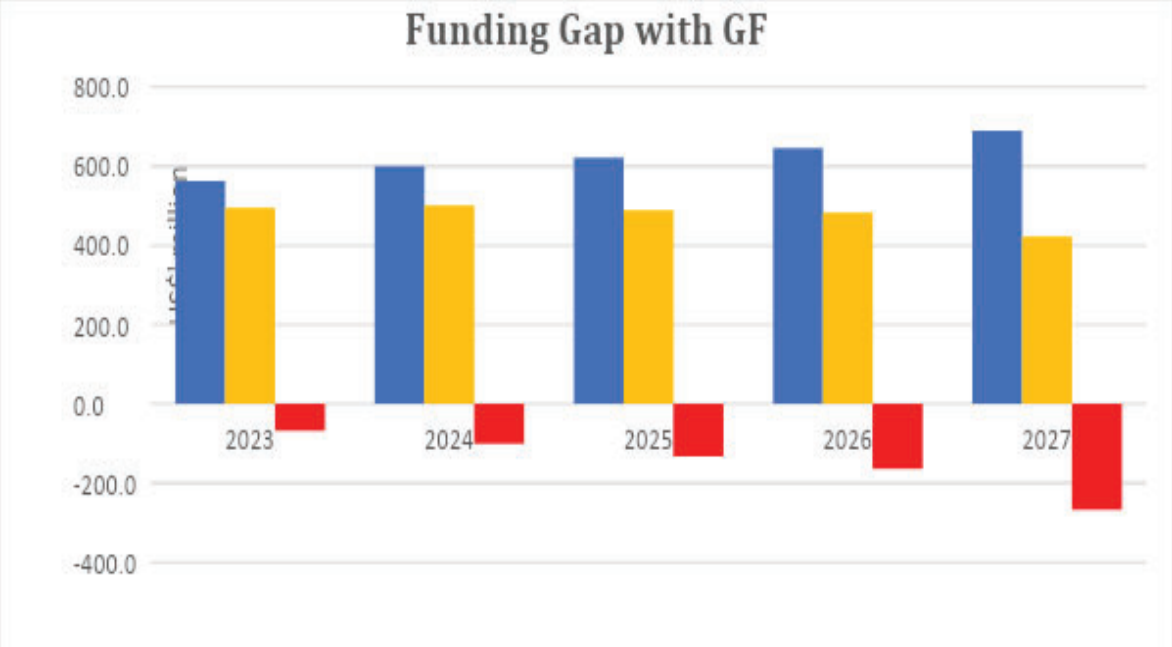
(US$' 000)	2022	2023	2024	2025	2026	2027
Total Resource Needs	**617,212.6**	**562,855.9**	**600,989.7**	**621,898.8**	**646,862.3**	**690,616.9**
Gov't Revenue	**46,957.6**	**46,772.5**	**46,772.5**	**46,772.5**	**46,772.5**	**46,772.5**
%	8%	8%	8%	8%	7%	7%
US Gov't	408,012.6	390,522.0	370,995.9	370,995.9	370,995.9	370,995.9
Germany	1,369.7	1,369.7	1,369.7	1,369.7	1,369.7	1,369.7

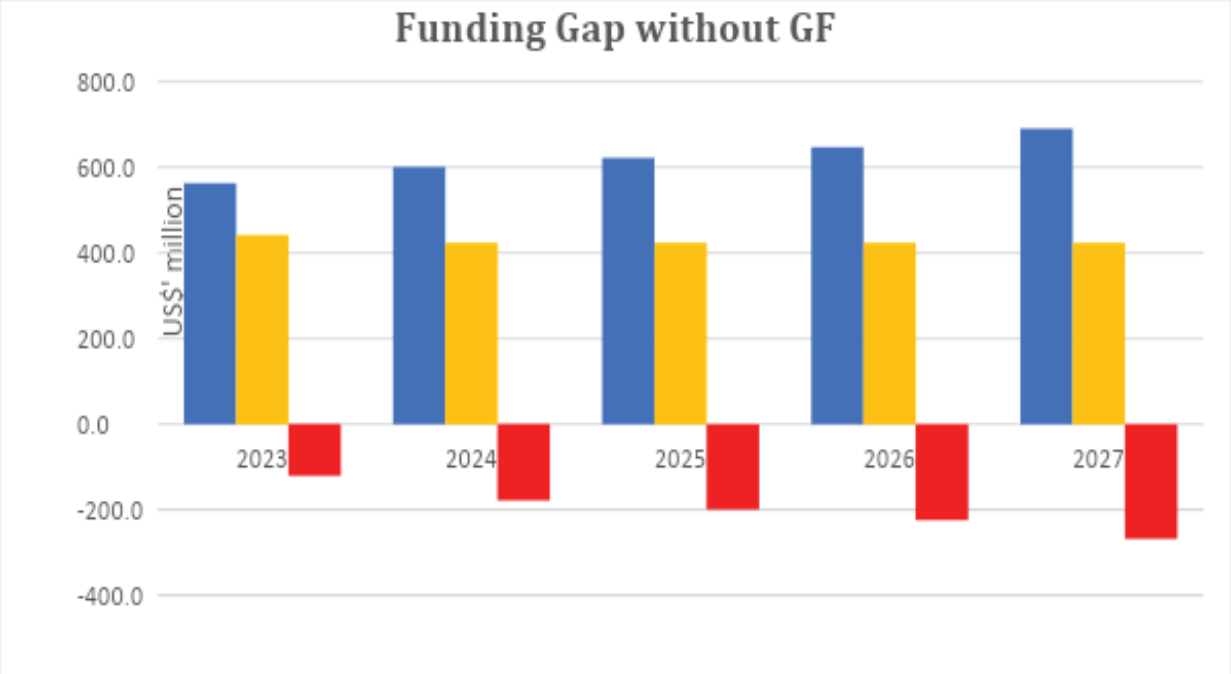
UNAIDS	514.4	514.4	514.4	514.4	514.4	514.4
UNFPA	1,543.4	1,453.4	1,453.4	1,453.4	1,453.4	1,453.4
UNHCR	50.0	50.0	50.0	50.0	50.0	50.0
UNICEF	1,428.9	1,428.9	1,428.9	1,428.9	1,428.9	1,428.9
Other Ext. Sources	413.4	413.4	413.4	413.4	413.4	413.4
Global Fund	77,379.5	52,691.1	77,800.8	66,142.0	59,987.9	-
Total Ext. Resources	**490,711.9**	**448,442.9**	**454,026.5**	**442,367.7**	**436,213.6**	**376,225.7**
% Ext. Resources	80%	80%	76%	71%	67%	54%
Total Available Resources	**537,669.5**	**495,215.4**	**500,799.0**	**489,140.2**	**482,986.1**	**422,998.2**
Gap	75,543.1	67,640.6	100,190.7	132,758.6	163,876.2	267,618.7
% Gap	15%	14%	20%	27%	34%	63%

