A COMPREHENSIVE HIV PREVENTION ROADMAP 2017-2021:

FRAMEWORK OF INDICATORS AND TARGETS

MARCH 2017
ZAMBIA

Table of Contents

List of Tables

List of Figures

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DBS	Dried Blood Spots
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women
eMTCT	Elimination of Mother-to-Child Transmission
FSW	Female Sex Worker
GBV	Gender Based Violence
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HMIS	Health Management Information System
HTS	HIV Testing Services
IBBS	Integrated Biologic and Behavioural Survey
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IDU	Injecting Drug Users
KP	Key Populations
M&E	Monitoring and Evaluation
MOGHE	Ministry of General and Higher Education
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National HIV/AIDS/STI/TB Council
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework

NGO	Non-Governmental Organisation
NZP+	Network of Zambian People Living with HIV/AIDS
OST	Opioid substitution therapy
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	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
SCT	Social Cash Transfer
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
VSU	Victim Support Unit
WHO	World Health Organisation
ZAMPHIA	Zambia Population-Based HIV Impact Assessment
ZDHS	Zambia Demographic and Health Survey

Foreword

As one of the sub-Saharan countries most severely affected by the HIV epidemic, Zambia has been implementing HIV prevention interventions since the first reported case of AIDS in 1984. The response started in the late 1980s and 1990s with psychosocial counselling, voluntary counselling and HIV testing (HTS), and evolved to include behaviour change interventions, condom use, treatment as prevention, prevention of mother to child transmission (PMTCT). More recently, this has also included voluntary medical male circumcision (VMMC) and a focus on most-at-risk populations. As a result of these efforts, the percentage of people infected with HIV has reduced and coverage for most HIV services has increased. Although the HIV prevalence has declined from 15.6% in 2001 to 11.2% in 2013, it is still a great source of concern and prevention efforts need to be stepped up in line with the global call to fast-track the response. Furthermore, the disparity in prevalence between men (8.5%) and women (13.6%) continues to be a source of serious concern.

Zambia has consistently developed frameworks to direct and focus our high impact interventions. The National AIDS Strategic Framework (NASF) has been developed based on the existing knowledge and evidence of the effectiveness of interventions in fighting the epidemic. The NASF has not only helped focus the response on well-thought-out strategies, but has also enabled tracking of the response for national planning and global reporting. This document has been developed as an excerpt of the NASF and focuses on HIV prevention as a key pillar and key priority area for fast-tracking the response.

In June 2016, a high-level meeting (HLM) was held in New York to catalyse the global committed to continue the fight to end the HIV/AIDS epidemic by 2030. As a result, interim targets were set for 2020. Zambia has ratified and domesticated these targets, revising a number of strategic documents and guidelines consistent with the global commitment. The 2020 strategic milestones include: less than 500,000 new HIV infections and AIDS-related deaths, and the elimination of HIV-related discrimination. This document is a reflection of our commitment to preventing new HIV infections as per the political declaration of ending AIDS by 2030.

This roadmap highlights our national commitment to very clear and specific targets that Zambia aspires and will aim to attain by 2020. It is developed in line with the 10 global commitments to end HIV by 2030. It presents indicators and targets, as agreed on by national level stakeholders, that will guide all partners working in different areas of HIV prevention in Zambia over the next five years. The targets are ambitious and will require front-loading of the response in order to accelerate progress toward the attainment of the set targets. This will require an investment in all areas of the response, particularly prevention. Continuing business as usual will erode the gains we have made so far and may result in an irreversible epidemic.

In addition, our record of success will not only depend on the successful implementation of various interventions, but also on the effective reporting of progress being made by all partners. As a nation, we will need to move from partner reporting systems to a coherent and effective national monitoring and reporting system.

Therefore, I appeal to all stakeholders in HIV prevention to dedicate sufficient efforts to enable the country to attain the targets set in this document. The Government of Zambia and NAC will remain committed to working with and supporting all partners to ensure the successful implementation of the HIV prevention roadmap.

_____

Dr. George Tembo
Chair Person
National HIV/AIDS/STI/TB Council

Acknowledgement

The National HIV/AIDS/STI/TB Council (NAC) wishes to acknowledge with gratitude the unwavering support of all partners who have expressed their commitment to continue supporting the national HIV response. This HIV prevention roadmap is yet another product of your relentless commitment and efforts.

The Council wishes to express special thanks and appreciation to members of the Adolescent Health Theme Group, the HIV Prevention Theme Group, and the National Prevention Team. Their policy, programme and technical insights have shaped this roadmap and contributed invaluably towards the development of this roadmap.

The Council further wishes to thank the various stakeholders, government ministries and departments, civil society organisations and non-governmental organisations for their meaningful participation throughout the process. Their participation has helped to build consensus, improve the quality and comprehensiveness of this document.

Last, but not least, the Council would like to express special thanks to the UN Family and all Cooperating Partners, for the technical guidance during the process of developing this document. Special thanks go to UNAIDS for technical and financial assistance that enabled the development of this roadmap. Finally, I want to express my gratitude to the staff of the National AIDS Council, for their dedication and collaboration during the entire process. Without their support, the development of this roadmap would not have been accomplished.

