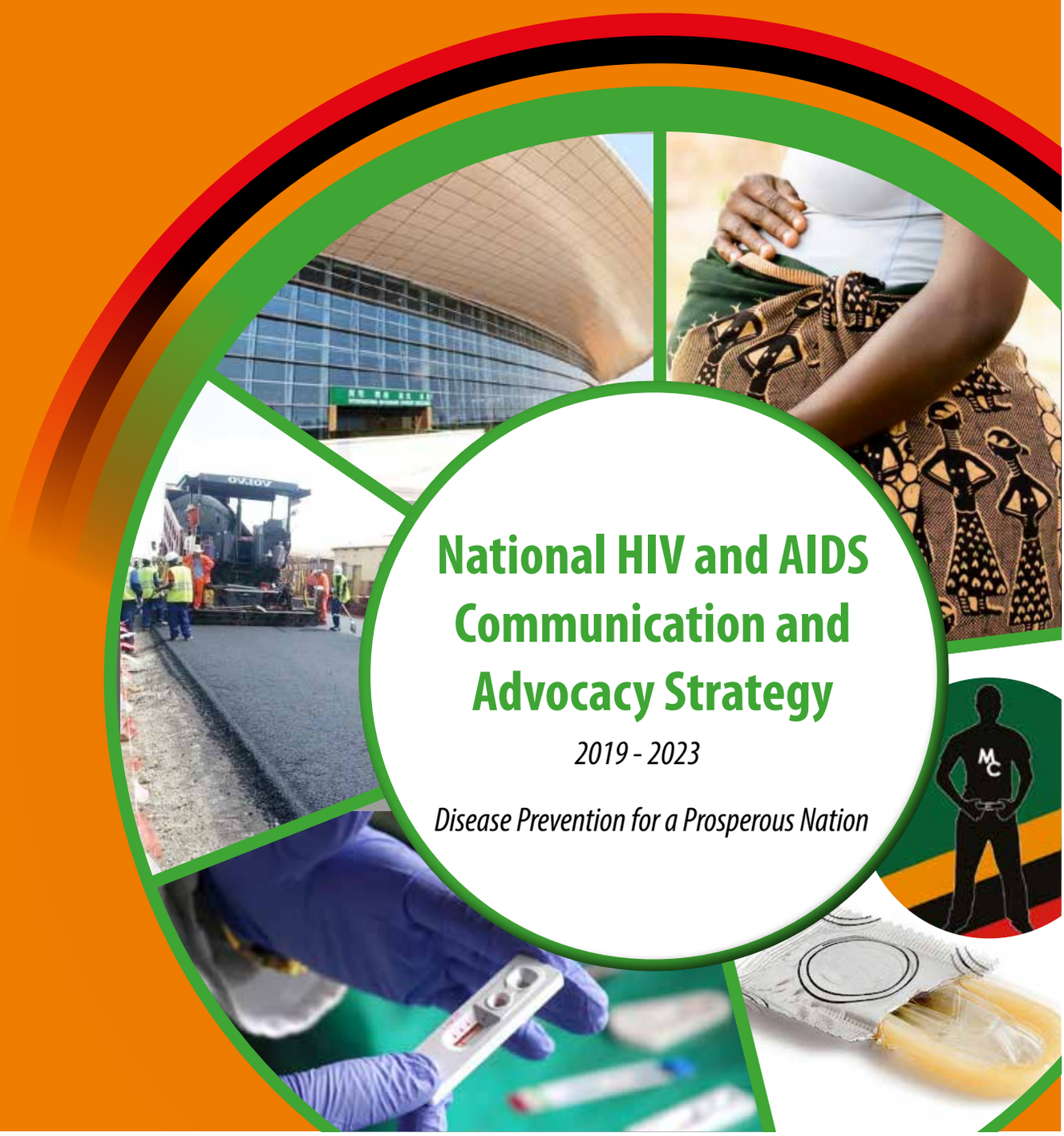
Republic of Zambia



National HIV and AIDS Communication and Advocacy Strategy

2019 - 2023

Disease Prevention for a Prosperous Nation

National HIV and AIDS Communication and Advocacy Strategy

Disease Prevention for a Prosperous Nation

2019 - 2022

CONTENTS

FOREWORD

The Government of the Republic of Zambia has embarked on an all-inclusive health delivery programme under the banner of Universal Health Coverage premised on empirical evidence that a healthy population is **sine qua non** for economic growth. Investment in health has been prioritized with a strong focus on health promotion, disease prevention and robust curative measures.

On the HIV and AIDS front, the Ministry of Health through the National HIV/ AIDS/STI/TB Council (NAC) has developed a multi-sectoral National HIV and AIDS Strategic Framework (NASF) 2017-2021 to guide the country on the execution of high impact interventions with correspondingly high health outcomes across the continuum of HIV prevention, treatment, care and support. The NASF clearly identifies key intervention areas and appropriate strategies to achieve intended results of attaining epidemic control and ultimately ending AIDS as a public health threat by 2030 with the UNAIDS 90-90-90 targets providing a framework for programming.

Other than identifying high impact interventions, the NASF goes a step further to segment population groups which are differently affected by the HIV epidemic and therefore requiring unique ways to respond to the needs of each of these sub populations. Although Zambia has a mature and generalized epidemic, its impact is not uniform across all demographic divide.

The development of this National HIV and AIDS Communication and Advocacy Strategy (NACAS) is borne purely out of the realization of the need to target different sub populations with the most appropriate Social and Behavior Change Communication (SBCC) materials according to needs. Each sub group is faced with its own set of unique barriers which might be an impediment to the adoption of behaviors that reduce risks of HIV infection and improve adherence to treatment on the part of those living with the virus.

This document is intended to help implementing partners design social and behavior change programmes especially on comprehensive HIV prevention with a full knowledge of the characteristics of their target audiences for maximum results and a guarantee of value for money. The NACAS is a useful resource which will help partners appreciate the social conditions, institutional and policy issues that may be shaping the behaviors of their target audiences.

Equipped with this knowledge, it should be less challenging for programme implementers to design social and behavior change communication activities with clear, age appropriate and social compliant messages for service demand creation. The NACAS clearly demonstrates the importance of targeted communication as a catalyst for programme success. No matter how elaborately thought out a programme is, it is doomed to fail if it is not complemented by a target centered social and behavior change communication effort. I am pleased to recommend this document to all players in the HIV and AIDS sector.

Dr Chitalu Chilufya
MINISTER OF HEALTH, MP

ACKNOWLEDGEMENTS

The National HIV/AIDS/STI/TB Council (NAC) is pleased to have successfully facilitated the development of this National HIV and AIDS Communication and Advocacy Strategy (NACAS) through a countrywide consultative process in order to secure full stakeholder ownership. Prior to the field situation analysis which covered seven out of the 10 provinces of Zambia, multiple sources of both primary and secondary information were utilized during the desk review to give the NACAS high quality and topical content.

Some of the main reference documents used were the 2017-2021 National Health Strategic Framework, the National HIV and AIDS Strategic Framework 2017-2021 and the National HIV and AIDS Communication and Advocacy Strategy 2011-2015.

The third level of national consultation in the development process of this document involved the participation of key stakeholders drawn from all the 10 provinces to collectively review a draft NACAS. During the national strategy review meeting held in Lusaka, the three provinces of Northern, Muchinga and Eastern which were not covered in the field situation analysis were given an opportunity to input into the data collection process.

NAC is indebted to many players for their critical roles in the successful completion of this document. These include the Ministry of Health for its leadership both at the central and provincial levels as well as NAC's sub national coordination structures and their membership which include civil society organizations. A full list of those who participated in the process can be found in Annex 2.

I pay special tribute to Breakthrough ACTION for rendering technical and financial support to the entire process of developing this document.

