ZAMBIA NATIONAL HIV PREVENTION COALITION ROADMAP

RESULTS OF THE STOCKTAKING EXERCISE

September 2017

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1.0 Introduction

The launch of a Global HIV Prevention Coalition scheduled for 10th and 11th October in Geneva has been necessitated by the realization that globally HIV prevention has been lagging behind with little or no investments being made to national programme. A need for creation of a positive policy environment that address prevention services bottlenecks and structural barriers that will facilitate an inclusive and adequate investments in prevention programme scale up has been acknowledged. The UNAIDS prevention Gap Report 2016, documented major gaps in the implementation of all prevention pillars and sustained increase in the number of new HIV infections, it is against this background that the UNAIDS executive director and the UNFPA acting executive director have called for a global HIV prevention coalition and the development of a 2020 HIV prevention roadmap to re-energize and re-invigorate primary HIV prevention especially in the top 25 high burden countries.

The Global Coalition on HIV Prevention has been necessitated by the recognition that although significant investments have been made in the overall HIV/AIDS programme, there is an urgent call to revamp primary HIV prevention programming, as the progress in reducing new infections has been insufficient to achieve the global target set by the 2016 Political Declaration, of reducing the number of new infection to fewer than 500,000 by 2020. Globally, the number of new infections among sex workers, gay and men who have sex with men has increased alongside the size of these key populations. In addition, the number of new infections among adolescents and young girls has remained high while the number of young people at risk of HIV infection is increasing. In line with UNAIDS strategy (2016 to 2021) and the 2016 political declaration and commitment to fast track high impact interventions, it is essential for countries to identify game changers that will put them on course to achieve the 2020 HIV prevention targets.

Zambia, like many high HIV burden countries had made significant progress in the last 20 years in regressing the HIV/AIDS epidemic, however, the number of new infections in the past decade has not been commensurate with the investments and scientific advancements made in combating the HIV/AIDS epidemic. The Zambia Population-Based HIV Impact Assessment of 2016, indicates a 0.66 percent HIV incidence among adults aged 15-59 translating to 46,000 new infections. UNAIDS estimates of 2017, indicates that 2 in 5 new infections in the Eastern and Southern Africa Region were among young people aged 15- 24 years, with 7 in 10 new infections coming from adolescent girls and women.

As part of developing the Global Coalition on HIV Prevention Roadmap that will not only track progress being made towards the 2030 target of ending the HIV/AIDS epidemic and the development of country led interventions developed on the premise of “Know your epidemic, know your response”, Zambia as a signatory to the United Nations High Level Meeting on HIV/AIDS held in June 2016 in New York has agreed to intensify the HIV response towards Ending AIDS as a Public Health threat by 2030, which is the AIDS related Sustainable Development Goal. The Government of the Republic of Zambia has already taken accelerated actions in adopting the fast track approach and has since revised national strategies aimed at attaining the targets that will ensure that the 90-90-90 targets are met by 2020.

As part of the development of the Roadmap for the Global Coalition, a two-fold country prevention assessment comprising of a UN supported prevention assessment and a national stock take exercise was conducted to review the status of national HIV prevention approaches, policy and legal environments in order to highlight existing gaps and to measure progress made towards the attainment of set targets. The process provided an opportunity for appraising the progress in all key pillars of HIV prevention, namely; combination prevention among adolescents and key populations and the delivery of the core preventions services, namely; condoms, voluntary medical male circumcision (VMMC) and pre-exposure prophylaxis (PrEP).

This paper presents findings from a stocktaking exercise of the five pillars of HIV prevention in Zambia, identifying gaps in each pillar and highlighting key game changers required to achieve optimal results. It is part of the process to identify barriers in HIV prevention related to target setting, policy and legal environments, resources and enablers so as to chart a course to sustainable HIV prevention in Zambia.

National consultation in progress

2.0 Stock taking exercise

In order to prepare for the global HIV prevention coalition and roadmap, a stocktaking exercise has been conducted in Zambia to assess the progress made in the key pillars of prevention, identify the gaps and recommend ways of strengthening HIV prevention interventions. Various consultations were held with key stakeholders to assess the extent to which the pillars remain relevant; are on track and using effective approaches; targets have been set; and to identify barriers and opportunities in HIV prevention.

The key questions asked for the assessment included, but not limited to the following key questions;

1. Are there full sets of national HIV prevention (and related) targets aligned with the 2016 Political Declaration on HIV and AIDS?
2. Is the country on track to reach these targets and commitments?
3. What are the key barriers preventing the prevention targets from being reached?
4. What policy and environment changes and/or new investment are required to reach the targets?
5. What management arrangements need to be put in place to ensure prevention programmes are scaled up, systematic and sustainable?