_____

Dr. Reuben Kamoto Mbewe
Director General
National HIV/AIDS/STI/TB Council

Prevention Conceptual Framework

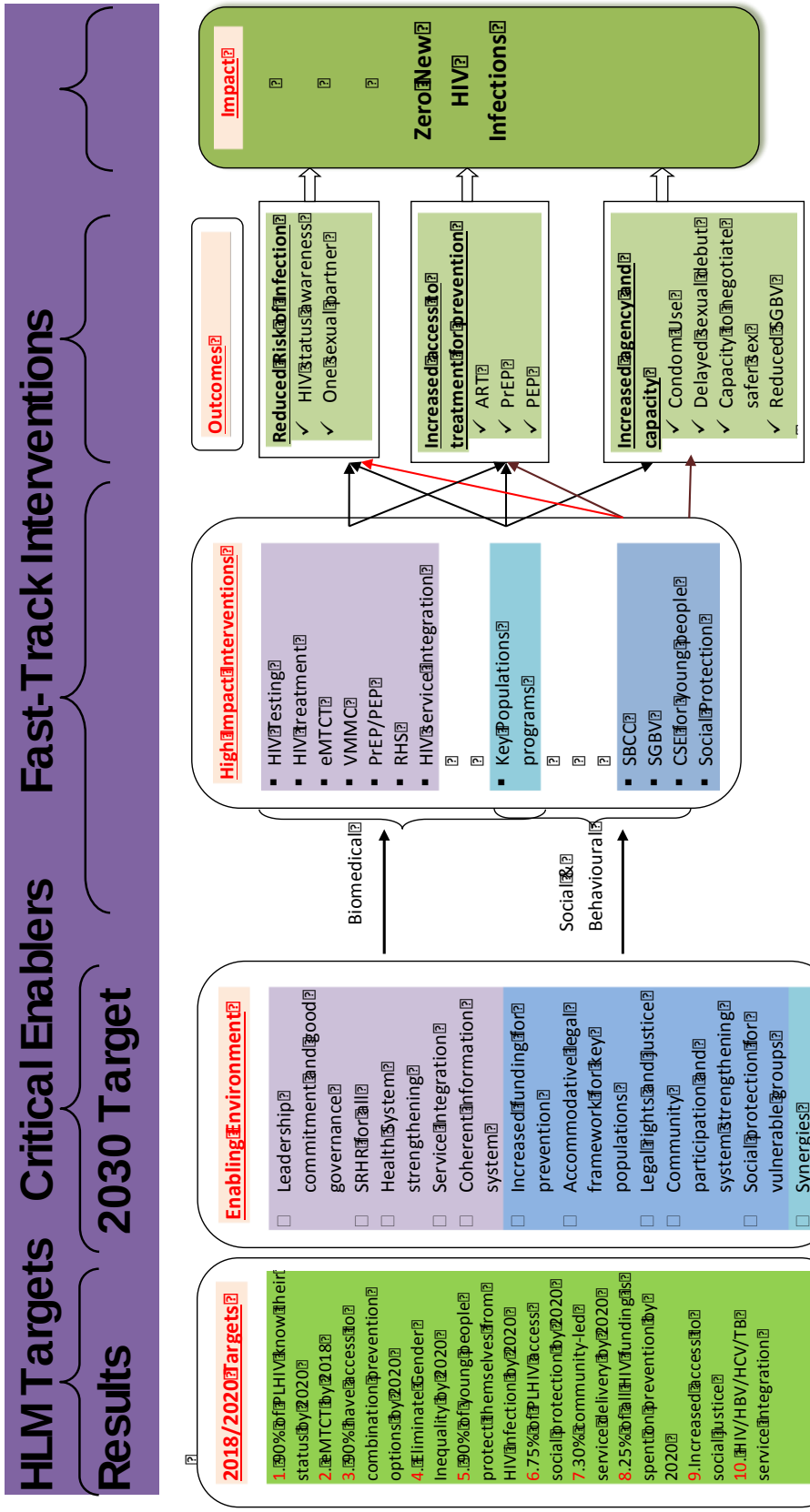


Figure 1: Prevention Conceptual Framework

1 Introduction

By the end of 2015, approximately thirty-seven million people were living with the Human Immunodeficiency Virus (HIV) worldwide and seventeen million people were on lifesaving anti-retroviral treatment (ART). New HIV infections were estimated at two million, and AIDS-related deaths at one million (UNAIDS, 2016).

In order to accelerate the prevention of new infections and increase the coverage of treatment and care for people with HIV, the United Nations Joint programme on HIV/AIDS (UNAIDS) introduced the Fast-Track strategy in 2014. This strategy was launched to step up the response in low- and middle-income countries amidst fears that the response and all the gains made so far will be outrun by the epidemic. The strategy aims to increase resources for high impact interventions and accelerate improved outcomes for HIV prevention. In addition, the UNAIDS strategic HIV treatment targets for 2017 to 2021 also refers to the pathway of linking all children, adolescents and adults who test HIV positive to HIV treatment so that they adhere to treatment and have achieve viral load suppression (VLS). Evidence suggests that VLS to non-detectable levels reduces chances of transmission and thus acts as a powerful prevention tool. This approach is facilitated by the WHO guidelines that everyone living with HIV is eligible for treatment and should be given anti-retroviral drugs (ARV).

The UNAIDS Fast-Track strategy re-emphasises the need for the global response to be 'front-loaded', so that more resources are committed and interventions are carried in earlier years than later, over the next few years to prevent the epidemic from rebounding. Given the importance of prevention in the HIV/AIDS response, countries will need to not only invest in, but also accelerate prevention interventions over the next five years to achieve global targets.

In June 2016, a HLM was held in New York to catalyse global commitment to the continued fight to end the HIV/AIDS epidemic by 2030. Political commitment was rallied for the global targets set by UNAIDS in consultation with other stakeholders.

1.1 High Level Meeting Commitment and Global Targets

According to the HLM commitment 2016 and UNAIDS strategy 2016-2021 (UNAIDS, 2015) the global strategic milestones for 2020 include: less than 500,000 new HIV infections, a reduction in AIDS–related deaths, and the elimination of HIV-related discrimination. The complete list of HLM commitment and global HIV targets include the following:

1. Ensure that 30 million people have access to treatment through meeting the 90-90-90 targets (90% of people living with HIV (PLHIV) know their status; 90% of PLHIV who know their status are receiving treatment; and 90% of people on treatment have suppressed viral loads) by 2020;
2. Eliminate new infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018;
3. Combination prevention options, including pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men (MSM), transgender people, sex workers and their clients, people who inject drugs (IDU), and prisoners;
4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, PLHIV and key populations by 2020;
5. 90% of young people have the skills, knowledge and capacity to protect themselves from HIV, and have access to sexual and reproductive health services by 2020;
6. 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020;
7. At least 30% of all service delivery is community led by 2020;
8. HIV investments increase to US$ 26 billion by 2020, including a quarter allocated to HIV prevention;
9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of justice;
10. Taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis (TB), cervical cancer and hepatitis B and C.

As shown in Figure 1 below, the goal of ending AIDS by 2030 cuts across five SDGs. The Fast-Track targets for 2020 are agreed on by the countries and adapted to the national targets and strategies (see Figure 2). Although significant progress has been made in fighting the epidemic, rising high-risk behaviours resulted in high rates of new infections, particularly among adolescent girls and young women. Additionally, significant new HIV infections have been reported among key populations who are still legally challenged in Zambia, particularly MSM and sex workers. Although scores of success have been reported in regards to VMMC, there is still progress to be made regarding HIV testing in order to reach the 90% target. Gaps in HIV testing not only fuel new infections, but also continue to contribute to low treatment coverage.