Dr Victor Mukonka
DIRECTOR GENERAL
NATIONAL HIV/AIDS/STI/TB COUNCIL

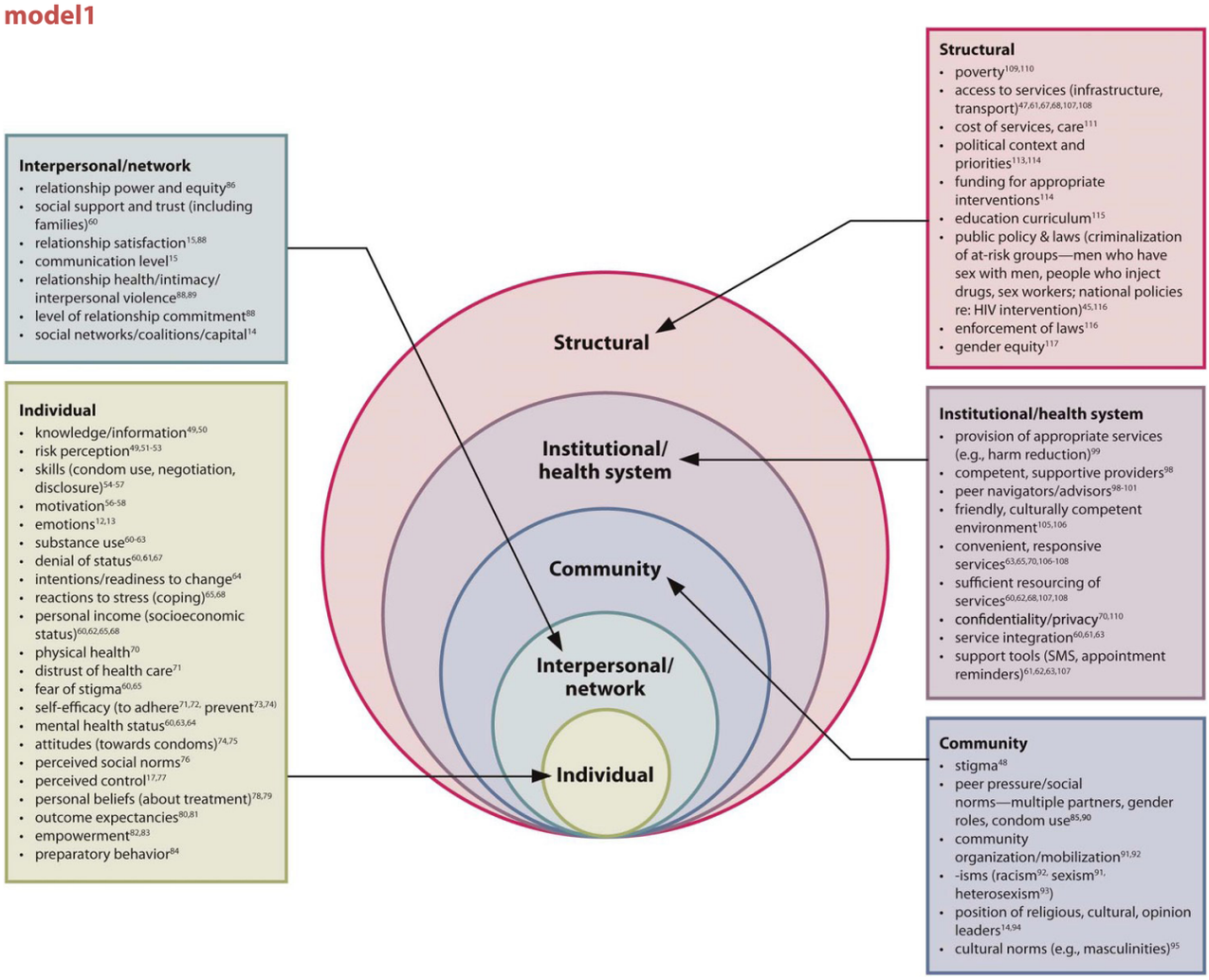
ACRONYMS

AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
eMTCT	Elimination of Mother-to-Child Transmission
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender-Based Violence
HTS	HIV Testing Services
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MTCT	Mother-to-Child Transmission
NAC	National HIV/AIDS/STI/TB Council
NASF	National AIDS Strategic Framework
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZAMPHIA	Zambia Population-Based HIV Impact Assessment

INTRODUCTION

The Zambia National HIV and AIDS Communication and Advocacy Strategy is designed to engage all stakeholders involved in Zambia's HIV response. The strategy identifies how social and behavior change communication (SBCC) may be most effectively used to increase HIV-related health-seeking behaviors through a variety of approaches that are appropriate within the Zambian context and considered to have high impact. Although Zambia has experienced great success in addressing its HIV epidemic, challenges remain in reaching targets across both the prevention and treatment continuum. Figure 1 provides an overview of the diverse influences relating to HIV to consider when developing social and behavior change (SBC) approaches. It is well understood that responding to HIV involves a complex set of behaviors influenced from multiple levels. By considering such influences, programmes may have greater impact and truly influence behavior.

Figure 1. Factors influencing HIV-related behavior and/or behavior change across the socioecological model1

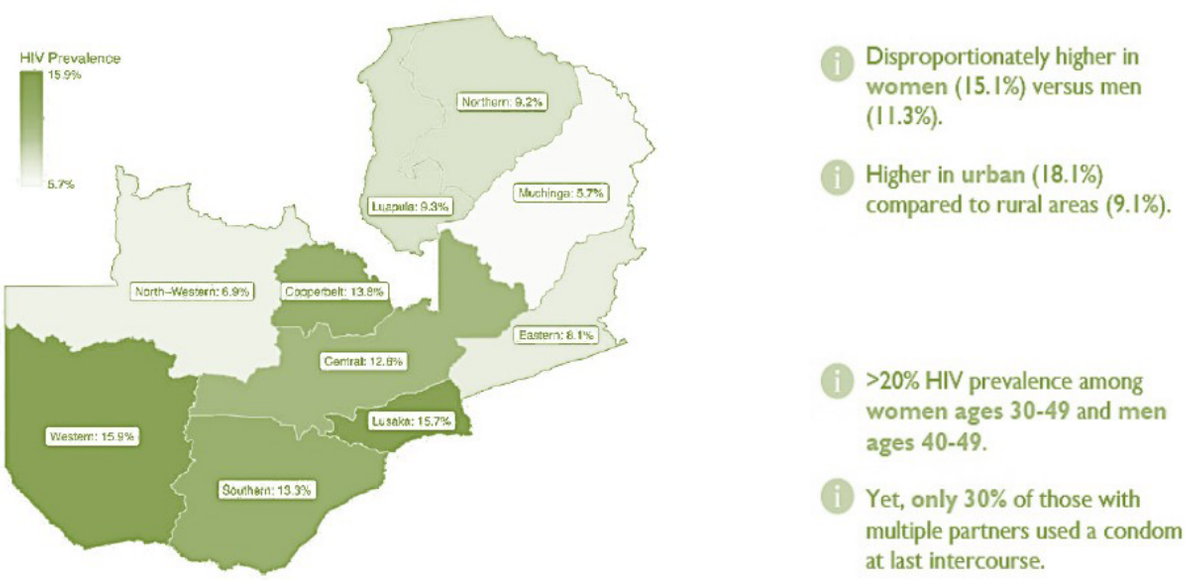


SBCC can be used to address barriers and create health-seeking behaviour on the demand side and to improve the quality of in-service counselling on the supply side. In the context of HIV, communication can motivate people to use condoms, seek voluntary medical male circumcision (VMMC), get tested for HIV, link people living with HIV (PLHIV) to care and treatment, support retention in care, and help reduce stigma. Research consistently shows evidence-based communication and advocacy programmes can produce changes in a wide range of HIV-related behaviours through a variety of ways, including increasing knowledge, improving self-advocacy, and shifting attitudes and cultural/gender norms. This strategy further articulates the specific ways in which communication and advocacy may be harnessed to improve HIV outcomes.

COUNTRY CONTEXT

According to the 2016 *Zambia Population-Based HIV Impact Assessment*, the annual incidence of HIV among adults ages 15 to 59 years was 0.61 percent (0.93 percent among females and 0.29 percent among males). This corresponded to roughly 43,000 new cases of HIV annually among adults ages 15 to 59 years in Zambia. HIV prevalence among adults in Zambia was 12.0 percent (14.6 percent among women and 9.3 percent among men), and there are approximately 961,000 PLHIV ages 15 to 59 years in Zambia. The prevalence of viral load suppression among adults ages 15 to 59 years living with HIV was 59.2 percent (60.4 percent among women and 57.2 percent among men). HIV prevalence among adults varied geographically, ranging from 5.7 percent in Muchinga Province to 15.9 percent in Western Province and 15.7 percent in Lusaka.[2]

Figure 2. HIV prevalence among adults aged 15-59 years, by province



Source: Zambia Population-Based HIV Impact Assessment (ZAMPHIA), 2016.

BACKGROUND

Through the National AIDS Strategic Framework (NASF) 2017–2021, the National HIV/AIDS/Sexually Transmitted Infection (STI)/Tuberculosis (TB) Council (NAC) has identified several factors influencing new HIV infections in Zambia: 1) intergenerational and transactional sex; 2) denial and marginalization of key populations and vulnerable groups; 3) stigma and discrimination; 3) marriage patterns and polygyny; 4) religious beliefs against antiretrovirals (ARVs) and condom use; 5) gender inequalities, including gender-based violence (GBV); 6) deepening poverty and food insecurity; 7) widespread abuse of alcohol and other substances; 8) poor enforcement of anti-discrimination laws; and 9) weak social and legal protection of vulnerable populations.[3]

The Joint Program of Support 2016–2021 by the United Nations Joint Team also highlights some of the major challenges that contribute to limiting access to health services in Zambia, including geographical barriers to service access, inadequate numbers of health workers, inadequate logistics management of drugs and medical supplies, inadequate electricity and Internet connectivity, poverty, and over reliance on external funding for HIV. In applying the Abuja Declaration, the national budget for health has decreased to 8.3 percent in the 2016 budget down from 9.6 percent in 2015.[4] These figures are far short of Zambia's commitment to allocate at least 15 percent of the national budget to health.