Review of policy and program documents, key informant interviews and focus groups discussions with key stakeholders were conduct to answer the above questions. In addition, key stakeholders responded to the above questions by completing a matrix for each prevention pillar. Results of the document review, interviews and completed matrices were consolidated by the consultant before presenting to the HIV Prevention technical working group and other stakeholders for review and validation. The final stage of the consultative meeting was a national consultation and validation that brought together the political leadership, policy makers, funding agencies, civil society and program implementers. The results of the consultations are presented in matrices below.

3.0 Results of the stock-taking exercise by Pillar

3.1 Voluntary Medical Male Circumcision (VMMC)

VMMC is a key pillar in Zambian HIV prevention. Since the formal launch of the programme in 2007, VMMC has been incorporated in most key national health policies and strategies and has become a core component of national HIV prevention strategy. The programme is implemented through a well-articulated operational plan (2016 to 2020) that is coordinated by the Ministry of Health. In Zambia, the package of services includes a defined minimum package of interventions that also highlights HIV testing and counselling, risk reduction, wound care and partner testing and referral tor cervical cancer screening. The current VMMC target for 2016-2020 is 1,985,083 males aged 10-49 with special focus on circumcising 15-29 years, as they will have a significant impact in terms of the number of new HIV infections averted. VMMC is a mature program and under the previous strategic plan which ended in 2015 the country circumcised a total of 1,005,425 males out of a set target of 1,864,396. The VMMC programme has also enjoyed a good buy-in from stakeholders and has recorded an increase in awareness among adolescents and young people. Decentralization has improved availability of VMMC services.

Table 1: VMMC

Key Questions	Status
1. Is this pillar/area a priority for the country?	**YES,** VMMC programme is a vehicle which promotes HIV testing and counselling in males and their partners and referral to HIV treatment for those testing HIV positive.
2. Does the National Strategic Plan include a set of prevention targets in line with the 2015 UNAIDS Strategy and Political Declaration (see annex1)?	**YES,** the NASF (2017-2021) and the VMMC operational Plan have set targets that will contribute to averting new HIV infections by 90%. The target is to circumcise 1,985,083 males aged 10-49 by 2020.
3. Has the (program/finance) gap against the target been estimated?	**YES,** a current gap of $85 million for five years has been acknowledged by the VMMC programme. This gap will decrease when the Global Fund application for 2018-2020 is approved and on an annual basis with PEPFAR funding.
4. What key challenges or constraints have been encountered in achieving	1. Insufficient capacity (technical and resources) to scale up VMMC services.[1] 2. Inadequate access to VMMC services due to limited number of static sites and limited mobile outreach services.

[1] Currently there are limited trained staff and infrastructure as well as inadequate resources to bring VMMC activities to scale.

these targets?	3. Lack of targeted massages for specific populations leading to myths and inadequate knowledge about circumcision.
5. What are the key programmatic actions necessary to achieve these targets?	1. Expand existing capacity to provide comprehensive VMMC services by introducing pre-service training; sustained in-service health worker capacity building; eliminating missed opportunities for service delivery as well as efficiently deploying innovative methods such as devices for service delivery. 2. Increase targeted awareness raising and behaviour change communication in communities to create and sustain demand for VMMC services and enhance the involvement of community based organisations as well as using champions to promote VMMC as well as utilising champions to promote VMMC. 3. Increase country ownership for programme coordination and sustainability including increased domestic financing.
6. What are the key policy/legal changes necessary to achieve these targets?	1. There are no policy/legal changes, however, there is need to strengthen national level capacity to coordinate, reorganize service delivery, and improve the management of the national program in line with the operational plan.
7. What new investments are necessary to achieve this target?	1. Increase resource mobilization and domestic funding, and training of more health providers for VMMC as well as standardise and harmonise the procurement of VMMC consumables and kits. 2. Invest in demand creation for VMMC through increased sensitisations and awareness raising. 3. Harmonise information systems between partners and the government's HMIS.
8. What are your country commitments to ensure the suggested prevention-related policy changes?	1. Zambia has already launched the VMMC programme, developed a VMMC operational plan (2016 to 2021), training manuals and Early Infant Male circumcision (EIMC) guidelines (to be launched in October 2017). 2. Both the NHSP (2017 to 2021) and NASF (2017-2017) have a VMMC component as a core HIV prevention tool.
9. What are your country commitments to ensure the suggested prevention programme implementation/ coordination changes?	1. Increase infrastructure for VMMC in health facilities and continue investing in VMMC campaigns and mobile services to the reach the 10-49 year-old males. 2. Develop capacity of health providers and establishment of differentiated service platforms such as community level VMMC service provision. 3. Develop a coordinated national reporting system for all VMMC services.