Figure 2: Link between Targets and SDGs

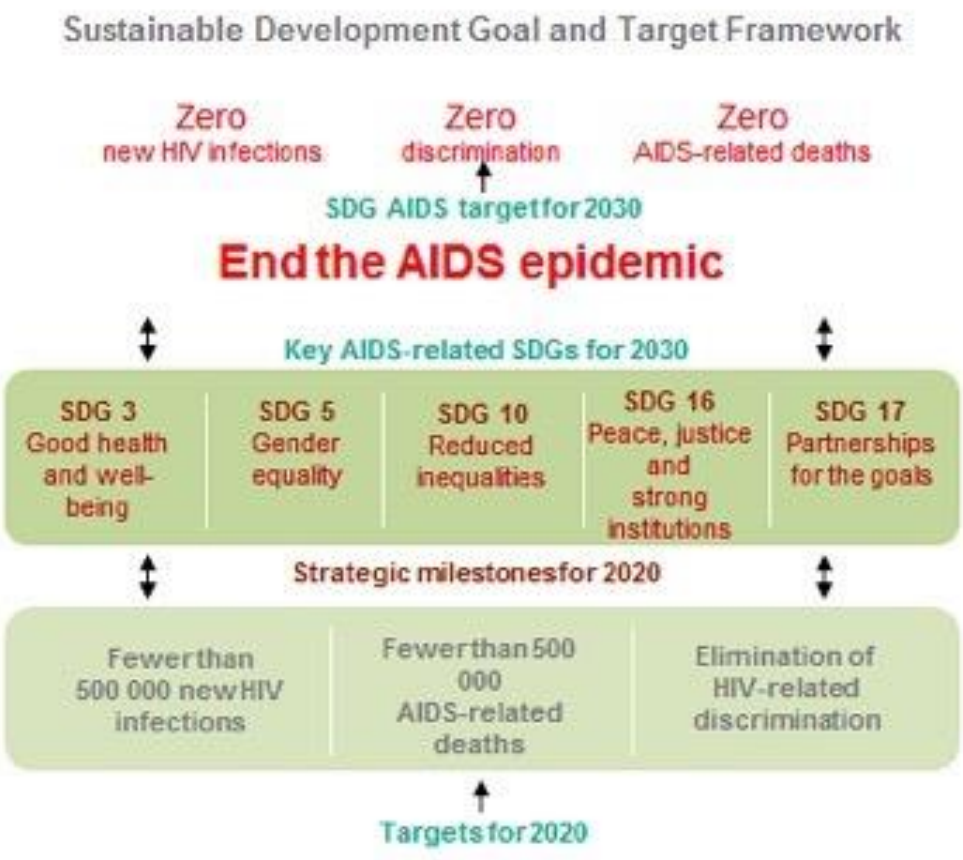
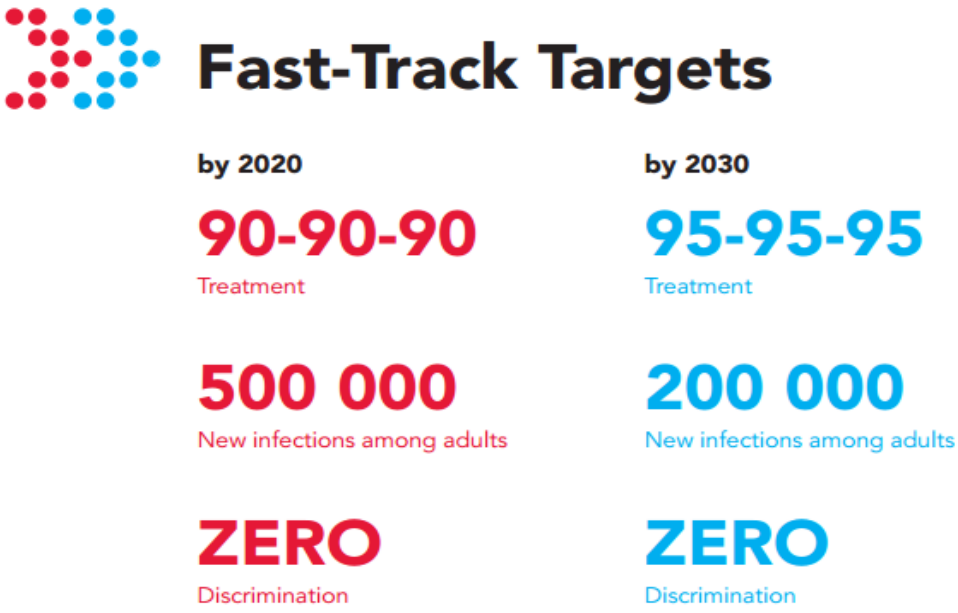


Figure 3: HLM Fast-Track Targets



Zambia has been implementing HIV prevention interventions since the first official case of AIDS was reported in 1984 (Illife, 2006; and Simbaya et al, 2013). Starting with psychosocial counselling and later voluntary counselling and HIV testing in the late 1980s and 1990s, the response evolved to include behaviour change interventions, condom use, treatment as prevention, PMTCT, and more recently, VMMC and a focus on most at risk populations. As a result, the percentage of people infected with HIV has reduced as coverage for most HIV services has increased over the years (NAC, 2015). Despite a noted decrease in HIV prevalence from 15.6% in 2001 to 11.2% in 2013, it is still a great source of concern and prevention efforts need to be stepped up in line with the global call to fast-track the response. In order to contribute significantly to the global targets, the Zambian HIV response will need to be accelerated. This will require Zambia to structure the response alongside four critical areas of intervention, specifically behaviour, biomedical, socio-cultural and economic enablers in policy and programme to synergies with development sectors and actors.

Zambia is one of the priority countries identified for fast-tracking the regional response in Southern Africa, and the areas outlined above are important for the prevention of new HIV infections. However, to be able to measure the success, it is imperative to develop indicators and

set targets that will benchmark the desired level of achievement by the year 2020. This will make the evaluation of the 2017 to 2021 National AIDS Strategic Framework (NASF) meaningful and will further facilitate the needed adjustments in the response to achieving the 2030 targets.

2 Rationale for a HIV Prevention Roadmap

HIV prevention programmes in Zambia are planned and implemented by various partners, however, there is not such a comprehensive roadmap that guides all the stakeholders with a set of standard indicators and shared targets. Targets are important for focusing intervention strategies and orienting stakeholders to existing national priorities. HIV prevention is among the key concerns that if not prioritised are likely to negate years of national development. Thus, setting ambitious, yet attainable targets will facilitate an environment for harnessing and focusing HIV prevention efforts consistent with global targets. Setting targets also guides organisations and individuals involved in the HIV/AIDS response to do their best to ensure the targets are met. In addition to serving as 'contracts' between the government and different stakeholders, these targets will serve as guideposts for measuring whether progress is being made on schedule and at the levels envisioned. Results will enable the stakeholders to reorient the response towards meeting the 2030 targets.

3 Roadmap Development and Target Setting

Target setting is a collaborative process, involving input from all cooperating partners including community-led organisations and networks, and other stakeholders such as representatives of government and civil society, service providers and clinicians. The approach followed for setting national targets in this roadmap was twofold: i) the establishment of baseline targets for indicators, and ii) setting fast-track targets for 2020 based on global targets and national commitments. Additionally, several consultative meetings were held with different stakeholders, including the HIV prevention Technical Working Group. The preliminary list of indicators and proposed targets were validated with representatives of multisectoral stakeholders through the forum of a national validation workshop.

4 Framework of HIV Prevention Indicators and Targets

HIV prevention programmes will be most effective and provide the best value for money when delivered to priority populations through tailor-made programmes. UNAIDS suggests the following focus areas as high impact interventions aimed at HIV prevention:

- Condom programming. Condoms remain the only available tool for triple protection against HIV, other STIs and unintended pregnancy;
- Use of ARVs to treat and prevent HIV; Pre-exposure prophylaxis with ARVs can be highly effective;
- Voluntary medical male circumcision (VMMC);
- Harm Reduction interventions such as needle–syringe programmes and opioid substitution therapy (OST) among IDU; and
- Communication and social change using specific communication targeting specific groups on intimate partner violence and prevention of HIV.

Following a consensus on the prioritisation of key high-impact prevention interventions as set out in the 2017 to 2021 NASF, the HLM targets were assessed within the country context before setting national targets. The resulting framework provides indicators and targets for each of the global targets. This roadmap focuses on the following key prevention areas with an emphasis on high impact performance areas:

1. HIV Testing Services;
2. HIV treatment as prevention;
3. Elimination of Mother to Child Transmission of HIV (eMTCT);
4. VMMC;
5. Condom programming;
6. Social behaviour change;
7. Combination HIV prevention programme to Key Populations;
8. Gender equality and empowerment;
9. Addressing stigma and discrimination; and
10. Investment in HIV control.