Laws, policies, and practices allowing for stigma, discrimination, and human rights violations are another challenge to the HIV response in Zambia and require intensified advocacy efforts to protect all persons, including vulnerable and key populations, from HIV. Although the 2005 National HIV/AIDS Policy espouses the protection and promotion of human rights and gender equality as guiding principles to the national response to HIV, these protections remain challenging to put into practice at times.[5] However, a number of policies, guidelines, and protocols are in place to shape the country's HIV response with a full list referenced in Appendix A. These policies not only lay out the priorities for the coming years, but also clearly the state the direction needed for a coordinated and decentralized response through the implementation of evidence-based programmes.

In addition to this background context, Zambia has made great strides in its HIV response and has delivered on many of the commitments outlined in the NASF 2011–2015 and is making progress towards the goals outlined in the current NASF 2017–2021. This strategy builds on the *National HIV and AIDS Communication and Advocacy Strategy* (2011–2015) and serves as a guide for stakeholders towards implementing a coordinated and effective national response to HIV.

STRATEGY PURPOSE

This strategy provides a "roadmap" for stakeholders involved in the HIV response focused on SBC efforts and ensures that communication and advocacy activities and outputs are coordinated to achieve agreed-upon goals and objectives. It is based upon evidence and outlines priority audiences and evidence-based approaches for SBC programmes, among other strategic design elements. The communication strategy is not a static product and must be responsive to an ever-changing environment. Adaptations may be necessary to respond to new research findings and data, unexpected events, changing priorities, or unforeseen results.

DEVELOPMENT PROCESS

This strategy was developed through a consultative and participatory process with stakeholders involved in the HIV response. The strategy is informed by existing evidence obtained from a literature review of documents, reports, and proven best practices from Zambia and other countries. Documents reviewed included national strategies, policies, implementation guidelines, reports, regional and global position documents, and peer reviewed literature. This desk review was then further complemented by extensive consultations with key informants through one-to-one interviews, focus group discussions (conducted by the NAC with key provincial and district stakeholders). Consultations were held in seven provinces (Southern, Western, Northwestern, Luapula, Copperbelt, Central, and Lusaka) and seven districts (Choma, Mongu, Solwezi, Mansa, Ndola, Kabwe, and Lusaka) on April 8–24, 2019. After the district and provincial discussions, a workshop was held with key national stakeholders in Lusaka on June 6–7, 2019, to further develop the strategy and make any final changes as needed.

GUIDING PRINCIPLES

- Results oriented and evidence based: The effectiveness of a communication effort should be ultimately determined by the health outcomes with activities and approaches built on empirical data and theories that improve service uptake and promote positive supportive norms.
- Client centered: Audiences for the interventions should be involved in co-design and participate in the process of shaping activities and messages to address their needs.
- Technical quality: Communication activities and products should be of the highest possible quality.
- Multi-channeled: A multi-channel approach should be used to enhance the effectiveness of communication and reach to the relevant audiences through multiple, appropriate ways to reinforce the behavioral objectives outlined throughout this document.
- Scalable: Effective communication initiatives and activities should be adapted as needed and expanded to reach the highest number of people to maximize reach and impact.
- Gender transformative and culturally sensitive: Communication interventions should be gender and culturally sensitive at all times with the goal of truly transforming gender norms to be more equitable.
- Cost effective: Communication resources should be focused towards the most effective approaches to maximize efficiencies and reach.
- Segmented by audience: Interventions should be highly focused and tailored to each audience segment as defined in this communication strategy.
- Government led: All SBCC implementing partners will work under the direction and guidance of the Ministry of Health (MOH) and NAC to ensure seamless coordination and minimize any duplication waste of resources.
- Equitable: Innovation and contextualized communication channels will be used to reach the hard- to reach and vulnerable communities.
- Mutual accountability: National government, service providers, funding agencies, and intended beneficiaries will share responsibility to monitor implementation progress including financial management and agreed commitments.

INTENDED USERS

This framework may be used by a variety of international, national, and subnational actors:

- Health communication experts, including those in the NAC, MOH health promotion units, nongovernmental organizations (NGOs), etc.: To adapt messages to the local context and design communication strategies to include messaging in existing or new activities
- Managers in MOH HIV units: To ensure that messages are effectively integrated at various points in the health system, as appropriate, such as pre-service or in-service training, service delivery, and SBCC programmes
- Civil society advocates, such as groups representing PLHIV: To guide local advocacy on HIV and ensure that the communities they serve are informed and aware of the latest evidence and programmes to improve their health and wellbeing
- Donors/international NGOs: To support countries in operationalizing the evidence through strategic SBCC approaches

STRATEGY COMPONENTS

A. Situation Analysis

The situation analysis focuses on gaining a deeper understanding of HIV in Zambia. The analysis includes learning about those affected and their perceived needs, understanding social and cultural norms that may affect the HIV response, identifying communication resources and existing capacity, and identifying potential barriers and facilitators for individual and collective change. It is based on available country-level research data and evidence and examines the social and behavioural drivers that facilitate or act as barriers to uptake of desired behaviour(s).

B. Key Audiences

Clarifying the key audiences through segmentation determines the specific population groups or subsets on which to focus when addressing the selected behavioral challenge. Audience segmentation ensures activities are tailored to be as effective and appropriate as possible for relevant audiences and that communication interventions are highly customized according to that audience's needs.

C. Social and Behavioral Objectives

Communication objectives are measurable statements that describe the specific changes to norms, policies, or behaviors that will be achieved as a result of the communication activities. Objectives answer the question, "What will this program accomplish?"

D. Key Benefits and Supporting Points

Positioning creates a distinct impression of a product, service, or behavior in the client's mind that is most compelling. Positioning provides direction for developing messages and helps determine the best

communication channels. It also helps ensure that all program outputs and activities use a consistent voice and reinforce each other for a cumulative effect.

E. Strategic Approaches

Strategic approaches describe how the objectives will be achieved, guide the development and implementation of activities, and determine the vehicles, tools, and channel mix used. A mix of approaches with mutually reinforcing messages is recommended. Approaches and activities should be carefully selected based upon timeline, cost, ability to reach the intended audience, and creative considerations. Referring to findings from the situation analysis will help guide strategic approaches and selection of activities.

NATIONAL AIDS STRATEGIC FRAMEWORK 2017–2021 FOCUS AREAS

The NASF is driven by a long-term vision for "a nation free from the threat of HIV" and a mission to control the HIV epidemic "by integrating it into the national development agenda and scaling up prioritised actions that are rapid and responsive to the needs of the local community to be served." The NASF 2017–2021 aims to intensify a combination of HIV prevention interventions to reduce new HIV infections and achieve the Joint United Nations Programme on HIV/AIDS 90-90-90 targets.

Importantly, the NASF highlights SBCC as a key focal area and its importance in promoting and sustaining positive behaviours through a variety of innovative approaches at scale to address the determinants of HIV and support positive social and behavioural change through high-impact interventions. This strategy aims to outline those interventions and suggest an illustrative list of approaches to address specific behavioural objectives within each technical area.[6]

NASF SBCC Programme Strategies

- Mobilise general, key, and vulnerable populations that are underserved
- Advocate for change of policies and discriminatory laws
- Strengthen implementation of age appropriate comprehensive sexuality education and information for learners in school settings and out-of-school youth
- Design and implement appropriate SBCC approaches and gender-sensitive information, education, and communication materials
- Scale up age-appropriate messaging and services to ensure an adolescent and youth-friendly environment in HIV testing services (HTS), condom promotion and distribution, VMMC, and treatment adherence
- Strengthen capacity of service providers and increase efficiency for delivery of HIV prevention and care services
- Strengthen the capacity of peer educators, community health workers, and outreach workers to effectively deliver stigma-free prevention services and provide effective referral to services
- Strengthen engagement and influence faith- and community-based organization leadership; PLHIV, traditional, civic and political leaders in implementation of SBCC interventions

- Strengthen integrating SBCC in elimination of mother-to-child-transmission (eMTCT), HTS, VMMC, GBV, condoms, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis, family planning (FP), sexual and reproductive health (SRH), and stigma/discrimination reduction programmes
- Scale up tailor-made HIV and harm reduction messaging to key populations through peer mobilisation

STRATEGIC PRIORITIES BY TECHNICAL AREA

Elimination of Mother-to-Child Transmission of HIV

Situation Analysis and Behavioural Determinants

The Fast Track Strategy (2017–2021) and NASF articulate the country's goal of achieving the eMTCT, with the target of reducing mother-to-child transmission (MTCT) to less than one percent by 2021. At present, coverage of prevention of MTCT (PMTCT) services varies across provinces with some provinces obtaining relatively low coverage. Among pregnant women living with HIV, 83 percent were accessing treatment or prophylaxis to prevent transmission of HIV to their children and an estimated 8,900 children were newly infected with HIV due to MTCT.[7] The eMTCT technical working group continues to oversee implementation of eMTCT services within antenatal care (ANC) in line with the updated eMTCT and antiretroviral therapy (ART) scale-up plan.