5.5 Potential funding shortfall for the NASF

When total available funds (inclusive of the anticipated new Global Fund grant (2004-2007)) are compared with the total estimated resource needs, there is an estimated overall potential funding gap of US$67.2 million in 2023, which increases to a possible US$132.8 million in 2025 and US$163.9 million in 2026. Without the anticipated new Global Fund resources, however, the funding gap is higher – US$120.3 million as against US$67.2 million and rises to US$223.9 million (as against US$163.9 million) in 2026. The funding gap for 2027 is the same (i.e. US$267.6 million) because being outside the GF funding period, no GF resources are included in either case. Figure 18 below shows the NASF funding gap, with and without the GF resources.

Figure 5-9: NASF 2023-2027 available HIV funds (total) versus resources needed and potential funding gap (US$' m), including and excluding new GF grant





Note: the above figures *exclude* the estimated MOH indirect shared HIV costs.

If the NASF resource needs are analysed by programme intervention, it reveals the fact that the funding gap is higher for certain interventions than for others. This is largely because the bulk of the external resources are targeted for specific HIV interventions

rather than pooled in the general funding basket. On the other hand, domestic resources are essentially targeted towards specific programmes. Based on the NASA data and information, Table 46 below shows how the NASF 2023 – 2027 resources (without GF resources) are expected to be allocated by programme intervention.

It will be noted therefrom that available domestic resources only go to support SBC, ART and programme support and enabling environment programmes. Consequently, SBC and ART have the lowest funding gap over the period 2024-2027 of 14 per cent and 27 per cent, respectively.

Table 5-4: NASF 2023 – 2027 Resource Allocation and Resource Gap by Programme (US$' million)

	NASF Resource Needs					Total Available Resources (Non-GF Ext + Domestic)					Funding Gap			
	2024	**2025**	**2026**	**2027**		**2024**	**2025**	**2026**	**2027**		**2024**	**2025**	**2026**	**2027**
SBC	5.38	6.58	7.25	9.42		4.99	6.36	6.60	6.60		0.39	0.22	0.65	2.82
Condoms	8.10	10.45	13.17	16.34		5.09	6.35	7.70	7.70		3.01	4.10	5.47	8.64
VMMC	5.16	5.06	4.99	4.84		3.24	3.08	2.92	2.92		1.92	1.99	2.07	1.92
PMTCT	8.09	7.65	7.18	6.98		5.09	4.65	4.20	4.20		3.01	3.00	2.98	2.78
PrEP	23.72	31.03	37.46	44.07		14.91	18.86	21.91	21.91		8.82	12.17	15.55	22.15
STIs	1.27	1.21	1.13	1.01		0.80	0.73	0.66	0.66		0.47	0.47	0.47	0.35
AGYW/ABYM	12.70	12.91	16.03	18.00		7.98	7.85	9.38	9.38		4.72	5.06	6.66	8.62
FSW/MSM	21.15	22.91	25.61	28.25		13.29	13.93	14.98	14.98		7.86	8.98	10.63	13.27
Blood Safety	2.30	3.00	3.60	4.00		-	-	-	-		2.30	3.00	3.60	4.00
Other Prioritys (PWID, TG, etc)	18.89	20.42	23.10	25.59		11.87	12.42	13.51	13.51		7.02	8.01	9.59	12.08
HTS	9.58	9.82	10.05	10.28		6.02	5.97	5.88	5.88		3.56	3.85	4.17	4.41
ART	317.24	319.28	320.60	336.28		242.30	237.03	230.45	230.45		74.95	82.25	90.15	105.83
TB prophylaxis	1.60	1.52	1.57	1.54		1.00	0.92	0.92	0.92		0.59	0.59	0.65	0.62
Social Protection, Econ Empowerment	43.68	43.68	43.69	43.69		30.08	28.44	27.43	27.43		13.60	15.25	16.25	16.26
Prog Support & Enabling Environment	122.11	126.36	131.43	140.32		77.29	77.29	77.35	77.35		44.90	49.07	54.09	62.98
Total	**600.99**	**621.90**	**646.86**	**690.62**		**423.88**	**423.88**	**423.88**	**423.88**		**177.11**	**198.02**	**222.98**	**266.74**

5.6 Sustainability of the HIV Response in Zambia

Review of past national HIV and AIDS strategic frameworks has revealed increasing total spending on the HIV response over the last five to ten years. This is largely because there has been consistent and increased commitment from both the Government of the Republic of Zambia (GRZ) and the country's cooperating partners to support the programme. The review has also shown that the available funding had been mostly allocated and utilised according to the NASF priorities and resource needs. These achievements will need to be continued and expanded.