3.1.1 GAPS

Review of the performance of the programme under the first operational plan (2012 to 2015) shows that the country was on course to achieve its set targets, except in 2015 when the programme suffered from inadequate funding, achieving 54% out of the 80% target. In order to achieve the 90% target for 2020, Zambia will need to circumcise 419,097 in 2016, 430,945 in 2017 and 392,829 in 2018. The remaining annual targets are 359,800 in 2019 and 382,412 in 2020. In 2016, the country achieved 75% of the set annual target. The funding gap has continued in the current operational plan amounting to US$85 million for the period 2016 to 2020.

In addition to the funding gap, there is inadequate capacity to row out VMMC to the required scale to reach the set targets for 2020. These capacities relate to appropriate infrastructure and trained staff to implement VMMC. Transport challenges to conduct outreach VMMC have also be experienced.

Investments in further training of staff and demand creation through continued sensitizations will be required to fast-track VMMC. In addition, there will be need for increased country ownership of the intervention through increased domestic financing as well as development and implementation of a clear policy on devices.

3.1.2 Summary Recommendations

1. Increase domestic funding for VMMC services and continue with mobilisation of external resources to close up the funding gap.
2. Scale up demand creation for VMMC services through BCC, sensitisations and awareness raising, including engagement of civic, religious and traditional leaders to champion VMMC.
3. Strengthen the harmonisation and coordination of the reporting system among all partners.

3.2 Pre Exposure Prophylaxis (PrEP)

To reach the global target of reducing new infections to less than 500,000 per year, countries will require a combination of strategies, including provision of pre-exposure prophylaxis (PrEP) to those in need. Zambia currently records about 46,000 new infections among adults aged 15 to 49 and an additional 10,000 among children each year. In order to reduce new infections to the targeted 15,000 per year among the 15 to 49

age group, new investments in PrEP especially among the growing number of key populations will need to be carefully planned and implemented. The National Health Strategic Plan (2017 to 2021) and the National AIDS Strategic Framework (NASF 2017 to 2021) both recognise the need for provision of PrEP to priority populations. Although the NASF (2017-2021) prescribes PrEP for all those at high risk of HIV infection, it specifically identifies discordant couples and sex workers as key populations that will need to be provided with PrEP. PrEP is also included in the comprehensive HIV Treatment National Guidelines. Thus, provision of PrEP to key populations at high risk of HIV infection is a priority prevention pillar for Zambia.

Table 2: PrEP

Key Questions	Status
1. Is this pillar/area a priority for the country?	**YES** This pillar is a priority for discordant couples and those at high risk of HIV infection including key populations.
2. Does the National Strategic Plan include a set of prevention targets in line with the 2015 UNAIDS Strategy and Political Declaration?	**NO** Some targets exist. However, they are not based on realistic population size estimation for key populations as one of the target recipients of PrEP. The country is in the process of scaling up PrEP, applying the lessons from the ongoing 'pilot' program.
3. Has the (program/finance) gap against the target been estimated?	**NO,** The funding gap for PrEP is yet to be set as it is a sub set for the ART programme, given that the target populations are yet to be clearly defined and quantified.
4. What key challenges or constraints have been encountered in achieving this target?	1. Unclear guidance on the provision of PrEP. There is no national implementation frame work (including clear definition of who is eligible for PrEP). This framework should include the following; a) Training on administration of PrEP and identification of potential clients. b) Advocacy and communication strategy to increase programme uptake. c) Integration of PrEP services and scale up of PrEP delivery points. 2. Limited training among health workers and care givers, negative attitudes, stigma and discrimination making it difficult for key populations to freely access PrEP. 3. Unavailability of size estimation of the population needing PrEP.
5. What are the key programmatic actions necessary to achieve this target?	1. Formulate a national implementation plan with a clear strategy that includes private sector engagement. 2. Carry out non- discriminatory sensitisation programmes for targeted populations and the health service providers on PrEP. 3. Develop PrEP targets and a system of tracking progress to differentiate PrEP clients from ART clients. [2]
6. What are the key policy/legal changes	1. The policy framework must be reviewed to provide PrEP to other high risk populations beyond discordant couples.

[2]To achieve this, there will be need to finalise size estimation of key population and disseminate results.

necessary to achieve this target?	2. Review the policy and legal framework to provide an enabling environment for key populations to access PrEP.
7. What new investments are necessary to achieve this target?	1. Training of health workers for provision of PrEP and raising awareness around PrEP among health workers and key populations. 2. Set up and scale-up PrEP delivery points (including unconventional sites, drop in centers, private health facilities). 3. Increase domestic funding to ensure availability of commodities and consumables.
8. What are your country commitments to ensure the suggested prevention-related policy changes?	1. NASF and ART guidelines recognises PrEP as prevention tool for key populations at high risk of HIV infection.
9. What are your country commitments to ensure the suggested prevention programme implementation/ coordination changes?	1. MOH has developed guidelines for implementation of PrEP and considers it as one of the prevention strategies in the Zambia NHSP (2017 – 2021).