Follow-up testing throughout pregnancy and the breastfeeding window remains a gap. Weak cohort monitoring systems are a limitation for tracking mother-baby pairs along the PMTCT cascade of care. There is poor 12-month retention with an increasing number of children infected during the breastfeeding period. Male involvement also remains limited, which impacts partner testing. Some women hide their status from their partners. Some women also deliver at home making it challenging to ensure the mother–baby pair are accessing the prevention tools available. A lack of confidentiality from health workers sometimes remains a challenge highlighting the need for improved counselling and a client-centred approach.[8,9,10,11]

eMTCT Behavioural Objective 1	
Behavioural Objective: To increase the proportion of women who attend ANC visits, are tested for HIV and know their status, deliver at a health facility, and return for HIV testing of their infants to ensure early infant diagnosis.	**Priority Audience:** Pregnant women and women of child bearing age
	Secondary Audience: Male partners of pregnant women, couples considering having children
	Communication Objective 1: To increase the levels of knowledge about the risk of HIV infection to babies during pregnancy, delivery, and breastfeeding, as well as the benefits of PMTCT approaches in protecting one's child from HIV acquisition **Communication Objective 2:** To mobilise and motivate women to use the PMTCT services available and to take the appropriate action to ensure they have healthy babies free of HIV

eMTCT Behavioural Objective 1	
	Key Benefit: Knowing your HIV status and attending ANC/PMTCT can provide a safe delivery for mothers and improve chances of having a healthy baby.
	Supporting Points: Seeking ANC services early and throughout pregnancy will help ensure your baby is free from HIV. By delivering at a facility, mothers can have safe deliveries with an increased chance of the baby born HIV free. Babies will also receive the necessary treatments. Returning for HIV testing will ensure that if your infant is positive, he or she may begin treatment immediately to maintain their health and wellbeing.
	Strategic Approaches: • Promote early ANC visits as soon as a woman knows she is pregnant to ensure HIV testing and treatment of HIV for all pregnant women to eliminate vertical transmission of HIV, during labour, and postpartum • Support HIV testing throughout the pregnancy and breastfeeding window per Zambia protocols • Expand and strengthen SRH services for adolescents and young women, including early ANC visits • Develop training curricula as needed focused on interpersonal communication and counselling by lay counsellors, mentor mothers, and other community-based supporters to encourage retention in PMTCT programmes and support mothers and their HIV-exposed infants after delivery to ensure the babies remain free of HIV • Engage communities of women living with HIV to provide support to one another while pregnant and post-delivery • Support mothers through ongoing counselling and mentor mother programmes to support their adherence and viral suppression to limit potential infection throughout and particularly during the breastfeeding period

eMTCT Behavioural Objective 2	
Behavioural Objective: To increase the number of male partners supporting their pregnant partners in the use ANC/PMTCT services.	**Priority Audience:** Male partners of pregnant women
	Secondary Audience: Pregnant women and women of child bearing age and other family members
	Communication Objective 1: To increase the percentage of men who discuss HIV testing with their pregnant partners, get tested, take their female partner to ANC/PMTCT services and support their significant other to remain on treatment and practice safe infant feeding practices.

eMTCT Behavioural Objective 2	
	Key Benefit: Male participation in aspects of pregnancy and throughout the postpartum period can improve the overall health of the baby and mother.
	Supporting Points: Involvement of supportive male partners can result in smooth pregnancy, safe delivery, and healthy babies free of HIV. Knowing your status is best for you, your wife/partner, and the baby. You and your partner do not necessarily share the same HIV status. Partners who test positive are leading healthy productive lives.
	Strategic Approaches: • Promote men as partners and advocates for PMTCT • Aspirational approach showing positive future for their unborn child as a source of pride • Mobilise community to encourage male involvement in their partners PMTCT services • Create space for male partners in ANC sites to ensure they feel welcome • Sensitize providers on how to engage male partners when visiting facilities

eMTCT Behavioural Objective 3	
Behavioural Objective: To increase the proportion of health care providers who have the knowledge and skills to provide caring client-centred PMTCT services.	**Priority Audience:** Facility and community-based health care providers
	Secondary Audience: Other facility level staff
	Communication Objective 1: To improve awareness about the importance interpersonal communication (IPC) and counselling skills to increase trust and motivation on the part of clients to access ANC/PMTCT services. **Communication Objectives 2:** To increase the number of providers who understand the benefits of male involvement and encourage its practice during service delivery.
	Key Benefit: Good client relations and communication play a key role in increasing PMTCT outcomes and bring job satisfaction.
	Supporting Points: Service providers can make a big difference in the lives of pregnant women living with HIV who seek care for themselves and their babies. Committing to supporting pregnant women helps build rapport and trust from community members. Approaching male clients positively and with respect leads to their positive outlook on ANC/PMTCT services and encouragement for their female partners to attend. Women, and their partners, are encouraged to access

eMTCT Behavioural Objective 3	
	services when treated with care and can be easily discouraged at the slightest hint of hostility.
	Strategic Approaches: • Facilitating friendly services for women seeking ANC/PMTCT services by working to improve interpersonal communication skills of health care workers and ensuring privacy and confidentiality • Develop communication materials, such as job aids and client facing materials, so that facilities have and display SBCC materials and use them with clients • Have health workers may regularly facilitate and attend community meetings and events to serve as trusted resource people • Develop a program on interpersonal communication skills for health care workers that can be aired and shared (e.g., through a phone app as a source of distance learning and visual example of provider best practices) • Establish a system for feedback on client experiences and celebrate providers who consistently provide high quality services • Train clinical and other personnel supporting PMTCT activities (e.g., lay counsellors, mentor mother programmes) and services for HIV-exposed infants in interpersonal communication • Promote and scale up male involvement in eMTCT programmes by ensuring providers have the tools and appreciation for the benefits of welcoming men during service delivery

Voluntary Medical Male Circumcision

Situation Analysis and Behavioural Determinants

VMMC remains a critical HIV prevention intervention, and the World Health Organization (WHO) has recently reaffirmed its continued support. VMMC not only reduces the risk of HIV acquisition for men by around 60 percent but has benefits for their partners including a reduction in cervical cancer as well. The ***National Operational Plan for the Scale-Up of VMMC in Zambia*** (2016–2020) highlights annual targets and builds on existing momentum to reach a new ambitious target of 90 percent coverage of 10–49-year olds, with a focus on the core age groups of 15–29 with the goal of reaching 1,985,083 VMMCs by 2020. By the end of 2018, the national achievement was 1.3 million. Communication and demand creation remain essential in effectively reaching men at risk of HIV acquisition as articulated in the plan with periodic campaigns proving successful. Addressing key barriers to and motivators for adolescents and men seeking VMMC is necessary to understand the nuances of messaging to men that speak to their needs and concerns including fear of pain in advance of as well as during the service provision. Segmenting and targeting audiences can help to address myths and inadequate understanding of the benefits of circumcision. Several stakeholders report inadequate demand creation for VMMC through SBCC including engagement with communities, rural health committees, and religious and traditional leaders to champion VMMC. Further, a need remains to capitalize on satisfied VMMC clients as advocates for reaching other men to encourage service uptake. Zambia has already rolled out early

infant medical male circumcision but awareness remains low and deserves attention as part of the country's sustainability plan progresses.[12,13,14,15,16,17,18,19,20]

<table>
<tr><th colspan="2">VMMC Behavioural Objective 1</th></tr>
<tr><td rowspan="5">Behavioural Objective:

To increase VMMC services uptake among adolescents and men</td><td>Priority Audience: Youth and men ages 10–49, with a focus on ages 15–29</td></tr>
<tr><td>Secondary Audience: Parents of adolescent boys and female partners of youth/men</td></tr>
<tr><td>Communication Objective 1: To increase the number of youth and men who understand the benefits of VMMC and seek the service</td></tr>
<tr><td>Key Benefit: VMMC reduces the chances of contracting HIV by 60% for men.</td></tr>
<tr><td>Supporting Points: VMMC improves personal hygiene and enhances sex appeal. VMMC helps reduce the risk of cervical cancer in women. It is a one-time procedure. Using condoms correctly and consistently, reducing the number of sexual partners, and knowing your HIV status are the best ways to prevent HIV after circumcision. Complete healing of the wound is very important following VMMC. Sexual intercourse during the six-week healing period increases the risk of acquiring HIV.</td></tr>
<tr><td>Strategic Approaches:

• Targeted demand creation with both adolescent boys and men including individualized interpersonal communication approaches to address each man's specific concerns
• Proactively address men's fear of pain and lack of understanding about the procedure, including related to wound care and healing time through all demand generation efforts
• Ensure dedicated community mobilisers are in place to engage communities in creating awareness and understanding about VMMC and generate demand
• Ensure active referrals are in place and mobile appointment booking is done where possible to easily follow up with potential clients to ensure they seek the service
• VMMC campaigns including mass media, call-in programmes, promotion of the 999 Health Talk line, social media, SBCC materials
• Use local male champions and client testimonials from those who have undergone the procedure to advocate for others to do the same
• Support the training and provision of age-appropriate sexual risk reduction counselling among providers
• Provide consistently high-quality counselling and share messages widely that VMMC is effective but does not provide 100 percent protection for men to ensure a solid understanding that other preventive measures must still be taken</td></tr>
</table>

VMMC Behavioural Objective 1	
	• Engage women (as mothers, wives, and sexual partners) to support VMMC uptake • Ensure the quality of the group and individual pre-procedure counselling as well as post-procedure follow-up and ensure the messages provided are age appropriate and discuss the need for ongoing preventive behaviours • Ensure easy access to free condoms in all communities and facilities • Integrate VMMC with other health programmes, including noncommunicable diseases, men's clinics, and youth programmes to leverage resources for demand generation and maximize entry points for HIV prevention • Create and use innovations in demand generation approaches • Ensure close collaboration with the directorate of health promotions and social determinants overseeing VMMC communication and demand generation • Consider expanding demand generation to also include early infant male circumcision among pregnant women, their male partners, midwives, and providers as the program moves towards the maintenance phase

VMMC Behavioural Objective 2	
Behavioural Objective: To increase supportive norms for VMMC uptake and improve the enabling environment.	**Priority Audience:** Youth, men, women
	Secondary Audience: Community, religious bodies, and social influencers
	Communication Objective One: To create an environment that fosters widespread acceptance of VMMC by talking with sexual partners, friends, neighbours, and others in the community about the benefits of VMMC
	Key Benefit: VMMC has benefits for men and women and has been proven to be an extremely effective prevention method.
	Supporting Points: VMMC reduces your partner's risk of acquiring HIV by up to 60% and if your partner is circumcised, the risk of getting cervical cancer is reduced. Evidence suggests that women appreciate that circumcised men are cleaner and more hygienic. Using condoms correctly and consistently, reducing the number of sexual partners, and knowing your HIV status are the best ways to prevent HIV after circumcision. Complete healing of the wound is very important after VMMC. Sexual intercourse during the six-week healing period increases the risk of acquiring HIV.
	Strategic Approaches: • Promote VMMC as a highly effective culturally neutral HIV prevention approach • Position VMMC as a smart choice for young men who care about their future

VMMC Behavioural Objective 2	
	• Reach out to women as advocates and champions for VMMC with their sexual partners in supporting the procedure • Organize community meetings (town hall meetings, meetings with specific groups within the community) to explain and advocate for VMMC service uptake • Capitalize on local male champions and client testimonials from those who have undergone the procedure to advocate with others • Systematically integrate VMMC into discussions about health in communities • Disseminate consistently high-quality messages widely that VMMC is effective but does not provide 100 percent protection for men to ensure a solid understanding that other preventive measures must still be taken • Ensure easy access to free condoms in all communities and facilities to support prevention among men even after VMMC • Involvement of gatekeepers at the community level to encourage VMMC uptake and encourage them to be champions for the service. • Use mass media to reach a wide audience (TV, community radio, social media, drama performances, etc.) should be targeted through advocacy with leadership particularly to provinces resistant to VMMC as a special emphasis • Support VMMC within traditionally circumcising communities to partner with them during their initiation ceremonies to incorporate medical circumcision

VMMC Behavioural Objective 3	
Behavioural Objective: To increase the proportion of adolescents and men who practice consistent preventive behaviours post-VMMC.	**Priority Audience:** Youth and men ages 10–49 with a focus on ages 15–29
	Secondary Audience: Female sexual partners, parents/guardians/family members of VMMC clients
	Communication Objective One: To encourage men who have recently been circumcised to abstain from sex and masturbation for six weeks until healing is complete **Communication Objective Two:** To increase safer sexual practices post-VMMC including consistent condom use
	Key Benefit: VMMC is not 100 percent effective in reducing the risk of acquiring HIV so with regular condom use and other preventive measures, a man can remain free from HIV.
	Supporting Points: Using condoms correctly and consistently, reducing the number of sexual partners, and knowing your HIV status are the best ways to prevent HIV after circumcision. Complete healing of the wound is very important after VMMC.

VMMC Behavioural Objective 3	
	Sexual intercourse during the six-week healing period increases the risk of acquiring HIV.
	Strategic Approaches: • Provide consistently high-quality counselling and share messages widely that VMMC is effective but does not provide 100 percent protection for men to ensure a solid understanding that other preventive measures must still be taken • Encourage providers to re-emphasize the prevention messages within all counselling including practicing abstinence during the wound healing period and using condoms as an essential prevention method post-circumcision • Engage women (as mothers, wives, and sexual partners) to ensure that ongoing prevention and condom use continues after VMMC • Ensure the quality of the group and individual pre-procedure counselling as well as post-procedure follow-up and ensure the messages provided are age appropriate and discuss the need for ongoing preventive behaviours • Ensure easy access to free condoms in all communities and facilities both immediately after the procedure as well as at the follow-up visit

Prevention Among Youth

Situation Analysis and Behavioural Determinants

Adolescent girls and young women remain at highest risk of infection and must be a primary target for prevention activities. Despite the number of new HIV infections substantially declining overall, HIV prevalence among 20- to 24-year-olds remains four times as high among young women (8.3 percent) than young men (2.0 percent). HIV incidence among those 15–24 years of age in Zambia was 0.57 percent (0.08 percent among young men and 1.07 percent among young women). According to the NAC Fast Track Strategy, adolescents comprise 23 percent of the Zambian population and have some of the lowest knowledge of ways to prevent HIV and protect themselves in addition to low risk perception. Although the legal age for sex in Zambia is 16, the *Zambia Demographic and Health Survey 2013–14* revealed that among the general population age 25–49, 13 percent of women and 11 percent of men had first sexual intercourse by age 15. By age 18, 58 percent of young women have had sex.[21,22,23,24,25]

Intergenerational and transactional relationships are common among adolescent girls for the economic benefits afforded by older men. Young women aged 15–24 with intimate partners more than five years their senior are at greater risk for HIV than their counterparts with age-comparable partners. In poor areas, parents and family members of female children are said to promote transactional sex or early marriage to older men. GBV furthers the spread of HIV by limiting women's ability to negotiate safe sexual practices, disclose their status, and access services because of fear of reprisal. Inadequate availability of victim support centres and youth-friendly victim/witness offices to facilitate arrests, where appropriate, and to monitor and follow up on complaints of sexual violence against young women remain a challenge.[26,27]

HIV disclosure among adolescents to their sexual partners is also reportedly low. According to one study, almost half of the adolescents (47 percent) informed partners about their HIV status and less than half (42 percent) knew if their partner had been tested.