4.1 HIV Prevention Impact

The impact result area for HIV prevention is HIV incidence. Table 1 below provides a fast track indicator and target for 2017 to 2020.

HLM target: Less than 500,000 new HIV infections by 2020

Table 1: Impact Indicator and 2020 Fast-Track Target

Indicator	Disaggregation	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
Number of people newly infected with HIV in the reporting period per 1,000 uninfected population	0-14	10,300	670	HMIS	Annually	
	15-59	46,000	15,000	ZAMPHIA ZDHS[1]	5 years	

The overall impact of HIV prevention interventions is to get to zero new HIV infections. Achieving this goal will require focused, high-impact HIV preventions; accelerated testing, treatment and retention in care; anti-discrimination programmes; and an unwavering commitment to respect, protect and promote human rights.

Zambia's goal of the elimination of vertical transmission of HIV by 2018 will need careful analysis, planning and target setting. A micro plan will specifically address the elimination indicators and targets. This plan will also need to improve the reporting system to measure the new infections in children at birth, at 6 months and at 18 months.

4.2 Outcome Targets

This section provides a tabulation of outcome indicators and targets specific to each HLM commitment. The second column presents baseline values from 2016, where they exist. The third column presents the 2020 fast-track targets, followed by the source of the data, and the frequency of data collection.

These provide some insights on the relevant challenge, suggested strategies to achieve the set target in each indicator. The suggested strategies are derived from the lessons learned and the

[1]Based on 2013/14 ZDHS

experience shared by the stakeholders at the national consultation. It is important to note that the second and third 90-90-90 related indicators are provided and discussed in a separate document focusing on treatment.

HLM Commitment 1: Ensure that 30 million people have access to treatment through meeting the 90-90-90 targets by 2020.

Table 2: Commitment 1, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
1.1 Percentage of sexually active adolescents aged 15-19 who have tested in the last 12 months	Female: 32.6% (n= 3,635) Male: 19.4% (n= 3,337)	90% 90%	DHS[2]	5 years	Need sex disaggregated data in global reporting
1.2 Percentage of people living with HIV (male and female; 0-14, 15-49, 50+) who know their HIV status	67%	90 % (n= 1,114,453)	HMIS DHS/ ZAMPHIA	Annually 5 years	Need age and sex disaggregated data in global reporting

To achieve the fast-track targets above, it will be imperative to build on existing structures and scored successes, by making use of HTS avenues that have proved effective. It will be essential to ensure that hard-to-reach populations such as men and adolescents are mobilised for HTS. Special attention will need to be given to key populations, where the HIV infection is most concentrated. While this will require significant changes in the legal environment, existing efforts for certain key populations could be harnessed and leveraged to provide targeted HTS work for key populations. Men are generally left behind in HIV testing so it is important to target them with appropriate strategies.

In addition, ensuring availability of HIV test kits and laboratories in all the health facilities are critical, hence the need to strengthen the entire health system, including more systematic and adequate investments in consistent procurement and supply management. Health facilities and testing centres must have their capacities strengthened to make sufficient forecasting and

[2] Based on 2013/14 ZDHS

requisition of the commodities. Particular attention must be given to ensuring that the revised guidelines are strictly followed in order to improve the quality of service delivery.

Suggested Strategies

In addition to the strategies outlined in the NASF, the following fast-track strategies are suggested to be adapted based on the lessons learned shared by the stakeholders at the consultation:

1. Full implementation of the revised HIV prevention and testing guidelines is a crucial step ahead;
2. Go where men are, targeting men through workplaces and other HIV testing programs;
3. Scale-up of HIV self-testing informed by the pilot testing approaches and populations;
4. Strengthen community-led HIV testing for marginalised populations;
5. Improve reporting by adapting the same indicators for all the partners working on HIV testing;
6. Strengthen coordination of data reporting at a national level through one national M&E system that works. Expand unique identifiers to address multiple HIV testing services through facilities, communities and self-testing; and
7. Motivate and engage lay community counsellors for their work through standardised incentive systems.

HLM Commitment 2: Eliminate new infections among children by 2020, while ensuring that 1.6 million children have access to HIV treatment by 2018.

Table 3: Commitment 2, National Indicators and 2018/2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
2.1 Percentage of exposed children whose HIV status is known at 6 weeks, 6 months, 12 months and 18 months.	6 weeks: (n= 1,081) 6 months: (n= 5,539) 12 months: (n= 970) 18 months: N/A	6 weeks: 95 % 6 months: 90% 12 months: 85% 18 months: 80%	HMIS	Annually	Need to agree on the target for 2018
2.2 Estimated percentage of children newly infected with HIV from mother-to-child transmission among HIV-positive women who have delivered in the past 12 months	5% (n= 10,300)	0.3% (n= 670)	HMIS/ PMTCT Impact Evaluation Studies	Annually 5 years	
2.3 Percentage of HIV-exposed children found to be positive at 6 weeks, 6 months, 12 months	6 weeks: 1.3 % 6 months: 2.3% 12 months: 2.5%	6 weeks: 0% 6 months: 0.15% 12 months: 0.3%	HMIS PMTCT Impact Evaluation Studies	Annually 5 years	
2.4 Percentage of HIV-exposed infants and children who received Cotrimoxazole Prophylaxis within 2 months of birth, in the last 12 months	94%	98%	HMIS	Annually	
2.5 Percentage of pregnant HIV-positive women who received ARVs to reduce the risk of mother-to-child transmission in the last 12 months	85% (n= 61,200)	95% (n= 68,400)	HMIS	Annually	

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
2.6 Percentage of women accessing antenatal care services who are (1) tested for syphilis; (2) tested positive; and (3) treated	(1) N/A (2) 3.5% (3) N/A	(1) 95% (2) <1% (3) 100%	HMIS	Annually	N/A data needs to be generated
2.7 Percentage of reported congenital syphilis cases (live births and stillbirths)	N/A	<1%	HMIS	Annually	

To achieve the Fast-Track targets for this commitment, there is a need to scale-up interventions that target eMTCT, including full coverage of Option B+ within all health facilities in Zambia. Coverage of ARVs for pregnant women must be stepped up in addition to their efforts to fully adherence to the treatment. In addition to strengthening the HMIS system to capture data, national MTCT studies that follow mother-baby pairs up until the cessation of breastfeeding must be implemented regularly to triangulate existing information and provide data on the status of eMTCT interventions.

Existing challenges in infant testing include stock-outs of testing kits (Dried Blood Spots) used to collect samples for the Polymerase chain reaction (PCR) test, challenges of transporting bundles, especially from rural facilities to district hubs, stock-out of reagents at laboratories, data capture at the lab and delayed feedback to facilities for timely interventions for exposed children who test positive. Training of staff in the appropriate collection method of DBS from children also needs improving in order to achieve the fast-track targets.