Over the last decade, external debt increased to unsustainable levels, which compounded by the effects of the COVID-19 pandemic resulted in a slow-down in economic growth. As a proportion of the Gross Domestic Product (GDP), the public debt stock (domestic and external) significantly increased from 22 per cent in 2006 to 119 per cent in 2021. This put fiscal pressure on the limited resources available for Government spending, including on the health sector, a situation which threatened to reverse the gains attained in the health sector.

To address this situation, the Government embarked on a reform agenda to get the economy back on a positive growth trajectory and bring the debt stock back to sustainable levels.

In August 2022 the International Monetary Fund (IMF) Executive Board approved a three-year $1.3 billion programme to support the Government's reform agenda, to address the public debt situation and enhance fiscal consolidation with key emphasis on prudent fiscal management, which, among others, cuts out wasteful expenditure while increasing revenue mobilisation. Enhancing revenue mobilisation and shifting resources to programmes of higher productivity across and within sectors is expected to create the impetus for enhanced economic growth and thereby help sustain investments in the health sector. Domestic revenue mobilisation is key for the Government to restore fiscal sustainability. Maximising mobilisation of both tax and non-tax revenues and shifting the resources to programmes of higher productivity across and within sectors, will sustain investment in health, education and other key sectors over the 2024-2026 medium term.

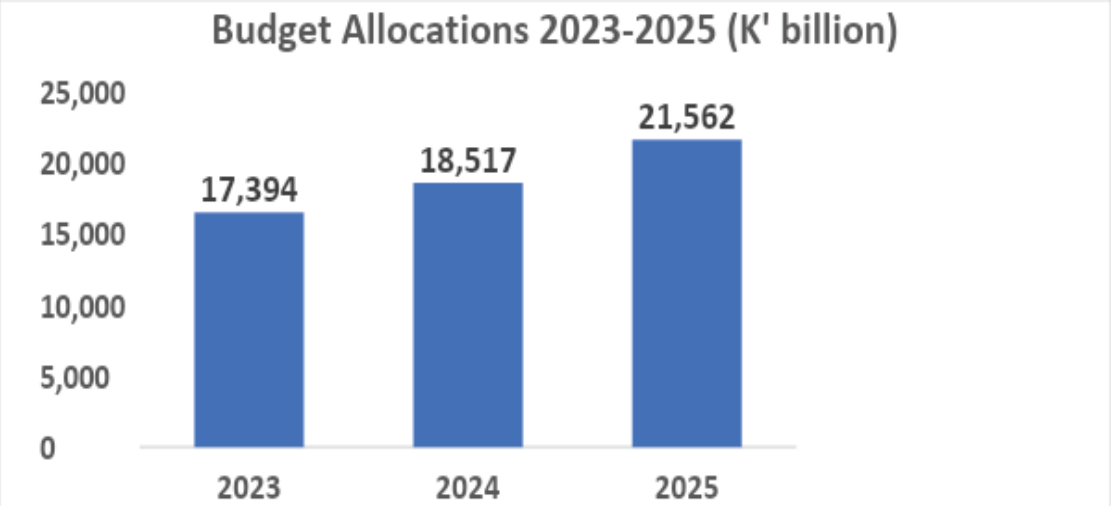
It is envisaged that once the debt restructuring position is concluded, the Government will create more fiscal space to address various needs, including those in the health sector.

According to the budget speech and projections according to the Medium-Term Budget Plan and Green Paper, the budget allocated to the health sector will increase by 55 per cent from 2022 to 2025. Also, the share of the budget allocated to the health sector in the national budget will increase from eight per cent in 2022 to almost 10 per cent in 2025. The Ministry of Health will actively engage the Ministry of Finance and National Planning (MoFNP) to advocate for an increase in the government allocations to health to achieve the Abuja target (15 per cent of the total GRZ budget).

Table 5-5: Government health expenditure as a share of the GRZ total budget

	2022	2023	2024	2025	TOTAL (2023-2025)
Health Financing (USD)	772,866,643	966, 377,772	1, 028,741,904	1, 197, 897,769	**3,193,017,445**
GRZ Total Budget (USD)	9,610,393,196	9,295,651,865	12,084,159,572	12,173, 613,207	**33,553, 424,644**
%	8%	10%	9%	10%	**10%**

Table 5-6: Budget Allocations for the Health Sector (2023-2025)



Note: 2024 and 2025 are projections.

Regarding the financing of the HIV and AIDS response, domestic resources are almost constant in absolute value. The trend is also almost constant compared to the strategic plan resources needs of around eight per cent. On the other hand, the estimated trajectory of external resources is declining, falling from 83 per cent in 2021 to 72 per cent in 2026. This is translated into an increase in the financing gap, which represents 21 per cent of overall needs in 2026.

Table 5-7: HIV Funding Landscape

HIV (USD)	2022	2023	2024	2025	2026
Total Funding needs for the National Strategic Plan	**617,212,605**	**562,364,704**	**600,989,686**	**621,898,767**	**646,862,262**
Current and anticipated DOMESTIC resources	**47,652,652**	**47,652,652**	**47,652,652**	**47,652,652**	**47,652,652**
%	*8%*	*8%*	*8%*	*8%*	*7%*
Germany	1,369,685	1,369,685	1,369,686	1,369,686	1,369,686
Joint United Nations Programme on HIV/AIDS (UNAIDS)	514,387	514,387	514,387	514,387	514,387
United States Government (USG)	408,012,583	390,522,000	370,995,900	370,995,900	370,995,900
United Nations Population Fund (UNFPA)	1,453,448	1,453,448	1,453,448	1,453,448	1,453,448
United Nations High Commissioner for Refugees (UNHCR)	50,000	50,000	50,000	50,000	50,000
The United Nations Children's Fund (UNICEF)	1,428,910	1,428,910	1,428,910	1,428,910	1,428,910
Unspecified - not disaggregated by sources	413,350	413,350	413,350	413,350	413,350
Global Fund	77,379,512	52,691,087	77,800,784	66,141,983	59,987,875
Total previous, current and anticipated EXTERNAL Resources	**490,621,875**	**448,442,867**	**454,026,465**	**442,367,664**	**436,213,556**
% external resources	*79%*	*80%*	*76%*	*71%*	*67%*
Total available resources	**538,274,527**	**496,095,519**	**501,679,117**	**490,020,316**	**483,866,208**
Gap	78,938,078	66,269,185	99,310,569	131,878,451	162,996,054
% Gap	*13%*	*12%*	*17%*	*21%*	*25%*