3.2.1 Gaps

The NHSP (2017 to 2021) and NASF (2017 to 2021) do not provide guidance on how PrEP should be implemented and operationalised. While the NASF identifies discordant couple and sex workers as target groups to access PrEP, there are no strategies in place to row out the interventions to sex workers and other key populations at high risk of infection. In addition, there is no regulatory approval in Zambia for the use of PrEP yet. After the 'pilot' phase, regulatory approve will need to be speedily done to fast-track row out. However, PrEP national guidelines have been developed and launched. Smooth implementation of PrEP is also linked to an enabling policy and legal environment for certain key populations. Although the NASF (2017 to 2021) recognises key populations, more is required to ensure that key populations come out in open to access services without fear of being stigmatised and discriminated. This will require a change in the legal framework.

Although PrEP is currently being provided through 3 public health facilities, the mobilisation of those in need is mainly done by government's implementing partners. Moreover, not all health staff in these facilities are trained to provide the services. In addition, the current HMIS does not provide indicators and tools for capturing PrEP clients. Currently they are recorded as ART clients. The few facilities providing PrEP are unable to have uptake data distinguished from ART and captured by the HMIS.

3.2.2 Summary Recommendations

1. There is need to develop an operational plan that integrates PrEP in combination prevention strategies and provides clear guidance to scale up and target recipients.
2. Review the policy and legal framework to provide an enabling environment for key populations (i.e. sex workers, MSM, TGP, prisoners) and others at high risk of HIV infection to freely access PrEP.
3. Train health workers and other service providers on how and when to administer PrEP including increasing knowledge and changing prevailing negative attitudes to allow PrEP to be provided within a human rights approach/framework.
4. Set national targets and scale-up PrEP, including a system of tracking service delivery and uptake.

3.3 Condom Programming

Condoms are a key HIV prevention tool for both general and key populations. Condoms also play a key role in family planning in Zambia. The Ministry of Health has adopted the national Comprehensive Condom Programming (CCP) strategies that aim to reduce sexual transmission of STIs, including HIV, and prevent unintended pregnancy. The CCP framework comprises the following pillars:1) Leadership, coordination and partnership; 2) Demand, access and utilisation; 3) Supply and commodity security; 4) Monitoring and evaluation; 5) Support for program implementation. The pillars should be fully implemented to maximise the benefits of efficient and effective comprehensive condom programming in preventing new HIV infections and promoting Sexual and Reproductive Health and well-being.

Table 3: Condoms

Key Questions	Status
1. Is this pillar/area a priority for the country?	**YES,** Condom programing is a priority in the National Health Strategic Plan (NHSP)and the National AIDS Strategic Framework (NASF).
2. Does the National Strategic Plan include a set of prevention targets in line with the 2015 UNAIDS Strategy and Political Declaration (see annex1)?	**YES,** Both the NASF (2017-2021) and the NHSP (2017-2021) have set targets for condom programming. However, there are funding, procurement and distribution challenges.
3. Has the (program/finance) gap against the	**YES**.

target been estimated?	Both the programme and funding gaps have been estimated. Previous quantification for condoms was mainly based on the family planning needs. The current quantification, despite existing challenges is in line with international standards for HIV prevention.
4. What key challenges or constraints have been encountered in achieving this target?	1. Logistical challenges in condom distribution to last mile due to their bulk packaging, leading to inconsistent and inadequate supply of both male and female condoms at service delivery point; inadequate funding also leads to inconsistent supply. 2. Limited implementation of total market approach for condoms. Public sector condoms are mainly distributed through health facilities leading to limited access by the general population. 3. Availability and access to condoms by Adolescents and young men in and out of school continue to be limited by existing policies such as the age of consent for adolescents and young people. This makes it difficult for young men and women to protect themselves against infections.
5. What are the key programmatic actions necessary to achieve this target?	1. Strengthen the procurement and supply chain of condoms to ensure continuous supply. 2. Diversify distribution points within and beyond health facilities with a good public-private mix. 3. Integrate condom promotion and distribution with a strong age segmented SBCC campaign to increase knowledge and use of condoms among the different age groups.
6. What are the key policy/legal changes necessary to achieve this target?	1. Review the age of consent and create more distribution points for young people to access condoms other than through health facilities. 2. Develop a new national strategy and operational plan for comprehensive condom programming. 3. Strengthen the coordination mechanism for condom programming (establishment of national support team). Strengthen community coordination mechanism for condom promotion and distribution using the NAC structures and strengthen linkages among TWGs (family planning, HIV, VMMC, supply chain) to enhance coordination.
7. What new investments are necessary to achieve this target?	1. Strengthening the procurement and supply chain for condoms to expedite condom distribution to avoid stock outs. This can be achieved through expanding and decentralising distribution channels for condoms including mandatory condom dispensers in all public places (bars, night clubs, hotels and loges, shopping malls). 2. Encourage use of condoms by making them more appealing to all age groups and providing more options and choices through adapting strategies such as rebranding, coverage increase of socially marketed condoms and commercial brands while adopting a total market approach to expand demand for and access to condoms. 3. Sustainable domestic financing for HIV response including primary prevention and condom programming.
8. What are your country commitments to ensure the suggested prevention-related	1. The NASF (2017 to 2021) and the NHSP (2017 to 2021) recognise condom programming as one of the pillars of HIV prevention.