Suggested Strategies

1. eMTCT cannot be achieved through carrying out business as usual, but requires accelerated innovative interventions. Furthermore, investments in capacity building of local structures and the decentralisation of health services are required to maximise coverage;

2. Prongs 1-2 of the PMTCT should be intensified to make an impact and to sustain the results;
3. Scale-up services for early infant diagnosis of HIV to all PMTCT sites and expand routine opt-out testing in all facilities;
4. Expand the roll-out of lifelong ART (Option B+) with an emphasis on retention in care for mother-baby pairs to reach all eMTCT sites in the country; and
5. Scale up community mobilisation to increase ANC attendance and facility deliveries for HIV-positive pregnant women by expanding community-led interventions. Capacitate PLHIV community groups to track and keep mother-baby pairs in care.

HLM Commitment 3: Combination prevention options, including PrEP, VMMC, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other MSM, transgender people, sex workers and their clients, IDUs and prisoners.

Table 4: Commitment 3, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
3.1 Percentage of men (15–49) that are circumcised; 3.2 Number of males (10-14 and 15-49 years) who have undergone voluntary medical male circumcision in the last 12 months	54% (n= 1,005,424) 222	90% (n= 1,985,083) 382	HMIS	Annually	
3.3 Percentage of respondents who say they used a condom the last time they had sex with a non-marital or non-cohabiting partner, in the last 12 months	59.5% (men)	90 %	ZDHS[3]	5 years	
3.4 Estimates of the size of specific key populations (Sex Workers, MSM, people who inject drugs, transgender people and Prisoners	FSW: 2.2% MSM: 0.89% IDU: 0.41%	NA	Key population Survey	5 years	
3.5 Percentage of sex workers who report condom-use at last sex	78%	90 %	Key population Survey	5 years	
3.6 Percentage of MSM who reported using a condom the last time they had anal sex with a male partner	N/A	90%	Key population Survey	5 years	
3.7 Percentage of people who inject drugs who reported using a condom the last time they had sexual intercourse	N/A	90%	Key population Survey	5 years	
3.9 Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex	N/A	90%	Key population Survey	5 years	

[3] Based on 2013/14 ZDHS

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
3.9 Number of people (10-19, 15+) receiving post exposure prophylaxis (PEP) to prevent HIV infection within 72 hours of unprotected sexual encounter	N/A	N/A	HMIS	Annually	
3.10 Number of people receiving oral PrEP for the first time during the reporting period	N/A	N/A	HMIS	Annually	
3.11 Percentage of specific key populations (Sex Workers, MSM, people who inject drugs, transgender people and Prisoners) currently living with HIV	SW: 56%	N/A	Key population Surveys	5 years	
3.12 Percentage of specific key population (Sex Workers, MSM, people who inject drugs, transgender people and prisoners) who know their HIV status.	SW: 93%	90 %	Key population Survey	5 years	
3.13 Percentage of people within key populations currently living with HIV receiving ART in the last 12 months	N/A	90 %	Key population Survey/IBBS	5 years	
3.14 Percentage of people in a key population who reported having received a combined set of HIV prevention interventions	N/A	90 %	Key population Survey	5 years	
3.15 Percentage of IDUs who reported using sterile injecting equipment the last time they injected	N/A	90 %	Key population Survey	5 years	
3.16 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes.	N/A	N/A	Programme data	Annually	
3.17 Percentage of people who inject drugs receiving opioid substitution therapy (OST)	N/A	N/A	Key population Survey	5 years	

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
3.18 Percentage of sex workers with active syphilis	21%	10%	IBBS	5 years	
3.19 Percentage of MSM with active syphilis	N/A	10%	IBBS	5 years	
3.20 Prevalence of hepatitis and co-infection with HIV among key populations	N/A	N/A	IBBS	5 years	

Attainment of the targets under Commitment 3 will require significant improvement in the existing legal, policy and programme environment. There is a need to change the legal environment to one that recognises the existence and contribution of key populations to the Zambian HIV epidemic. Evidence suggests that key populations contribute significantly to new infections. To achieve the 2020 fast-track targets, the country will need to reorient the health system, and ensure that prevention interventions and services are friendly and easily accessible by key populations. The acceptance of the existence of key populations in Zambia has improved over time, however, they need to be decriminalised to ensure improved access to HIV services.

Suggested Strategies

1. Urgent need to have an estimation of key populations, and with clear association of risky behaviour and targets to measure the new infections among the population group;
2. Strengthen community sensitisation about the role of VMMC in HIV prevention to counter existing myths and traditions about male circumcision;
3. Integrate and mainstream the human rights approach in provision of HIV prevention services, especially to key populations;
4. Scale up key population-friendly HIV prevention messages through peer mobilisation and support including offering harm reduction interventions. Access to HIV testing among the key populations can be improved by providing them with various testing options through people and community-centred services including clinics and self-testing;

5. Expand access, demand, and use of condoms among sexually active populations;
6. Ensure that male and female condoms are made available and promoted to reach adolescents and young people, key populations and other marginalised groups who face barriers to condoms and lubricants;
7. Scale up VMMC sites and enhance the capacities and skills of VMMC providers;
8. Implement appropriate, evidence-informed, communication and advocacy strategies to increase both healthcare provider and public awareness of PrEP within the context of HIV prevention in a way that eliminates stigma for users, and minimises potential for risky behaviours and harm resulting from overuse of PrEP; and
9. Promotion of a coherent national information system that will make data easily available for monitoring the response.

HLM Commitment 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV, and key populations by 2020.

Table 5: Commitment 4, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comments
4.1 Percentage of adolescent girls (15-19) who have experienced sexual violence in the last 12 months.	4.2%	0.5%	DHS[4]	5 years	
4.2 Percentage of young women (20-24) who have experienced sexual violence in the last 12 months.	10.2%	1%			
4.3 Percentage of married adolescent girls (15-19) who have experienced sexual violence from a male intimate partner in the last 12 months.	29.8	3%			
4.4 Percentage of women (25-40) who experienced sexual violence from a male intimate partner in the past 12 months	8.9 %	1%	DHS	5years	
4.4 Percentage of women (>40 years) who experienced sexual violence from a male intimate partner in the past 12 months	N/A	1%			
4.5 Percentage of women (25-40) who experienced physical violence from a male intimate partner in the last 12 months	16.7%	2%	DHS	5 years	
4.6 Percentage of women (>40 years) who experienced physical violence from a male intimate partner in the last 12 months	N/A	2%			
4.7 Percentage of survivors of sexual violence (10-19, 20+) who received post exposure prophylaxis (PEP) within 72 hours of sexual assault	N/A	90%	VSU/One Stop Centre Record/ Reports	Annually	

[4] Based on 2013/14 ZDHS

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comments
4.8 Percentage of women and men (15–49) who reported discriminatory attitudes towards people living with HIV	N/A	N/A	DHS	5 years	
4.9 Percentage of specific key populations (SW, MSM, IDU and transgender people)who avoided HIV services because of stigma and discrimination	N/A	N/A	Key population Survey	5 years	

The youth and adolescents are the main populations on whom the nation relies for its prosperity. However, these populations face all types of challenges in regards to being healthy citizens. They are vulnerable to HIV infections, child marriage, teenage pregnancy which is further exacerbated by limited empowerment and access to services. The elimination of child marriage and early pregnancy is central to the success of achieving this target. In Eastern and Southern Africa, 34% of girls are married as a child, at the age of 13. Child marriage has been associated with higher exposure to intimate partner violence and commercial sexual exploitation.