In terms of sustainability, it is worth mentioning the institutional and operational capacities built during all these years that the country has launched and maintains an effective response to HIV and AIDS. This response is steered through costed strategic plans for the response to HIV and AIDS, which constitute the reference for the mobilisation of financial resources. The Ministry of Health has built skills and competencies of health personnel as well as operational guidelines to manage the three diseases benefiting from

Global Fund financing. All these skills are the result of a synergy of technical and financial partners supporting the health sector.

Also, the Government continues to increase investments in health infrastructure such as the construction of general hospitals, specialist hospitals and mini hospitals as well as health posts; and human resources for increasing the access to quality health care. Thus, the population to doctor ratio improved to 5, 900 per doctor in 2019 from 10, 886 in 2016, while the population to nurse ratio also improved to 995 per nurse from 1, 366. Additionally, interventions aimed at ensuring universal health access that were implemented resulted in an increase in the proportion of eligible people covered by the national health insurance to 29 per cent in 2020 from 3.9 per cent in 2016.

In reference to the Eighth National Development Plan 2022-2026, it is expected that the client to health personnel ratio will reduce to 3, 500 persons per doctor in 2026 from 6, 750 in 2020; 3, 000 persons per clinical officer from 4, 600; and 500 persons per nurse or midwife from 750. It is also expected that the availability of essential drugs and medical supplies will increase to at least 90 per cent fill rates by 2026 from 40 per cent in 2020. Further, it is envisaged that the proportion of hospitals with fully functional recommended equipment will improve to 85 per cent by 2026 from 20 per cent in 2020. By 2026, the target is for all Zambians to be covered by the national health insurance from the coverage of 25 per cent in 2021.

Also, the community led response approach for managing HIV and AIDS is a guarantee of operational sustainability that will lead to reducing inequalities for accessing health services.

Table 5-8: Unit Costs used in the Costing of the NASF 2023 - 2027

Intervention/Commodity	Unit Cost	Source
MSM	$114.07	Lori Bollinger, Steven Forsythe and John Stover. Avenir Health. November 2020. *Costing Assumptions for 2021-2030 Resource Needs Estimates:* Background paper
FSW	$77.19	
PWID	$209.14	
Transgender	$124.51	
Prisoners	$119.72	
PMTCT	$142.30	
ART – Ped Treatment	$278.07	
STIs	$47.51	
ART – Adult Treatment	$247.96	COP22 SDS Investment Profile
Lubricants	$0.20	
VMMC	$25.19	
PrEP	$40.57	
HIV Testing	$4.12	
OVC Packages	$56.67	
AGYW Reached	$18.32	NASA Data (2019-2021) & AIDS Info.
ABYM Reached	$10.19	
Condoms	0.21	
ABYM Reached – Cash transfer	$40.12	
SBC – AGYW CSE	$22.36	Directorate of Planning and Information, Ministry of Education, November 2020; Education Statistics Bulletin 2019
EID Test – Exposed infants	$44.50	GC7 Unit Cost
TB Prophylaxis	$30.00	TB Strategic Plan
SBC Adults 25-49	$3.33	Namibian Unit Cost
Blood Screening	$10.00	
Insurance (NHIMA)	$33.33	National Health Insurance Management Authority (NHIMA) Concept Note (K50/month/household)
Social Cash Transfer (SCT)	$266.67	National Health Insurance Management Authority (NHIMA) Concept Note (K400/month/household)

6.0 MONITORING AND EVALUATION OF THE NASF 2023 - 2027

Zambia has a range of management information systems in place (e.g. HMIS, NACMIS, DATIM, EMIS among many), including routine public health monitoring and evaluation activities; and varied and robust surveillance activities and rigorous epidemiologic, laboratory and programmatic research. However, while Zambia generates substantial data on HIV, TB and STIs, the country lacks a nationally cohesive and planned approach to the generation and use of strategic information. This gap diminishes the country's ability to fully leverage strategic information to drive progress towards NSP Goals, improve programmes over time, maximise efficiencies and close research gaps.

Key components of Strategic Information:

(a) Monitoring and evaluation (M&E)

This involves the on-going collection, reporting and evaluation of programmatic and service delivery data. The NAC secretariat is responsible for monitoring and evaluation of the NASF through the Directorate of Policy and Planning. At the highest level, the M&E system for the national response will be monitored using multiple data sets from multiple data systems within the broader Health Information System (HIS) held by the Ministry of Health and NAC. These data sets converge where it is intended and are used to generate information products that support strengthening the national response.

(b) Surveillance and Surveys

This entails the systematic collection, analysis, interpretation and dissemination of health data. Standardised surveys that are repeated enable tracking over time. These data enable stakeholders to better understand the HIV, TB and STI situation, including the populations and geographic locations most affected. Surveillance data is also essential for modelling the impact of various interventions and informing decision-making. Second Generation Surveillance is used to track the course of the HIV and TB epidemics; assess the burden of disease; and identify where newest infections are likely to occur. Biological and behavioural probability surveys, population size estimation of key populations, facility-based sentinel surveillance and longitudinal household surveys are undertaken. Numerous surveillance activities and surveys have been conducted since the last NSP and have provided valuable information on prevalence, mortality, treatment and drug resistance and social and behavioural information. Lack of consensus on optimal data sources, delayed release of results and financial constraints have occurred.