policy changes?	
9. What are your country commitments to ensure the suggested prevention programme implementation/ coordination changes?	1. NASF (2017 to 2021) plans for a national condom support team and provides for development of national strategy for implementation of condom programming.

3.3.1 GAPS

Although comprehensive condom programming has been implemented for many years in Zambia, there have been challenges related to the supply chain that have made it difficult for condoms to be easily and consistently accessed by all those in need. Last mile distribution is still a challenge. In the past, government partners have worked closely with government to procure condoms on a large scale. There is a shift toward government procurement of condoms complimented by a social marketing programme. In addition, the national comprehensive condom programming strategy that outlines key interventions for condom promotion and distribution expired in 2014 and has not yet been replaced.

There have also been gaps related to sensitisation on condoms and their consistent and correct usage as evidenced by the limited uptake of female condoms. Moreover, access to and use of condoms by adolescents is low. The current legal framework that pegs the age of consent at 16 makes it difficult for young people below the age of 16 who need condoms for family planning and HIV prevention to freely access them.

About 40% of adolescents and young girls report condom use at last sex. This implies a lack of gender-transformative social assets and skills to negotiate safer sexual practices. This is partially facilitated by the absence of effective and innovative non-HIV community-driven programmes and strategies to distribute condoms and make them easily accessible by young people.

3.3.2 Summary Recommendations

1. Improve quantification and strengthen the procurement and supply of condoms to ensure continuous and last mile supply and easy access by all in need, including AGYW and their partners.
2. Expand distribution points beyond health facilities to make them easily accessible by all in need.
3. Create safe spaces for young people to freely access condoms without discrimination.
4. Strengthen the national, sub-national and community coordination mechanism and develop a national strategy and operational plan for effective condom programming.

5. Encourage use of condoms by making them more appealing to all age groups by providing more options and choices through adapting strategies such as rebranding, coverage increase of socially marketed condoms and commercial brands while adopting a total market approach to expand demand for and access to condoms.
6. Strengthen the information system for condoms to effectively monitor distribution and use.

3.4 Key Populations

The NASF (2017-2021) includes about 13 categories of people in its definition of key populations. These include people living with HIV, adolescent girls and young women, young men, correctional facility inmates, migrants and displaced persons, people who inject drugs, sex workers, gay and other men who have sex with men, transgender people, children and pregnant women living with HIV and people aged 50 years and older.

Some key populations are a new and growing phenomenon in Zambia. While female sex workers have been around for a long time, male sex workers, gay and men who have sex with men, transgender people and people who inject drugs have increased to sizable proportions worth the attention of HIV prevention only in recent years. Although the legal framework does not provide for conjugal rights in Zambian correctional facilities, considerable amounts of sex takes place among same-sex prisoners. In addition, injecting drug users have also increased. Recognising the existence of these key populations and cross-transmission of HIV infection among key and general populations, the NASF (2017 to 2021) has identified key populations as one of the key HIV prevention pillars.

Existing interventions such as Open Doors Project implemented by FHI360 for female sex workers use a targeted programming approach using 'queen mothers' to identify sex workers in communities and link them to HIV prevention services. The project locates hot spots and uses peer educators to create demand. Some sex workers have been trained as community health workers who support treatment and other services within the continuum of care.

In addition to MSM being included as key target population for HIV prevention in the NASF (2017 to 2021), Zambia has a presence of organisations targeting MSM which have aimed to enhance capacity to provide services to MSM through trainings and collaborations. The focus of capacity building efforts have been non-discrimination and confidentiality among service providers and increased awareness among law enforcers. Staff from Zambia Police Services and faith-based organisations have been included in trainings to increase awareness and foster inclusive approaches in provision of HIV prevention services.