When it comes to young people that are part of the key populations, the challenges are further multiplied. Existing cultural norms and traditions tend to hinder the elimination of gender inequalities and also fuel gender-based violence (GBV), particularly against women and girls. Furthermore, evidence already shows that gender inequalities fuel infection rates. To reach the 2020 fast-track targets, Zambia needs to invest in critical social enablers that will reduce discrimination and violence against women and young girls. To do this, there is a need for continued investment into gender awareness and sensitisation, already in place by the Ministry of Gender and other partners. The successful strategies for youth empowerment such as DREAMS should be scaled up to make a greater impact.

Additionally, there is a need to create capacities at all levels to collect data on the indicators mentioned above. Currently, data is not collected in a consistent and coordinated manner to measure the entire national response.

Suggested Strategies

1. Fully mobilise communities to create safe spaces for adolescents and young women, and engage gatekeepers such as traditional and religious leaders to fight existing harmful traditional and cultural norms. Additionally, men need to be equally engaged in the elimination of GBV and the promotion of gender equality by acknowledging their role in a non-threating way;
2. Building capacity of already existing structures such as the Victim Support Unit (VSU) within the Zambia Police Service and fast-track courts, will be an effective way of eliminating gender inequalities and GBV. Furthermore, there is a need for strong enforcement of PEP to the survivor of sexual violence and assault;
3. Scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights (SRHR); and
4. Provide special support to key populations and people with special needs, such as people with disabilities, in order to demand and access to services on time.

HLM Commitment 5: 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020.

Table 6: Commitment 5, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comments
5.1 Percentage of adolescents (15 -19) with comprehensive knowledge of HIV prevention	Female: 39% Male: 42%	90%	ZDHS[5]	5 years	
5.2 Percentage of young women and men (20-24) with comprehensive knowledge of HIV prevention	Female: 45% Male: 53%	90%			
5.3 Percentage of adolescent in-school girls and boys (10-15 and 15+) with Life Skills based Comprehensive Sexuality Education knowledge and skills	N/A	90%	Annual School Census forms & Standards monitoring reports	Annually	Based on the MoGHE newly introduced curriculum of CSE.
5.4 Percentage of adolescent girls and boys (15–24) who accessed family planning services in last 12 months	N/A	90%	DHS Programme data	5 years Annually	
5.5 Percentage of adolescent girls and boys (15- 24) who accessed Adolescent Sexual Reproductive Health services (access to family planning and condoms) in last 12 months	N/A	90%	ZDHS Programme data	5 years Annually	
5.6 Percentage of adolescent in-school girls and boys (15 -24) who accessed Adolescent Sexual Reproductive Health services in last 12 months	N/A	90%	ZDHS Joint Annual Review	5 years Annually	

[5] Based on 2013/14 ZDHS

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comments
5.7 Percentage of never married adolescents (15–19) who used a condom at last sexual encounter	Female: 37% Male: 43%	90% 90%	ZDHS	5 years	
5.8 Percentage of young adults (20-24) who used a condom at last sexual encounter	Female: 45% Male: 56 %	90% 90%			
5.9 Percentage of young men and women (15-24) who had sex before age 15	Female: 11.7% Male: 16.2%	10% 10%	ZDHS	5 years	
5.10 Percentage of in-school young men and women (15-24) who had sex before age 15	N/A	10%	ZDHS Joint Annual Review	5 years Annually	
5.11 Percentage of women (15-19) who had sexual intercourse with someone who was 10 or more years older than them in the last 12 months	7.2%	0.7%	ZDHS	5 years	

Changing the course of the epidemic requires addressing the root causes and understanding the core conditions that exacerbate the vulnerability of young people, which have resulted in an increase in new HIV infections. The following core conditions stand out:

- Inadequate access to good-quality sexual and reproductive health (SRH) information, commodities and services, in some measure due to age of consent to access services;
- Low personal agency, meaning women are unable to make choices and take action on matters concerning their own health and well-being;
- Harmful gender norms, including child, early and forced marriage, resulting in early pregnancy;
- Transactional and unprotected age-disparate sex, often as a result of poverty, lack of opportunity or lack of material goods;

- Lack of access to secondary education and comprehensive age-appropriate sexuality education; and
- Intimate partner violence, which impacts risk and health-seeking behaviour.

These factors severely inhibit the ability of young women and adolescent girls to protect themselves from HIV, violence and unintended or unwanted pregnancy. Gender inequality and the lack of women's empowerment or agency, are key themes that cut across these drivers.

To reach the 2020 Fast-Track targets, Zambia will need to accelerate the provision of youth-friendly HIV prevention commodities and services, as a means of increasing their accessibility to and utilisation. Trends also show that sexual debut often occurs before the age of 15 years. While the current efforts of the Ministries of General and Higher Education (MoGHE) to introduce a CSE curriculum starts from grade 5 (about 10 years old), the knowledge and information needs to be complemented by services and commodities. However, access to condoms for youth and adolescents has been a major challenge as reported by the programme partners, as well as the youth themselves. These efforts need to be stepped up to ensure that all children and young adults in schools and colleges receive CSE and are capacitated to protect themselves against HIV.

Out-of-school, unmarried and unemployed youths must also be targeted with a set of combination prevention options including promoting access to condoms and HTS, as well as PrEP where needed. Both out-of school and in-school young girls and boys must have access to reproductive health services.

Suggested Strategies

1. Mobilise peer educators to reach more in-and-out of school young people, with correct information and empower them to make correct decisions;
2. Youth and adolescents need to have more convenient and friendly points of condom distribution. This includes making condoms more attractive by producing them in different flavours and selling them through vending machines in various places such as outside the schools, talk-time and fruit sellers at the traffic lights at various junctions of the cities etc;

3. Provide training to health workers on the issues adolescents face and ensure the implementation of national adolescent HIV programme guidelines effectively;
4. Implement life skill development programme for adolescents and young women; and
5. Provide youth-friendly spaces in all health facilities to increase uptake of SRHR/GBV/HIV services by the youth.

HLM Commitment 6: 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

Table 7: Commitment 6, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
6.1 Percentage of the poorest households receiving social cash transfer support in the last three months	N/A	75%	NASA	2 years	Using criteria developed by the WB
6.2 Number of young women and girls who benefit from HIV-sensitive social protection or economic empowerment programmes	N/A	N/A	Programme data	2 years	Programme partners/MCDSW an generate this data
6.3 Percentage of people living with HIV in need of, and receiving social protection	N/A	75%	Programme data	2 years	NZP+ to generate this data

Social protection programmes have increasingly become HIV-sensitive and more numbers of vulnerable households affected by HIV are being reached through these programs. Social protection programmes enable the HIV/AIDS response to be more effective in addressing the underlying economic drivers of the epidemic, reduce the social and economic barriers to universal access, contribute to reductions in new infections, increase access to prevention and treatment services and help mitigate the impact of the epidemic.