Legal barriers, including the age of consent for those under 16 years old, limit access to HIV prevention services, such as condoms and HIV testing, as do restrictions on distributing condoms in schools. Less than half of youth (both women and men) aged 15–24 used a condom during their last sexual encounter. The MOH 2017 National Health Strategic Plan further highlighted key challenges for addressing adolescents and youth health:[28]

- Inadequate implementation of adolescent health strategies at lower levels
- Inadequate knowledge among adolescents of existing health services
- Inadequate knowledge among health care workers of key adolescent health issues
- Inadequate HIV/SRH outreach services for adolescents
- Lack of adolescent health-specific indicators in the current health management information system related to HIV

This reality creates many other challenges for helping protect those adolescent and youth most vulnerable to infection.[29,30,31,32]

Adolescent and Youth Behavioural Objective 1	
Behavioural Objective: To increase the number of adolescents who protect themselves from HIV infection and who test positive for HIV and start and adhere to treatment	**Priority Audience:** Adolescent girls, young women, and young men aged 15–24
	Secondary Audience: Parents/caregivers, service providers, gatekeepers
	Communication Objective 1: To increase the knowledge and practice of using condoms consistently and correctly from the very first time you have sex **Communication Objective 2:** To increase the number of those who know their HIV status, insist on knowing the status of any sexual partners, and start treatment for those who test positive for HIV
	Key Benefit: Avoiding HIV infection or getting pregnant can keep your dreams on track and protect your future and that of your partner.
	Supporting Points: Condoms can protect against risk of infection and pregnancy. Adulthood is a big responsibility. Waiting to start sexual activity when you are confident and sure you know how to protect yourself and your partner, will help you avoid HIV, STIs, and unplanned pregnancies. Testing can tell you how to live your life going forward. If you are negative, you can take steps to stay that way. If you are positive, you can get ARV treatment immediately and continue to live your life to its fullest.
	Strategic Approaches: • Address individual, community, and structural factors that increase girls' HIV risk, including poverty, gender inequality, GBV, and a lack of education

Adolescent and Youth Behavioural Objective 1	
	• Conduct highly targeted interventions to identify those most vulnerable to HIV infection through the use of risk assessment tools • Support wellness days to specifically reach at-risk adolescent girls and young women (AGYW) with both HIV and FP services • Integrate adolescent SRH/HIV services into outpatient care • Focus on building sustainable individual protective assets such as self-esteem, problem-solving abilities, confidence, and social networks that support increased education and economic participation through small group interventions with AGYW. • Actively link AGYW to services and track completed referrals • Ensure condoms are widely available to youth for both prevention of pregnancy as well as HIV infection • Foster community level dialogue to identify and address norms that increase risk for HIV and violence among AGYW • Embed norms change and gender-related messaging into existing community-based HIV prevention programmes • Engage men and boys in community conversations about HIV and violence-related issues: gender norms, sexuality, relationships, joint decision-making, and alcohol use • Advocate for supportive national laws, policies, guidelines, and address community norms that may prevent AGYW from accessing condoms • Work closely with communities to create safe spaces for young people and build social assets among youth • Support violence prevention measures at both national and community level • Develop youth-focused programmes to screen for and respond to GBV in schools, clubs, clinics, and social services • Advocate for and support the roll-out of comprehensive youth sexuality education and other curriculum-based school and community interventions to prevent sexual violence • Support curriculum-based parenting skills building activities that emphasize the benefits of delayed sexual debut and the prevention of sexual violence • Support AGYW in the use of PrEP by encouraging its use and generating demand for it as another prevention method • Develop curricula and/or adapt existing training for service providers in adolescent-friendly violence screening and post-violence care

Condom Promotion

Situation Analysis and Behavioural Determinants

Comprehensive condom programming is highlighted in the NASF 2017-2021 as an important focal area in preventing new HIV and STI infections as well as unintended pregnancies, yet consistent condom use remains low. According to the ZAMPHIA, of those who reported having sex in the past 12 months with a non-marital, non-cohabitating partner, condom use at last intercourse was reported by only 37.6 percent for those aged 15-59. Expanding access while creating and sustaining user driven demand, targeted distribution and use of condoms among sexually active populations remains an impactful approach to ensure condoms are available, accessible, and attractive to users. Yet, according to the NAC Prevention Technical Working Group, there remains inefficient national, subnational, and community coordination mechanisms to implement a quality national strategy and operational plan for effective condom programming.[33,34,35,36]

Gaps remain related to condom sensitization, and accessibility is a challenge for adolescents. Social and cultural factors have also negatively impacted condom promotion in Zambia particularly in reaching young people and key populations. The Ministry of General Education does not allow distribution and demonstrations of condoms in primary and secondary schools. Condoms continue to be seen as taboo for families to discuss with many barriers remaining, including a lack of safe spaces for young people to freely access condoms without discrimination. Further, some faith groups lack an understanding of the role of condoms for discordant couples.[37,38]

In addition, the NAC highlighted weak logistical management of condoms leading to persistent stock-outs as a programmatic challenge of the national HIV response. Willingness to pay for condom studies in Zambia reveal that most Zambians (86.8 percent) use the least expensive condoms, two percent of users bought the most expensive brands most often, and 10 percent used mid-range brands costing between six and 10 Kwacha. These findings demonstrate that a total market approach is necessary to be efficient in providing a full range of products within the condom market including the commercial sector while also including free and socially marketed condoms for the lower end of the market. And finally, female condoms are not widely accepted nor promoted and yet remain an important prevention method.[39,40,41,42]

<table>
<tr><th colspan="2">Condom Use Behavioural Objective 1</th></tr>
<tr><td rowspan="3">Behavioural Objective:

To increase the percentage of sexually active individuals, including young people, who use condoms correctly and consistently</td><td>Priority Audience: All sexually active individuals regardless of age or sexual orientation</td></tr>
<tr><td>Secondary Audience: Sexual partners, communities at large</td></tr>
<tr><td>Communication Objective 1: To increase knowledge on correct and consistent use of both male and female condoms for the prevention of HIV, other STIs, and pregnancy

Communication Objective 2: To change perceptions and attitudes towards the acquisition and use of condoms so that their use is free of judgement and stigma</td></tr>
</table>

Condom Use Behavioural Objective 1	
	Key Benefit: If used correctly and consistently, condoms will protect you from HIV, STIs, and unintended pregnancies.
	Supporting Points: Condoms provide over 90 percent protection from HIV infection and other STIs and pregnancies when used correctly and consistently.
	Strategic Approaches: • Focus activities on removing social, behavioural, and structural barriers to use while also promoting condom use as a doable action free of stigma • Use multimedia channels (posters, brochures, mobile visual-units, interpersonal communication, TV/radio discussions, drama, live performances, Facebook/Twitter, SMS, etc.) • Develop alternative, less technical, and more encouraging promotion messages that are well understood by users • Include condom promotion as part of comprehensive youth sexuality education in schools and ensure condom promotion and provision is a key component of all adolescent-friendly SRH services • Support provision of condoms to key populations through peer outreach, small-group evidence-based prevention activities and in hot-spots • Support a total market approach including coordination, increasing coverage and availability, improving equity of access, and promotional activities across each market segment • Use peer role models and social media influencers to talk to young people about protecting themselves today for a brighter tomorrow, choices they made/wish they made • Strengthen program monitoring and evaluation (M&E) and ensure consistent condom supplies

Condom Use Behavioural Objective 2	
Behavioural Objective: To increase the supportive norms, enabling environment and political will to encourage condom use for all who choose to use them	**Priority Audience:** Policy makers and opinion leaders (community leaders, religious leaders, leaders in education, and civic leaders)
	Secondary Audience: Communities and families
	Communication Objective 1: To advocate for wider availability and acceptability of both male and female condoms across the country for those who are sexually active regardless of age. **Communication Objective 2**: To create awareness and increase the knowledge of religious/influential leaders on the importance of condom use to enable them to advocate for broader condom promotion

Condom Use Behavioural Objective 2	
	Key Benefit: Increased use of condoms will minimize new infections, reinfection, and unintended pregnancies while also reducing the impact and costs of the HIV epidemic to the country and within communities.
	Supporting Points: Condoms provide over 90% protection from HIV infection and other STIs and pregnancies when used correctly and consistently and are a low-cost intervention. Studies have demonstrated clearly that condoms do not promote promiscuity.
	Strategic Approaches: • Economic arguments on loss of productivity when youth become parents too early • Activities should be focused on removing social, behavioural and structural barriers to use through both high-level advocacy efforts at the national level as well as at the district and community level. • Strengthen advocacy with policy makers and opinion leaders while also engaging the media and creating a more supportive normative environment for condom use across all segments of the population. • Develop briefs tailored to policy maker's specific interests to create more acceptance for condom use for all and identify allies to further strengthen advocacy efforts. • Interpersonal approaches and one-to-one communication with key leaders to discuss this potentially sensitive topic. • Capacity building to provide sensitization training on the benefits of condoms as part of a wider prevention package inclusive of SBCC materials

Pre-Exposure Prophylaxis

Situation Analysis and Behavioural Determinants

PrEP is highly effective at reducing the risk of HIV infection among numerous populations, and WHO guidelines recommend offering oral PrEP to those who are HIV negative and at substantial risk of HIV infection. The National Health Strategic Plan (2017–2021) and the NASF 2017–2021 recognise the need for providing PrEP to priority populations including discordant couples and sex workers. Pregnant and breastfeeding women in high HIV-prevalence settings also are at substantially high risk for HIV acquisition. WHO guidelines recommend using PrEP as part of a package of comprehensive prevention services that includes risk reduction education and counselling, condom promotion, VMMC, and structural interventions to reduce vulnerability to HIV infection.[43,44,45,46,47,48,49,50]

PrEP is integrated in the comprehensive HIV Treatment National Guidelines, and the Government of Zambia supports the implementation of non-discriminatory sensitisation programmes for targeted populations and

health workers on PrEP. Given that PrEP is relatively new in Zambia and not yet offered at scale, myths about it remain as do some concerns that it may contribute to an increase in STIs due to limited condom use. Limited training among health workers, stigma, and discrimination make it difficult for key populations to freely access PrEP.[51]