Table 4: Key Populations

	Sex Workers	MSM	IDU
Key Questions	**Status**	**Status**	
1. Is this pillar/area a priority for the country?	**YES** The NASF 2017-2021 has embraced key populations including Sex workers for the first time.	**YES,** The NASF 2017-2021 has embraced key populations including MSM for the first time.	**YES** The NASF 2017-2021 has embraced key populations including IDU, TG and other key populations.
2. Does the National Strategic Plan include a set of prevention targets in line with the 2015 UNAIDS Strategy and Political Declaration (see annex1)?	**NO** Although key populations have been recognised, other policy and legal frameworks have not changed simultaneously. International NGO/partners have been implementing HIV programmes among sex workers for more than 15 years now. The prevention target at national level has been set at 90% in the prevention roadmap. However, there are no baseline data and size estimation of the population in need.	**NO,** The legal environment does not allow free implementation and expansion of prevention programmes among MSM.	**NO** Although research has shown that this is a growing phenomenon, there have been no programmes implemented among this key population group except for few and small scale harm reduction programmes implemented by partners.
3. Has the (program/finance) gap against the target been estimated?	**NO** Estimation of population in need has not been done.	**NO** Estimation of population in need has not been done.	**NO** Estimation of population in need has not been done.
4. What key challenges or constraints have been encountered in achieving this target?	1. The policy and legal framework does not provide an enabling environment to scale-up the standard package of care for sex workers. 2. Limited implementation of HIV programmes for sex workers and prevailing negative attitudes and stigma towards KPs.	1. The policy and legal framework does not provide an enabling environment to scale-up the standard package of care for MSM. 2. Limited implementation of HIV programmes for MSM and prevailing negative attitudes and stigma towards KPs. 3. Lack of accurate data on size	1. Absence of established harm reduction programmes. 2. The policy and legal framework does not provide an enabling environment support implementing of HIV prevention programmes

	3. Lack of accurate data on size estimates on sex workers.	estimates on MSM.	among IDUs.
5. What are the key programmatic actions necessary to achieve this target?	1. Engage leaders (civic and traditional) in national sensitisations to reduce stigma and discrimination of key populations. 2. Need to promote research on sex workers to increase knowledge while utilising existing evidence in planning and implementation of suitable programmes for sex workers. 3. Need to scale up training for health workers to provide services to sex workers in key population friendly facilities.	1. Make available evidence-based combination prevention strategies, including availability of lubricants and other prevention tools, to MSM and other key populations. 2. Engage leaders (civic and traditional) in national sensitisations to reduce stigma and discrimination of key populations 3. Need to scale up training for health workers to provide services to MSM in key population friendly facilities.	1. Greater investment is required to develop and provide a comprehensive package of HIV services for people who inject drugs.
6. What are the key policy/legal changes necessary to achieve this target?	1. Increase government commitment to address policy and legal barriers to facilitate implementation of public health programmes as rights of each citizen. 2. Establish a national coordination mechanism for key population programming (E.g., TWG) that will provide technical oversight and effectively engage with sex workers' association.	1. Increased government commitment to address policy and legal barriers including facilitating the importation of HIV prevention consumables for MSM, prisoners and other key populations. 2. Establish a national coordination mechanism for key population programming (E.g., TWG).	1. Develop human rights-based policies to provide services to IDUs and reduce stigma and discrimination associated with drug use. 2. Develop a comprehensive package of service for IDU.
7. What new investments are necessary to achieve this target?	1. Review the legal framework to address barriers to provision of HIV prevention services to sex workers including dealing with gender issues. 2. Train and sensitise health workers on service provision to key populations. 3. Develop a comprehensive package of	1. Nationwide sensitisation of MSM and on the availability of prevention services. 2. Regularly conduct size estimations for sex workers and institutionalise/ regularise MSM national surveys to monitor the progress on prevention efforts among key populations.	1. Advocate for enabling law enforcement practices and for greater domestic investment for harm reduction. 2. Investment in strategic information in order to identify gaps, build capacities and

	service for key populations including sex workers.	3. Develop an evidence-based comprehensive package of service for MSM, train and sensitise health on service needs of MSM.	review policies and legislation.
8. What are your country commitments to ensure the suggested prevention-related policy changes?	1. Government has demonstrated political will by creating an environment for partners to deliver services to key populations.	1. Government has demonstrated political will by creating an environment for partners to deliver services to key populations.	2. The Narcotic Drug Act is being reviewed and may provide opportunities to provide therapeutic services to IDU.
9. What are your country commitments to ensure the suggested prevention programme implementation/ coordination changes?	1. NASF (2017 to 2021) has identified Sex Workers as one of the targets for PrEP.	1. NASF (2017 to 2021) has identified Sex Workers as one of the targets for PrEP.	1. The NASF (2017 to 2021) and the NHSP (2017 to 2021) recognise people who use drugs as a key population and highlights the need for targeted interventions.