(c) Research

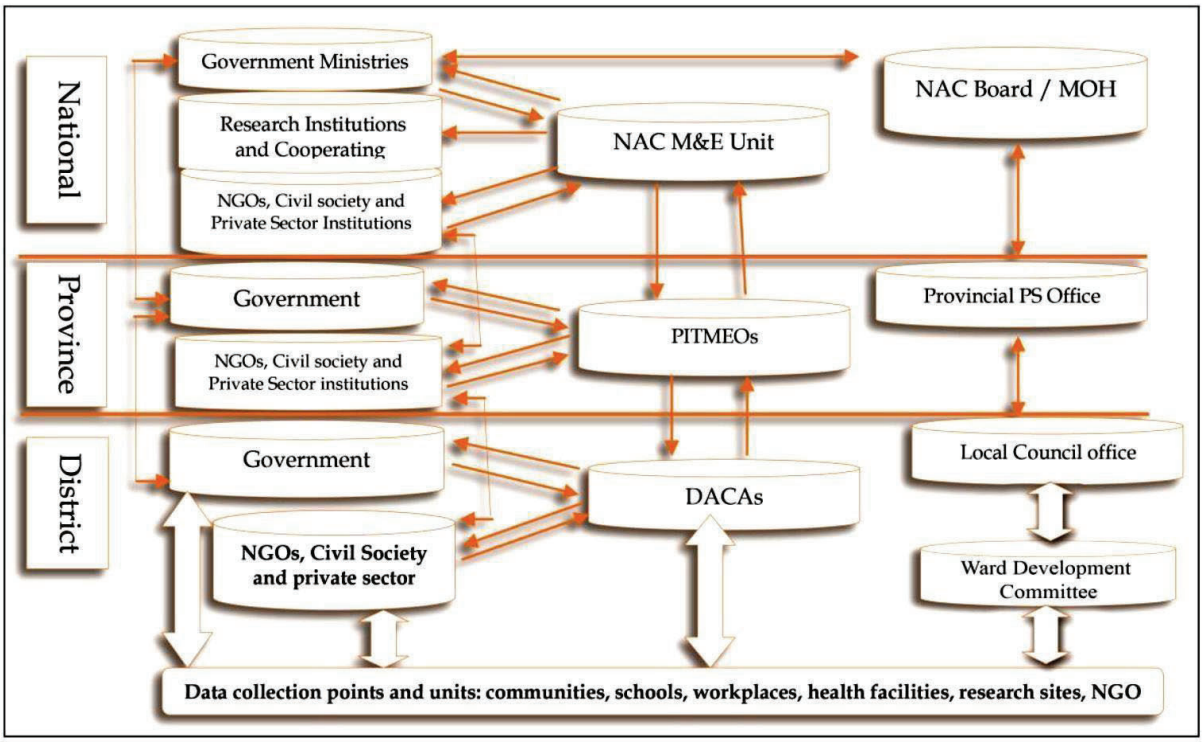
Research helps to develop new prevention and treatment technologies and drugs; optimise the delivery of interventions and strategies; and answer key implementation questions not fully addressed through surveillance and surveys. Zambian researchers have been involved in many multi-country and local studies, including those being used to inform this NASF. These include the ZDHS, ZAMPHIA, SPECTRUM, NASA, Modes of Transmission surveys, Stigma and Discrimination Index, the use of PrEP, sexual transmission pathways, short course preventive therapy for TB, treatment choices for

multidrug-resistant (MDR) TB, programmes that reach adolescent girls and young women and models to improve differentiated care.

(d) Reporting

At national, provincial and district levels, reporting on the core set of indicators shall be done through standardised reporting tools. The NASF 2023 - 2027 will emphasise and promote data use at the level of collection. All data submitted to the next level shall be quality assured and signed off by designated officers to certify that the data is accurate. Data flow will continue to be guided by Figure 16 below.

Figure 6-1: Data Flow arrangements



Source: RNASF 2017-2021

7.0 REFERENCES

Abbott, S.A. et al. “Female Sex Workers, Male Circumcision and HIV: A Qualitative Study of Their Understanding, Experience, and HIV Risk in Zambia' PLOS ONE online.” 2013.

Awad SF, Sgaier SK, Tambatamba BC, et al. Investigating Voluntary Medical Male Circumcision Programme Efficiency Gains through Subpopulation Prioritization: Insights from Application to Zambia. PLoS One. 2015;10(12): e0145729. Published 2015 Dec 30. doi: 10.1371/journal.pone.0145729

Baggaley, R. et al. “HIV counselling and testing in Zambia: the Kara Counselling Experience.” *SAFAIDS*, 1998: 6(2):2-9.

Beazley, Rodolfo, and Ludovico Carraro. *Ø Assessment of the Zambia Social Protection Expansion Programme Targeting Mechanisms.* Lusaka: UNICEF [Zambia], Oxford Policy Management, 2013.

Cheelo, Caesar. *Estimation of Supply and Demand for HIV Services at District level in Zambia.* Washington, DC: World Bank, 2016.

Cintron C, Mudhune V, Haider R, Cogswell H, Gutierrez J, Angira J, and Avila C. April 2017. Costs of HIV Viral Load and Early Infant Diagnosis Testing in Kenya. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc. https://www.hfgproject.org/costs-hiv-viral-load-early-infant-diagnosis-testing-kenya/

CSO. *Zambia Demographic and Health Survey 2007.* Lusaka: Ministry of Health (MoH), Central, Statistical Office (CSO), Tropical Diseases Research Centre (TDRC), University of Zambia (UNZA), 2009.