Presently, under the leadership of the Ministry of Community Development and Social Welfare, several government departments and non-governmental organisations are piloting and implementing social protection programmes to improve the wellbeing of vulnerable populations in Zambia. However, spelling out PLHIV as a target group in the national policy limits the concept of HIV-sensitive social protection. There is a need to build on the HIV-sensitive social protection assessment done in 2015 in Zambia and ensure that PLHIV and key populations in need have full access to and utilisation of the programmes to reduce the impact of AIDS on vulnerable households and individuals. To reach the fast-track targets set above, there is a need

to triple existing efforts with a special emphasis on reaching vulnerable young women and girls. There is also need for the PLHIV networks to ensure that their members benefit from the national social protection programme including SCT program. Furthermore, these networks should provide the required data generated and feed into the information system.

Suggested Strategies

Social enablers play a critical role in reducing vulnerability to HIV infection among vulnerable populations. Vulnerability should not only be defined as a reflection of economics as there are social and legal factors marginalising some populations that are vulnerable to HIV infections. Additional strategies for ensuring the attainment of fast-track targets for Commitment 6, as highlighted in the NASF will include to:

1. Scale up innovative social protection delivery mechanisms that are responsive to the needs of people affected and living with HIV, and enhance outreach and cost effective mechanisms;
2. Ensure that appropriate legal redress mechanisms exist to improve access to social protection services free from stigma and discrimination;
3. Advocate for inclusive, enabling and HIV-sensitive social protection policy and regulatory environment;
4. Improve collaboration among the major players in social protection programmes including Ministries of Community Development and Social Services, Agriculture and Livestock and Local Government and Housing;
5. Strengthen the coordination, M&E of social protection measures to ensure the inclusion of all vulnerable groups, including those vulnerable as a result of HIV; and
6. Operationalisation of the Social Health Insurance Scheme.

HLM Commitment 7: At least 30% of all service delivery is community led by 2020.

Table 8: Commitment 7, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
7.1 Percentage of people tested for HIV through community-based service delivery	N/A	30%	HMIS/ NACMIS	Annually	The can be done by the CSO self-coordinating mechanism
7.2 Percentage of PLHIV who receive ART through community collection points	N/A	30%	HMIS/ NACMIS	Annually	

These indicators are set as a preliminary indicative, one based on the available global reporting tool. More indicators will be added in the coming year in this commitment area as the global reporting tools and guidelines will be available for reporting. To achieve the fast-track targets under Commitment 7, it will be essential to improve and strengthen accountability, commitment and good governance of the national multi-sectoral HIV and AIDS response that ensures community-lead strategies in addition to provincial and district lead strategies.

Furthermore, if HIV prevention service delivery targets are to be met, there should be meaningful community engagement with the relevant key government stakeholders such as the Ministry of Community Development, Ministry of Chiefs and Traditional Affairs, Ministry of Gender and CSOs. There is a need to increase resources for community support services such as funding for community health workers involved in HIV counselling and other related HIV prevention services at community level. Community based advocacy will also need to be carried out to sensitise communities on HIV prevention services such as PrEP and PEP services.

Suggested Strategies

Community-led health services cater for communities and increase service uptake, therefore it is important to engage communities in HIV service delivery to complement the health system's capacity for HIV prevention. It is also important to work with local government and city councils to empower community groups for delivering services and making them part of the local government in the HIV response.

1. Sustain leadership at community levels by promoting partnership with the local government;
2. Support key populations at a decentralised level to form their support groups and capacitate them in leadership and service delivery;
3. Enhance leadership, governance and oversight for implementing of the CSO self-coordinating mechanism and promote its ownership on the community response to HIV/AIDS;
4. Utilise traditional and religious leaders to encourage uptake of HTS and SRHR; and
5. Develop mechanism for the recognition of HIV response Champions at community levels.

HLM Commitment 8: HIV investments increase to US$ 26 billion by 2020, of which a quarter is allocated to HIV prevention.

Table 9: Commitment 8, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
8.1 Percentage of HIV resources invested on HIV prevention programmes	N/A	25 %	NASA	2 years	

The Zambian Government has continued to increase spending on the national health budget with increasing allocations for annual HIV programmes, and provides varying budgetary allocations to Ministries for public sector HIV and AIDS mainstreaming activities. Alternative funding options including National Health Fund and Social Health Insurance Scheme are being explored and HIV has been mainstreamed into the public sector. However, HIV financing is not completely integrated and there is no framework to compel funding partners to report their contributions to the HIV response. The bulk of support still targets specific areas of the response. Attaining all fast-track targets by the year 2020 will require more resources, given the funding challenges; it will be imperative to enhance efficiency in programmes and in the use of funds, increase domestic resource mobilisation and ensure equity of access and utilisation.

Suggested Strategies

In light of the highlighted lessons learnt above, the following additional strategies are required for the attainment of the fast-track targets.

1. Effective resource mobilisation locally is required as donor assistance has declined steadily over the past several years and is likely to continue;
2. There is a need to showcase the positive impact of successful strategies with clear evidence to motivate external funding agencies; and
3. There is a need to strengthen financial resource tracking to determine the amount of funding allocated to health services, specifically the HIV services. A good financial resource tracking system will also enable the response to provide data on the proportion of HIV funding is spent on HIV prevention.

HLM Commitment 9: Empower people living with, at risk of and affected by HIV to know their rights, and to access justice and legal services to prevent and challenge violations of justice.

Table 10: Commitment 9, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/ Status 2016	Target for 2020	Means of verification	Frequency	Comment
9.1 Percentage of PLHIV who are aware of their legal rights	N/A	N/A	PLHIV Survey	5 years	
9.2 Percentage of PLHIV who reported a violation of their legal rights in the last 12 months who accessed legal services	N/A	N/A	PLHIV Survey	5 years	
9.3 Percentage of key populations (SW, MSM, IDU and transgender people) living with HIV reporting denial of health services	N/A	N/A	Key population Survey	5 years	
9.4 Percentage of key populations (SW, MSM, IDU and transgender people) living with HIV who report experiencing discrimination from health workers in the last 12 months	N/A	N/A	Key population Survey	5 years	

Attainment of fast-track targets for 2020 under Commitment 9 will require the integration of health services and advocating with government for supportive policies. There will be a need to advocate and promote legal reforms against laws and policies that hinder access to HIV services. It will also be imperative to support communities to harmonise their customary laws with statute law, national policies and human rights principles. Key population's access to legal support will also need to be improved if the targets are to be achieved by the year 2020.

Suggested Strategies

In addition to the strategies highlighted above, the following strategies are vital in attaining the fast-track targets for Commitment 9.

1. Eliminate discrimination against PLHIV and other key and marginalised populations; and
2. Establish mechanisms for stakeholder engagements with the Law Development Commission and law policy and enforcing bodies to change discriminatory laws.

HLM Commitment 10: Taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for TB, cervical cancer, and hepatitis B and C.