3.4.1 Gaps

Government has provided an environment in which partners can discuss, design and implement programs for key populations. However, the policy and legal framework does not provide an environment in which key populations can access HIV prevention services without stigma and discrimination. There are no clear policy guidelines governing particular key populations such as sex workers and men who have sex with men. In addition, the legal framework does not provide an enabling environment and presents legal barriers for key populations that make it difficult to address structural issues affecting certain key populations such as gender-based violence among sex workers.

Although government has allowed implementation of HIV prevention programmes for key populations, there continues to be structural barriers inhibiting programmes to be fully scaled to levels required to make an impact on the HIV epidemic. In addition, the existing services are provided by partners only. In certain cases, partners struggle to bring into the country some of the essential prevention tools for HIV among some key populations such as Lubricants. There are also negative attitudes toward key populations by both the general public and health workers. This deters key populations from accessing services such as STI and PrEP services.

3.3.2 Summary Recommendations

1. There is need for increased government commitment to review policy and legal barriers affecting the implementation of HIV prevention services among key populations and to take ownership and expand and row-out key population-friendly facilities.
2. There is need to promote research on key populations to increase knowledge and promote evidence-based programmes.
3. There is need for a national coordination mechanism for key populations such as a technical working group to support the design and implementation of HIV prevention interventions for key populations.
4. There is need for sensitization campaigns around key populations that genuinely engage leaders (Civic and traditional) to destigmatise Key Populations and provide a platform for key populations to access services without fear and discrimination.
5. There is need to training and sensitize health workers to change the prevailing negative attitudes experienced from health workers by key populations.

3.5 Adolescent Girls and Young Women

Adolescent girls and young women, including young men and boys, are a top priority group for HIV prevention in Zambia. This is clearly supported by the epidemiology, as HIV prevalence is more than four times higher among young women (8.6%) as compared to their male peers (2.1%). However, the need to focus on adolescent boys is equally supported by the data: A trend analysis of DHS surveys shows that while HIV prevalence among adolescent girls fell between 2007 and 2014, prevalence rose among adolescent boys over the same time period. In addition, adolescent girls and young women not only have an increased HIV prevalence but have high adolescent fertility rate, high teenage pregnancy rate and high child marriage rate, all predisposing them to HIV transmission risk.

The NASF (2017 to 2021) and Global Fund request focuses on six-pronged comprehensive package of health and empowerment programs for adolescents and young people, with an amplified focus on AGYW. The six prongs include interventions around: (1) Social and behavioural change communication (SBCC) and comprehensive sexuality education (CSE); (2) Adolescent-friendly service provision; (3) Socio-economic support (cash transfers and school support); (4) Research and implementation science; (5) Adaptive leadership; and (6) Coordination and youth engagement in design and delivery of programs.

The SBCC prong will support age-appropriate delivery (grouped in age brackets of 10–14, 15–19 and 20–24) of life skills. For in-school adolescents and youth, the focus will be on teacher training around the existing national CSE curriculum, spearheaded by the Ministry of

Education. For out-of-school adolescents and youth, peer educator groups set up by CSOs/FBOs will use the new out-of-school CSE curriculum designed to equip these young people with social assets that are key to prevent HIV infection. The program will also support the promotion and distribution of male and female condoms targeting adolescents and young people, through social marketing, social media platforms and mass media. This responds to the findings of Zambia's 2013-2014 DHS, which found that while HIV testing went up among adolescents, reported condom use and teenage pregnancy rates did not change.

For the service provision prong, funding will support interventions aimed at strengthening the quality of services and increasing access to adolescent and youth-friendly SRH/HIV/STI, GBV and psychosocial services. These services will include access to contraceptives, increasing the uptake of HTS, VMMC, ART, condom use, STI screening, TB treatment, among others. In particular, funding will support the scale-up of current models which create safe spaces for adolescent girls, in line with the Adolescent Health Strategy. Importantly, this activity aims to ensure that young people will be able to access youth-appropriate HIV services in the areas where they study or live, especially where there may not be a functioning adolescent health services platform.

The research component will build on existing Legal Environment Assessment (LEA) operational research to understand how the legislative environment can play a role in influencing HIV and SRHR services utilisation efforts in favour of adolescents and young people, particularly AGYW.