CSO. “Zambia Demographic Health Survey.” 2014.

de la Fuente, Alejandro, Andreas Murr, and Ericka Rascón. *Mapping Subnational Poverty in Zambia.* Washington, DC: World Bank, 2015.

Di Giorgio, L., Moses, M.W., Fullman, N. *et al.* The potential to expand antiretroviral therapy by improving health facility efficiency: evidence from Kenya, Uganda, and Zambia. *BMC Med* 14, 108 (2016). https://doi.org/10.1186/s12916-016-0653-z

Fagan, Thomas, and Wu Zeng. *Sustainable HIV Financing in Zambia: Baseline Analysis and Prospects for New Domestic Resource Mobilization.* Washington, DC: Palladium, Health Policy Project, 2015.

Fleming, D T, and J N Wasserheit. “From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection.” *Sexually Transmitted Infections*, 1999.

García DC, Antunez CP, Alexander L, Cameron D, Silva GM, Obure CD, Marseille E, Vu L, Kahn JG, Vassall A, Gomez G, Bollinger L, Levin C, Arredondo SB. 2019. A meta-analysis approach for estimating average unit costs for ART using pooled facility-level primary data from African countries. https://www.tandfonline.com/doi/abs/10.2989/16085906.2019.1688362

GRZ. *Constitution of Zambia (Amendment) Act No. 2 of 2016.* Lusaka: Government of the Republic of Zambia (GRZ), 2016.

GRZ, CSO. *2010 Census of Population and Housing: National Analytical Report.* Lusaka: Government of the Republic of Zambia (GRZ), Central Statistical Office (CSO), 2012.

GRZ, CSO. *2010 Census of Population and Housing: Population and Demographic Projections 2011 - 2035.* Lusaka: Government of the Republic of Zambia (GRZ), Central Statistics Office (CSO), 2013.

GRZ, CSO. *2010 Living Condition Monitory Surveys (LCMS).* Lusaka: Government of the Republic of Zambia (GRZ), Central Statistics Office (CSO), 2011.

GRZ, CSO. *Census of Population and Housing.* Lusaka: Government of the Republic of Zambia (GRZ), Central Statistics Office (CSO), 2010.

GRZ, MCT. *HIV and AIDS Policy for the transport sector in Zambia.* Lusaka: Government of the Republic of Zambia, Ministry of Communications and Transport (MCT), 2010.

GRZ, MoH. *Joint Annual Review 2011: Health Sector Performance Review.* Lusaka: Government of the Republic of Zambia (GRZ), Ministry of Health (MoH), 2012.

GRZ, NAC. *HIV Prevention Response and Modes of Transmission Analysis.* Lusaka: Government of the Republic of Zambia (GRZ), National HIV and AIDS/STI/TB Council (NAC), 2009.

GRZ, NAC. *The National HIV /AIDS/STI/TB Policy 2005.* Lusaka: Government of the Republic of Zambia (GRZ), National HIV /AIDS/STI/TB Council (NAC), 2005.

Hewett, P.C., Nalubamba, M., Bozzani, F. et al. Randomized evaluation and cost-effectiveness of HIV and sexual and reproductive health service referral and linkage models in Zambia. BMC Public Health 16, 785 (2016). https://doi.org/10.1186/s12889-016-3450-x

ICAP at Columbia University. *Summary Sheet: Preliminary Findings; Zambia Population-Based HIV Impact Assessment.* New York, NY, 2016e.

ICAP at Columbia University. *Summary Sheet: Preliminary Findings; Zambia Population-Based HIV Impact Assessment.* New York, NY, 2016.

IHME. *Health Service Provision in Zambia: Assessing Facility Capacity, Costs of Care, and Patient Perspectives.* Seattle, WA: Institute for Health Metrics and Evaluation (IHME), 2014.

ILGA. “State Sponsored Homophobia 2014.” 2014.

Kalibala, Samuel, and Drosin Mulenga. *Situation Assessment of the HIV Response among Young People in Zambia.* Geneva, Switzerland: UNAIDS, 2011.

Kasongo, Webster, Mathias Tembo, David Mwakazanga, Joseph Kamanga, Flavia Mwape, and Lazarus Chelu. *Integrated Biological and Behavioural Surveillance Survey (IBBSS) among Female Sex Workers and Behavioural Surveillance Survey*

(BSS) among Male Long Distance Truck Drivers in Five Corridors of Hope Project District Sites in Zambia, 2015. Lusaka: NAC, USAID, PEPFAR, FHI360, 2016.

Lippman S., James, W., Frierson, R. "AIDS and the family: Implications for counselling. AIDS Care, 1993,." *AIDS Care*, 1993: 5: 347-357.

M, Ankhra. "The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited." *AIDS Care*, 1993: 5:5-22.

Mangenah C, Mwenge L, Sande L, et al. Economic cost analysis of door-to-door community-based distribution of HIV self-test kits in Malawi, Zambia and Zimbabwe. J Int AIDS Soc. 2019;22 Suppl 1(Suppl 1): e25255. doi:10.1002/jia2.25255

Masak, Emi, et al. *Zambia's HIV response: Prioritised and strategic allocation of HIV resources for impact resources for impact and sustainability; Findings from the HIV allocative efficiency study.* Washington, DC: World Bank, University of New South Wales (UNSW), 2015.

MOH. "Zambia Consolidated Guidelines for Treatment & Prevention of HIV infection." 2016.

MoH, CSO, Macro International Inc. *Zambia HIV/AIDS Service Provision Assessment Survey 2005.* Maryland, USA: Ministry of Health (MOH) [Zambia], Central Statistical Office (CSO) [Zambia], and Macro International Inc. [USA], 2006.

MSMGF (. "MSM in Sub-Saharan Africa: Health, Access & HIV." 2014.