<table>
<tr><th colspan="2">PrEP Behavioural Objective 1</th></tr>
<tr><td rowspan="5">Behavioural Objective:

To increase demand and use of PrEP among HIV negative individuals most at risk</td><td>Priority Audience: Serodiscordant couples, pregnant and breastfeeding women, sexually active AGYW living in areas of high HIV incidence, sex workers, and other high-risk individuals such as men in multiple concurrent partnerships</td></tr>
<tr><td>Secondary Audience: Health care providers (particularly those providing FP, ANC, and youth-focused services), and sexual partners</td></tr>
<tr><td>Communication Objective 1: To increase knowledge about PrEP and its benefits

Communication Objective 2: To create awareness and a positive perception about the availability of PrEP services</td></tr>
<tr><td>Key Benefit: PrEP is a highly effective intervention used by HIV-negative individuals who are at substantial risk of acquiring HIV.</td></tr>
<tr><td>Supporting Points: If used consistently as prescribed, PrEP reduces HIV infection and leads to healthy communities. PrEP does not protect against other STIs and pregnancy and should be used with other prevention strategies. PrEP can fit discreetly in your life.</td></tr>
<tr><td>Strategic Approaches:

• Support awareness-building and demand-creation efforts including the use of radio, television, social media, and other SBCC channels to reach communities with oral PrEP messages
• Focus on reaching women where they access FP and other services to introduce PrEP
• Support interpersonal communication approaches through community mobilisers and peer-to-peer interventions given their effectiveness in PrEP initiation for AGYW
• Incorporate information on PrEP into SRH curricula for AGYW
• Provide support for ongoing adherence and client-centred counselling and link daily medication use with a daily habit (such as waking up, going to sleep, or a regular meal) to help clients develop pill taking strategies that work for each individual's daily life
• Build capacity of health care providers and community health volunteers, including sensitization and training to provide quality counselling to at-risk individuals, and help those who have discontinued PrEP to jointly determine if they are still at risk and return to use as needed
• Reinforce adherence through innovative approaches</td></tr>
</table>

PrEP Behavioural Objective 1	
	• Support community support groups and ensure their availability to reinforce adherence for people on PrEP • Support group content and SBCC materials should address counselling messages related to what to expect when starting PrEP including possible side effects, how to deal with stigma, and how to manage taking a daily pill to minimize drop off during the first few months in particular while ensuring easy access to staff and support • Use several media channels including social media to further support PrEP users and may be helpful for peer-to-peer sharing of experience and challenges • Actively engage men who act as "gatekeepers" for women considering starting oral PrEP • Support technical working groups for the continued roll-out of PrEP • Prioritize sex workers as a unique audience for PrEP (see key population section below)

Sexually Transmitted Infections

Situation Analysis and Behavioural Determinants

STIs increase susceptibility to HIV infection. Complications due to STIs can have a profound impact on SRH, particularly for women who are disproportionately affected. Zambia uses a syndromic management approach for STIs in accordance with WHO recommendations. This approach allows frontline health care providers to manage STI patients without laboratory-based diagnostics that are not always readily available. Overall, the prevalence of having ever been infected with syphilis among those aged 15–59 years was 6.8 percent (7.2 percent among women and 6.3 percent among men). The NASF 2017–2021 supports improved screening and management of STIs as an integral component of the HIV prevention strategy.[52,53,54]

STI Behavioural Objective 1	
Behavioural Objective: To increase the number of high-risk individuals and their sexual partners who are tested and treated for STIs	**Priority Audience:** High-risk sexually active adolescent girls, boys, women, and men
	Secondary Audience: Sexual partners, peers, traditional counsellors and service providers, traditional healers, and traditional leaders
	Communication Objective 1: To increase knowledge and understanding of the behaviours that put them at risk of STIs, STI symptoms, and encourage prompt care seeking
	Key Benefit: As somebody identified as high-risk for HIV infection, after testing and treating your STI, you can take care of yourself, and are less likely to pass it to

STI Behavioural Objective 1	
	others. STIs increase the chance of getting HIV so should be treated as soon as possible.
	Supporting Points: Free treatment is available at health facilities.
	Strategic Approaches: • Conduct targeted strategic SBC campaigns to improve knowledge, correct misconceptions and create demand for STI screening • Implement awareness campaigns on STI management to promote early treatment seeking behaviour, partner notification and referrals • Ensure that STI screening is integrated as part of other comprehensive prevention SBCC activities • Strengthen youth friendly services for integrated STI screening and management, HTS, condom promotion and distribution for adolescents • Roll out vaccination against human papillomavirus as part of a comprehensive approach to cervical cancer prevention, including health promotion, which targets adolescents • Use SBCC materials including print, tv, radio, posters, brochures, bumper stickers, murals, comic books, and the use of social media, and audio-visual billboards • Support high quality counselling and support from providers through training and SBCC materials to ensure non-stigmatizing and non-discriminatory service delivery • Ensure approaches are in place for contact tracing and offer treatment to sexual partners • Ensure comprehensive youth sexual health education is widely available in school curricula for adolescents and generate demand among school-going adolescents and youth for STI education, screening and treatment • Involve community-based organizations, traditional leaders, and peer networks in the planning and delivery of services • Engage with traditional healers and drug store owners to provide referrals to health facilities • Advocate for strengthened documentation of STIs in all service delivery points and for key populations

HIV Testing Services

Situation Analysis and Behavioural Determinants

The NASF has outlined some individual-level barriers to seeking HIV testing: low perceived risk, concerns of privacy and confidentiality at the health worker level, separate labelling of HIV services, perceived psychological burden of living with HIV, gender inequality undermining women's option and decision-making autonomy, and fear of stigma. Although Zambia has made great progress overall with testing those most at risk including more targeted testing and higher yields, many still shy away from testing due to fear, shame, and uncertainty that come with getting tested. These include fear of a positive result, fear of being rejected by partner/spouse and/or by parents/family, and fear of "being laughed at" within the community and thought of as untrustworthy, promiscuous, or "bad." According to the ZAMPHIA, 72.3 percent of those aged 15-59 years reported ever having tested for HIV and receiving their results. Targeted testing approaches including index testing to reach the highest yield have proven effective and will continue to be scaled up as outlined in the NASF 2017–2021. Index testing is an approach where the exposed contacts, including past or current sexual partners and biological children of PLHIV known as the index client, are offered HTS. This targeted testing approach has proven highly effective at identifying PLHIV and will continue to be a priority approach as noted in the NASF.[55,56]

Although progress has been made, structural challenges remain in ensuring adequate staff are available to implement index testing. The Prevention Technical Working Group has identified the need for more community-level promotional activities and several districts have noted the need for additional community-based counsellors to support greater testing uptake of those most at risk. Concerns also exist to address the amount of over testing, both at the community level and through provider-initiated testing and counselling within facilities. Linkages to care remain a gap with calls for more coordination in ensuring that those who test positive are initiated on treatment immediately.[57, 58,59,60]

Self-testing is a relatively recent testing modality in Zambia. As a result, there is inadequate information on where to access and how to use a self-test kit and, if found positive, inadequate understanding about the need for a confirmatory test and how best to link to care remains a challenge. Self-testing using several different models can reach a high proportion of men, youth, and first-time testers, some of whom may have not tested otherwise, as has been proven in Zambia. Studies have proven that linkage to care can be successfully ensured following a self-test conducted outside facilities though challenges remain in Zambia.[61,62,63,64]

Provider-Initiated Testing and Counselling Behavioural Objective 1	
Behavioural Objective: To increase the number of PLHIV who are tested and know their HIV status	**Priority Audience:** High-risk sexually active adolescent girls, young women, and men as well as those who present with signs or symptoms suggestive of HIV
	Secondary Audience: others at high risk for HIV
	Communication Objective 1: To increase providers ability to identify and counsel clients so they understand of the benefits of testing and treatment to encourage uptake
	Key Benefit: When somebody is identified as at high-risk for HIV infection, after they test and know their HIV status, treatment is available and effective for those

Provider-Initiated Testing and Counselling Behavioural Objective 1	
	who are HIV positive so they can take care of themselves and are less likely to pass the virus to others.
	Supporting Points: Knowing your HIV status can give you peace of mind. Free treatment is available that improves your health, prolongs your life, and greatly lowers your chance of spreading HIV to others.
	Strategic Approaches: • Build the capacity of providers to ensure high-quality counselling and in using screening tools to identify those most at risk for targeted testing • Development of interpersonal communication and counselling tools and job aids to support providers in providing high-quality interactions with clients • Refine testing environments to ensure they are free from stigma and welcoming to youth and men in particular • Design targeted strategic SBC campaigns to improve knowledge, correct misconceptions, build support, acceptance, and use of HTS services generally • Link PLHIV identified through testing efforts at the community level to treatment programmes for immediate initiation of ART • Support facility-based providers to link PLHIV identified through testing within facilities to immediate treatment initiation