Table 5: Adolescent girls, Young Women and their partners

Key Questions	Status
1. Is this pillar/area a priority for the country?	YES, It has been incorporated in the NHSP (2017-2021) and NASF (2017-2021). MOH has since launched Adolescent Health Strategy 2017-2021.
2. Does the National Strategic Plan include a set of prevention targets in line with the 2015 UNAIDS Strategy and Political Declaration (see annex1)?	YES, The NASF (2017 to 2021) and the National Adolescent Health Strategy (2017 to 2021) have clear HIV prevention targets for adolescent girls and young women.
3. Has the (program/finance) gap against the target been estimated?	YES Partially done – Under the MOH Adolescent Health Strategy, PEPFAR DREAMS and ACT COP 17 funding
4. What key challenges or constraints have been encountered in achieving this target?	1. Low HIV risk perception and low comprehensive knowledge on HIV among adolescents and young people leading denial of their vulnerability to HIV. 2. Inadequate implementation of the adolescent sexual reproductive health services platform

	resulting into low access to adolescent friendly services (AFS). 3. Legal barriers (such as age of consent), limiting access to HIV prevention services such as condoms and HIV testing.
5. What are the key programmatic actions necessary to achieve these targets?	1. Design targeted and age specific comprehensive social and behavioural change communication messages delivered through diversified methods and media to reach in and out of school adolescents and young people with Comprehensive Sexuality Education and address significant HIV transmission misconceptions and risk perceptions among adolescents and young people. 2. Scale up integrated and comprehensive age specific adolescent friendly SRH/HIV services/spaces, including messaging and access of condoms by in and out of school adolescents and young people. 3. Adopt and implement an ecological model that focuses on individual, household and community, including interventions that aim to eliminate harmful cultural practices, gender inequalities and gender-based violence; and strengthen referral system for adolescent health services through innovative ways such as electronic referral systems.
6. What are the key policy/legal changes necessary to achieve these targets?	1. Extend national level coordination structures (such as Technical Working Groups) to sub national levels to enhance service delivery and scale up implementation of adolescent friendly spaces and services (AFS). 2. Review the age of consent to increase access to HIV prevention services by adolescents and young people. 3. Develop a clear policy for in and out of school young people that clearly defines age specific package of services and elaborate a referral system that enables young people to access SRH/HIV services including family planning in adolescent friendly spaces.
7. What new investments are necessary to achieve these targets?	1. Promote and increase access to comprehensive adolescent sexual reproductive health services including utilisation of a mix of social marking and public provision of condoms for young people while promoting exiting commercial brands. 2. Apportion significant resources to support the in and out school adolescents and youth – with training and resource materials. 3. Invest in social assets for adolescents by equipping adolescents with life and other skills to assertively negotiate and decide for safer and less risky behaviours.
8. What are your country commitments to ensure the suggested prevention-related policy changes?	1 The NASF (2017-2021) prioritises adolescents and young adults and emphasises provision of HIV and SRH services such of condoms to adolescents and young people.
9. What are your country commitments	1. Strengthen the technical working group for adolescents and young people to provide continued

to ensure the suggested prevention programme implementation/ coordination changes?	technical support to the design and implementation of services for adolescents and young people. 2. Establish more community-based platforms to address the needs of adolescents and young people.

3.5.1 Gaps

Although significant resources have gone to HIV prevention among adolescent girls and young women, low HIV risk perception and low comprehensive knowledge on HIV persist among adolescents and young people. In addition, despite increases in uptake of HTS and VMMC services, there is low reported condom use among adolescents at last sex. There are also barriers to service access related to the age of consent. In Zambia, any person below the age of 16 needs parental/guardian consent to access HIV prevention services such as counselling and testing and cannot easily access condoms provided through the health staff at public facilities.

Government and its partners have developed an adolescent health national strategy to guide implementation of health services, including HIV prevention. However, the implementation of the adolescent health services platform, which includes adolescent friendly spaces, is yet to be scaled up. In addition, branding of existing condoms do not appeal to the young people and they continue to experience barring attitudes from health workers.

3.5.2 Recommendations

1. Intensify Comprehensive Sexuality Education for both in school and out of school young people through development and implementation of a policy that will clearly define the package of services including family planning that each category will access.
2. Scale-up implementation of adolescent friendly spaces for integrated and comprehensive SRH services.
3. Significant scale up of condom programming including rebranding of condoms to make them more appealing to young people and reconstitution of a national coordinating mechanism for condom programming. Invest in innovative ways of distributing condoms to reach young people such as condom dispensers, through street vendors and other community based channels that enable young people to easily and comfortably access condoms.

4. Intensify AGYW and young men comprehensive social and behavioural change communication campaigns through mass media and interpersonal communication to address the significant HIV transmission misconceptions and risk perceptions among adolescents and young adults.
5. Review the age of consent for young people to increase access to HIV prevention services by young adolescents.
6. Invest in social assets for adolescents; invest in equipping adolescent girls and young women with skills to assertively negotiate and decide for safer and less risky behaviours and reject harmful practices including child marriage and puberty rites.

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NATIONAL CONSULTATION MEETING ON HIV PREVENTION COALITION
22 September, 2017

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