Mwanza, Patrick, Vicky Kelly, and Terri Collins. *Toolkit for the community response to HIV and AIDS in Zambia.pdf.* Lusaka: Government of the Republic of Zambia (GRZ), National HIV/AIDS/STI/TB Council (NAC), 2009.

NAC. *Devolution of Position of District AIDS Coordination Advisor, to be called District HIV/AIDS Mainstreaming Planner*. 2015.

NAC. 2020. Analysis of HIV and SRH-Related Risk and Vulnerabilities of Adolescents and Young People in Zambia. National AIDS Council.

NAC. "GARPR Zambia Country report 2013." 2014.

NAC. "GRPR Zambia Country Report 2014." 2015.

NAC. *Joint Mid-Term Review of the NASF 2011-2015.* Lusaka: NAC, 2013.

NAC. "Mode of Transmission Analysis." 2009.

NAC. "Review of the Revised National Strategic Framework." Lusaka, 2017.

NAC. *Revised National AIDS Strategic Framework.* Lusaka: NAC, 2014.

NAC. "Revised National HIV/AIDS Strategic Framework." 2014.

NAC/FHI/TDRC. "Integrated Biological and Behavioural surveillance Survey (IBBSS) among Female Sex Workers and Male Long-Distance Truck drivers in Five Corridors of Hope Project Districts in Zambia, 2015." 2016.

Nichols BE et al. 2019. Monitoring viral load for the last mile: what will it cost? Journal of the International AIDS Society, 22: e25337. http://onlinelibrary.wiley.com/doi/10.1002/jia2.25337/full | https://doi.org/10.1002/jia2.25337

Nyirenda, Banda, M Sampa, and S.M.C Hüsken. *Baseline study: Nutritional status, food security and fish consumption among people living with HIV/AIDS in Zambia. Regional Programme Fisheries and HIV/AIDS in Africa: Investing in Sustainable Solutions.* Lusaka: The WorldFish Centre, 2010.

NZP+, GNP+. *People Living with HIV Stigma Index Zambia Country Assessment 2009.* Lusaka: Network of Zambian People Living with HIV/AIDS (NZP+), 2012.

PEPFAR 3.0. *Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation.* Washington, DC: The Office of the U.S. Global AIDS Coordinator, 2014.

PEPFAR. *Country Operational Plan (COP) 2016: Strategic Direction Summary.* PEPFAR, 2016.

PEPFAR. "PEPFAR Latest Global Results." 2016b.

Population Council. "Identifying Key populations in Zambia." 2016.

Pretorius C, Schnure M, Dent J, Glaubius R, Mahiane G, Hamilton M, Reidy M, Matse S, Njeuhmeli E, Castor D, Kripke K. (2020). Modelling impact and cost-effectiveness of oral pre-exposure prophylaxis in 13 low-resource countries. https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25451

Roberts DA et al. 2019. The role of costing in the introduction and scale-up of HIV pre-exposure prophylaxis: evidence from integrating PrEP into routine maternal and child health and family planning clinics in western Kenya. JIAS 2019, 22(S4): e25296http://onlinelibrary.wiley.com/doi/10.1002/jia2.25296/full | https://doi.org/10.1002/jia2.2529671

SALC. *"They should protect us because that is their job": A preliminary assessment of sex workers' experiences of police abuse in Lusaka, Zambia.* 2016.

Samuels, F., Ndubani, P., Walker, D., & Simbaya, J. "Baseline Study: Stamping Out Gender Based Violence (STOP- GBV) in Zambia. ." *Overseas Development Institute (ODI), London.*, 2015.

SAT Zambia. *Consolidated Inputs from Key Population Organisations Into the development of the National HIV and AIDS Strategic Framework (NASF) 2017 - 2021.* Lusaka: Southern Africa AIDS Trust Zambia (SAT Zambia), 2016.

Sharma, Suneeta, and Rebecca Mbuya-Brown. *Brief: Beyond 2015 - How Health Policy Can Help Countries Plan for the Future.pdf.* Washington, DC: PEPFAR, USAID, Health Policy Project, 2015.

Shattock AJ, Kerr CC, Stuart RM, et al. In the interests of time: improving HIV allocative efficiency modelling via optimal time-varying allocations. J Int AIDS Soc. 2016;19(1):20627. Published 2016 Feb 23. doi:10.7448/IAS.19.1.20627

Sikwese, Kenly. *PRESENTATION: Treatment optimization & Feasibility in Africa; Fast Tracking Stakeholders Commitment & Action Towards Achieving 90-90-90 Targets by 2020 & ending AIDS as Public Health Threat by 2020.* Abuja, Nigeria: African Community Advisory Board (AFROCAB), 2016.

Simwaba. "An Overview of Disability and HIV/AIDS Response in Zambia." 2014.

Stewart. "The sexual health and behaviour of male prisoners: The need for research." *The Howard Journal of Criminal Justice.,* 2007: 46:1 (43-59). .

Support to the HIV/AIDS Response in Zambia (SHARe) project. *Ø Tracking Gender Mainstreaming in HIV/AIDS Workplace Policies of Zambian Government Line Ministries.* Bethesda, MD: SHARe, Abt Associates Inc., 2010.

TIP. *Policy Brief: The State of Sexual Reproductive Health Integration in Zambia.* Lusaka: The Integration Partnership (TIP), Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS), Youth Vision Zambia (YVZ), Population Action International (PAI), Irish Aid, 2011.

UNAIDS. "90–90–90: an ambitious treatment target to help end the AIDS epidemic.." Geneva, 2014b.

UNAIDS. "Caring for carers: managing stress in those who care for people with HIV/AIDS. Best Practice Collection." 2000.

UNAIDS. *Fast-Track Commitments to end AIDS by 2030.* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS), Undated.

UNAIDS. *Key Population Action Plan.* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2014.

UNAIDS. *Policy Brief: The Greater Involvement of People Living With HIV.* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS, 2007.