Table 11: Commitment 10, National Indicators and 2020 Fast-Track Targets

Indicator	Baseline/Status 2016	Target for 2020	Means of verification	Frequency	Comment
10.1 Percentage of people living with HIV newly enrolled in HIV care with active TB disease*	N/A	N/A	HMIS	Annually	
10.2 Percentage of people living with HIV newly enrolled in HIV care started on TB preventive therapy**	N/A	N/A	HMIS	Annually	
10.3 Percentage of women living with HIV (30−49) who reported being screened for cervical cancer using any of the following methods: visual inspection with acetic acid or vinegar (VIA), Pap smear or human papilloma virus (HPV) test	N/A	N/A	HMIS	Annually	Report available only for the pilot project

* *Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care (pre–antiretroviral therapy or antiretroviral therapy) during the reporting period*

** *Number of patients started on treatment for commitment latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period. Recommendation of a strong and coherent information system*

Mechanisms for the coordination of collaborative TB/HIV interventions need to be strengthened if fast-track targets under Commitment 10 are to be attained by 2020. What also requires strengthening are TB/HIV infection prevention and control measures in health care and community settings. There is also need to scale up TB/HIV control in special settings and populations such as prisons.

Additionally, there is need to promote orientation, training, mentoring and technical support for healthcare workers in TB/HIV interventions. Attaining these fast-track targets will also require the support of coordinated TB case finding among PLHIV and ensuring that partners of TB patients who are co-infected are tested for HIV. Coordination, linkages and referral systems between TB and ART programmes will also need to be strengthened and community health

workers will need to be mobilised and engaged to support referral systems of patients from one programme to another in order to reduce loss-to-follow up.

Suggested Strategies

In addition to the strategies highlighted above, the following fast track strategies will need to be given priority:

1. Increase programme visibility and priority within the health portfolio and at all levels of the health care system;
2. Strategically disseminate critical information to key stakeholders including regular campaigns on TB, cervical cancer and hepatitis B and C;
3. Support the provincial level through secondment, joint-planning and direct budget support for TB, cervical cancer and hepatitis B and C activities, depending on the provincial needs;
4. Revamp the District Technical Committees to enable routine programme management and partner collaboration at this level; and
5. Expand existing capacity to provide comprehensive TB, cervical cancer and hepatitis B and C services by introducing pre-service training, eliminating missed opportunities for service delivery and efficiently deploying innovative methods such as devices for service delivery.

Health system, Supply chain management and leadership, and Coordination-related recommendations

There are areas which cut across the 10 commitment that are critical enablers to the success of the program. The following are suggested cross-cutting strategies across the HLM commitment areas to enhance access to, quality of, constant and equitable services aimed at target populations within the HIV response:

1. Strengthen supply chain management systems and ensure continuous availability of quality HIV commodities at every point of service delivery;
2. Timely orientation, training, mentoring and technical support for healthcare workers to integrate HIV/SRHR/GBV services to improve universal health coverage, including treatment for TB, cervical cancer and hepatitis B and C;
3. Provide training for health workers to handle GBV using the WHO global guidelines on Addressing GBV within healthcare settings. The training also includes the right of patients to receive non-discriminatory services;
4. Revise the HMIS to accommodate the new targets including on the areas of GBV, age and gender disaggregation etc.:
5. Enhance enabling legal and social environment to the key populations, who are at risk of, and mostly affected by HIV;
6. Strengthen leadership to the HIV prevention programme for its harmonised planning, implementation and reporting. Create synergy to the programme implemented by line ministries specially on GBV, social protection and decentralisation; and
7. Care analysis and strategy development for integrating gender equality in the entire health program.

References

GRZ: Ministry of Health. (2016). Zambia Population-Based HIV Impact Assessment ZAMPHIA 2015-2016.

GRZ: Ministry of Health. (2016). Adolescent HIV Guidelines.

GRZ. (2016). Zambia Country Report: Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access.

GRZ, Ministry of Health. (2016). AIDS Response Fast Track Strategy 2017 - 2021.

GRZ, Ministry of Health. (2016). National Cancer Control Strategic Plan 2016 – 2021.

GRZ: Ministry of Health. (2016). Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection.

GRZ: Ministry of Health. (2016). National Operational Plan for the Scale-Up of Voluntary Medical Male Circumcision of Voluntary Medical Male Circumcision (VMMC) in Zambia (2016-2020) (VMMC) in Zambia (2016-2020).

GRZ: Ministry of Health. (2015). Community Comprehensive Childhood and Adolescent HIV Care: Facilitator's Guide.

GRZ: Ministry of Health. (2015). Community Comprehensive Childhood and Adolescent HIV Care: Participant's Handbook.

GRZ: Ministry of Health. (2015). Community Comprehensive Childhood and Adolescent HIV Care: Reference Manual. November, 2015.

GRZ, Ministry of Health. (2015). National Guidelines for SRH, HIV and GBV Services Integration.

GRZ. (2015). National guidelines for SRH, HIV and GBV service integration

Iliffe, J. 2006. The African AIDS Epidemic: A History. Athens: Ohio University Press.

National AIDS Council. (2017). National AIDS Strategic Framework 2017 – 2021

National AIDS Council. (2014). Revised National AIDS Strategic Framework 2014 to 2016

National AIDS Council. (2010). National AIDS Strategic Framework 2017 – 2021

Simbaya J. and Moyer E. (2013): The emergence and evolution of HIV counselling in Zambia: a 25-year history, Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, DOI:10.1080/13691058.2013.794477

UNAIDS. (2016). Global AIDS Monitoring 2017. Indicators for Monitoring the 2016 United Nations Political Declaration on HIV and AIDS

UNAIDS. (2016). Global AIDS Update 2016.

UNAIDS. (2016). HPV, HIV and Cervical Cancer: Leveraging Synergies to Save Women's Lives.

UNAIDS. (2016). Global AIDS Monitoring 2017. *Indicators for monitoring the 2016 United Nations political declaration on HIV and AIDS. Geneva*

UNAIDS. (2006). Setting National Targets for Moving Towards Universal Access

USAID. (1996). Performance Monitoring and Evaluation TIPS: Establishing Performance Targets, Number 8.

USAID. (2012). Target Setting of HIV Services.

WHO. (2015). Tool to Set and Monitor Targets for HIV Prevention, Diagnosis, Treatment and Care for Key Populations: Supplement to The 2014 Consolidated Guidelines For HIV Prevention, Diagnosis, Treatment And Care For Key Populations

WHO. (2012). A Comprehensive Global Monitoring Framework Including Indicators and a Set of Voluntary Global Targets for the Prevention and Control of Non-communicable Diseases. Second WHO Discussion Paper, 2012, March 22.

WHO/UNODC/UNAIDS. (2009). WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

WHO. (2009). WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.

Appendix

10 High Level Meeting (HLM) 2016 Commitment on HIV/AIDS

1. Ensure that 30 Million people have access to treatment through meeting the 90-90-90 (90% of PLHIV (children, adolescents and adults) know their status; 90% PLHIV who know their status are receiving treatment; 90% of people on treatment have suppressed viral loads) targets by 2020.

2. Eliminate new infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018.

3. Combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.

4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

5. 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020.

6. 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

7. At least 30% of all service delivery is community led by 2020.

8. HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention.

9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of Justice.

10. Taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for Tuberculosis, cervical cancer and hepatitis B and C.

The HIV Prevention Roadmap was developed and printed with the technical and financial assistance from UNAIDS.