UNAIDS. "Prevention Gap Report." 2016b.

UNAIDS. *Report on the implementation of the decisions and recommendations of the Programme Coordinating Board.* Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services, 2016.

UNAIDS. *UNAIDS 2016–2021 Strategy: On the Fast-Track to end AIDS.* Geneva, Switzerland: Joint United Nations Programme on HIV and AIDS (UNAIDS), 2016.

UNAIDS. "UNAIDS Briefing book." 2015.

UNAIDS. "UNAIDS Briefing Book." 2015c.

UNAIDS. *Understanding Fast-Track: Accelerating Action to end the AIDS Epidemic by 2030.* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2015b.

UNAIDS. "Zambia: HIV and AIDS estimates." 2015.

UNDP. "Human Development Report 2014: Sustaining Human Progress: Reducing Vulnerabilities and Building resilience." 2014.

WHO. “Guidelines on the use of ART for the prevention and early treatment of HIV infection.” 2015.

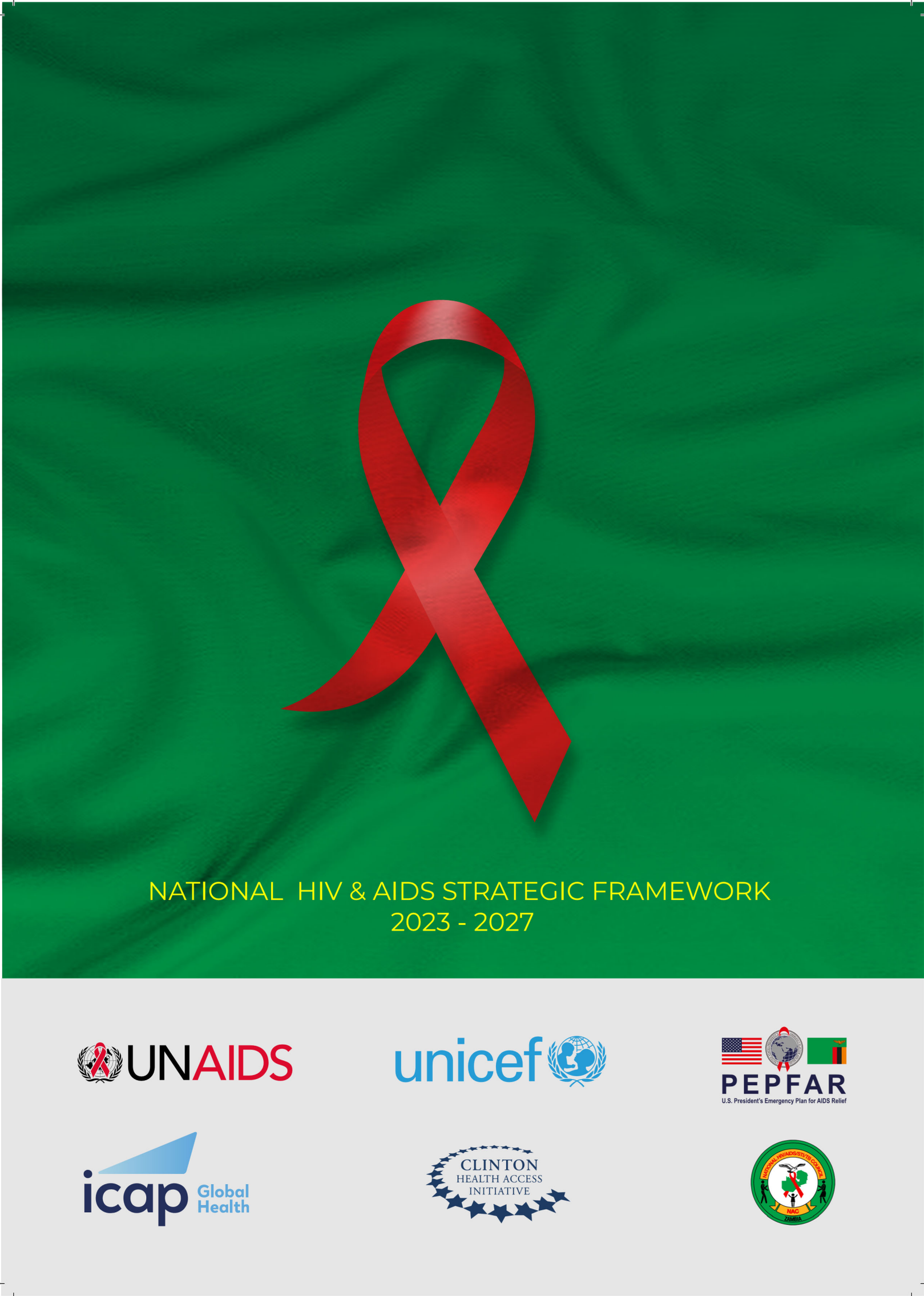
WHO. “WHO Country Statistics: Zambia.” 2016.

World Bank. *Country Partnership Strategy for the Republic of Zambia 2017 - 2020.* Washington, DC: World Bank, 2016.

Zambia Prison Services. “Zambia Prison Services Strategic Plan 2015-2020.” 2015

ZAMDHARP. *Write-up on Persons with Disabilities vis-a-vis next NASF 2017 – 2021.* Lusaka: Zambia Disability HIV/AIDS Human Rights Programme (ZAMDHARP), 2016.

ZISSP. *Community Health Service Gap Analysis at District, Health Facility and Community Level.* Bethesda, MD: Zambia Integrated Systems Strengthening Programme (ZISSP



NATIONAL HIV & AIDS STRATEGIC FRAMEWORK 2023 - 2027

UNAIDS

unicef

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

icap Global Health

CLINTON HEALTH ACCESS INITIATIVE

NATIONAL HIV/AIDS/STI/TB COUNCIL
NAC
ZAMBIA