Index Testing Behavioural Objective 2	
Behavioural Objective: To increase the number of sexual partners and biological children of PLHIV who are tested and know their HIV status	**Priority Audience:** Current or past sexual partners of PLHIV
	Secondary Audience: Biological children of PLHIV
	Communication Objective 1: To increase risk perceptions and encourage testing uptake
	Key Benefit: As somebody identified as high-risk for HIV infection, given your exposure, it is important to get tested so you can take care of yourself.
	Supporting Points: Knowing your HIV status can give you peace of mind. Free treatment is available that improves your health, prolongs your life, and greatly lowers your chance of spreading HIV to others.
	Strategic Approaches: • Scale up best practices in effective community index testing • Link PLHIV identified through testing efforts to treatment programmes for immediate initiation of ART • Sensitize health care workers to deliver rights-based, comprehensive HTS

Index Testing Behavioural Objective 2	
	• Use partner notification (active or passive) to identify potential HIV-positive cases quickly and efficiently • Strengthen the capacity of service providers in encouraging immediate treatment initiation after HIV testing • Engage communities in design and implementation of partner notification testing and involve community- and peer-led organizations in delivering technically competent, high-quality services • Develop job aids for providers when conducting index testing that meet WHO's 5C minimum standards, including consent, counselling, confidentiality, correct test results, and connection to HIV prevention, and HIV care and treatment

Community Testing Behavioural Objective 3	
Behavioural Objective: To increase the number of high-risk individuals who are tested and know their HIV status	**Priority Audience:** High-risk sexually active adolescent girls, young women, and men
	Secondary Audience: Others at high risk for HIV (adolescent boys and youth, men aged 25–49) and community-based volunteers
	Communication Objective 1: To increase knowledge on risky behaviours and understanding of the benefits of treatment to encourage testing uptake **Communication Objective 2:** To minimize stigma and discrimination to create a more supportive environment for HIV testing among those most at risk **Communication Objective 3:** To strengthen the knowledge and skills of community-based volunteers to screen and identify those most at risk at the community level
	Key Benefit: After testing and knowing your status, if positive, you can freely access treatment and are less likely to pass the virus to others. If negative, you can protect yourself.
	Supporting Points: Knowing your HIV status can give you peace of mind. Free treatment is available that improves your health, prolongs your life, and greatly lowers your chance of spreading HIV to others.
	Strategic Approaches: • Map hot spots to ensure targeted testing • Mobilise to support demand creation and identify those missing who may be unaware they are living with HIV; men in particular

Community Testing Behavioural Objective 3	
	• Scale up best practices that facilitate mobilisation and community-based testing in high-burden areas • Target strategic SBCC campaigns to improve knowledge, correct misconceptions, and build support, acceptance, and use of HTS • Use SBCC materials including print, tv, radio, posters, brochures, bumper stickers, murals, comic books, billboards, and the use of social media. • Link PLHIV identified through testing efforts to treatment programmes for immediate initiation of ART • Ensure high-quality counselling and support from lay community counsellors and/or peer navigators to take clients to treatment sites • Apply and adapt risk assessment tools to reach the highest yield in community testing activities • Reduce stigma and support the development of supportive social norms through the design and implementation of community-level tools and work with opinion leaders • Design tools and approaches to improve risk perception and overcome fears, particularly among men ages 24–49

Self-Testing Behavioural Objective 4	
Behavioural Objective: To increase the number of high-risk individuals who use self-tests	**Priority Audience:** Sexually active adolescent girls, young women, and men
	Secondary Audience: others at high risk for HIV
	Communication Objective 1: To increase awareness of self-tests and the benefits of using a test discretely and confidentially **Communication Objective 2:** To ensure linkage to care and treatment if positive
	Key Benefit: You can take an HIV test discreetly and in a confidential setting of your choosing.
	Supporting Points: Knowing your HIV status can give you peace of mind. Free treatment is available that improves your health, prolongs your life, and greatly lowers your chance of spreading HIV to others.
	Strategic Approaches: • Provide self-testing and generate demand for this testing modality as well as ensuring linkage to confirmatory testing and treatment for those who test positive, and risk reduction for those who test negative. • Use community-based approaches to HIV self-testing through distributing self-testing kits to community members through volunteers or community health workers

Self-Testing Behavioural Objective 4	
	• Provide support to users before and after testing (e.g. demonstrations of the procedure, presence of peer support, telephone hotline, social media, mobile phone text messages) • Ensure linkages are made from HIV self-testing to further confirmatory testing and for linkages to care and treatment • Conduct home visits, phone calls, and SMS reminders to ensure linkage to care • Support the routine offer of voluntary assisted HIV partner notification services to delivering HTS • Promote couples and partner HIV testing, in particular offering HTS to the partners of people diagnosed with HIV through PMTCT programmes and the like • Develop and distribute brochures and flyers distributed together with HIV self-testing kits, containing information on HTS and HIV prevention, treatment and care, as well as information on TB and STIs • Explore use of vouchers, coupons, or rebates to facilitate linkage, particularly among populations facing structural barriers to accessing services, such as long distance and costly transportation • Develop and use appointment cards and referral slips for clients to facilitate linkage by including the day and time of an appointment or the name and phone number of a contact person and facility where services can be sought • Develop SBCC tools, including brochures and job aids, to raise awareness • Distribute self-test kits in workplaces to capture men • Promote self-test kits through social media as a channel for reaching key populations

HIV Treatment

Situation Analysis and Behavioural Determinants

The MOH *Consolidated Guidelines for Prevention and Treatment of HIV Infection* (2018) recommended implementation of differentiated services as a means of realizing client-centred HIV services across varied settings and circumstances. The country reached 80 percent of the target for clients newly initiated on treatment and has made significant progress in linking clients to treatment after diagnosis with roughly an 80 percent linkage rate in fiscal year 2018. In addition, Zambia has achieved 82 percent viral load suppression nationally though suppression rates differed greatly when comparing children (70 percent) and adults (84 percent). Current country goals are to reach the PEPFAR 95-95-95 targets. Viral load suppression has been particularly low among children, aged 0–14 years, and young adults, 15–24 years, reflecting a need for diagnosis and effective treatment among these age groups. Those lost to follow-up remain high with some going without ART for extended periods of time or completely disengaged from treatment. [65,66,67,68]

Barriers to ART initiation and adherence include transportation, food insecurity, and financial costs associated with the frequency of required visits and refill visits along with distance to testing and treatment facilities. Many

still fear HIV-status disclosure, which keeps them from seeking help from their social support network. Further, men are influenced by gender norms, including perceptions of being weak or non-masculine, that may discourage them from accessing and adhering to treatment and often assume their status based on their partners.[69]

Exposure to GBV, particularly intimate partner violence, is associated with lower ART use, lower ART adherence, and significantly lower rates of viral suppression among women. According to the ZAMPHIA, 7.0 percent of respondents aged 15–24 years experienced sexual or physical violence in the last 12 months, which was low compared to previous data on intimate partner violence in Zambia; intimate partner violence was likely under-reported in the survey. Norms that sanction violence against women and the control of women by male partners decreased the odds of ART use among PLHIV. The Ministry of Gender and Development has highlighted the need for community awareness campaigns to increase the knowledge of rights and available redress available while also noting the need for changing attitudes and behaviours associated with harmful gender norms. These norms have impact on treatment outcomes for both men and women. Given current gaps, for example, Zambia must scale up faster and find missing men, given that adult male ART coverage is at 62 percent according to President's Emergency Plan for AIDS Relief 2019 Country Operational Plan communication.[70,71,72,73]

Further, the paediatric program is struggling with case finding, poor yield, low early infant diagnosis coverage, and poor viral load suppression. Just over half of the children who were reported to be on treatment had suppressed viral loads, indicating a need for improved adherence, retention, and treatment monitoring. Improving the effectiveness of cohort tracking (using tools to track each child's health and development), ensuring availability and supply of preferred paediatric ARV formulations, implementing interventions to reduce loss-to-follow-up, promoting medication adherence, and monitoring routine viral load are among the interventions that are needed to promote paediatric adherence, retention and treatment.[74]

Adult Treatment Behavioural Objective 1	
Behavioural Objective: To increase the proportion of adults living with HIV who are on treatment and virally supressed	**Priority Audience:** Adults living with HIV
	Secondary Audience: Partners and other family members; health care providers
	Communication Objective 1: To increase knowledge and understanding that early treatment and ongoing adherence can lower the risk of HIV transmission to children and sexual partners while ensuring your own good health and ability to take care of yourself and your family **Communication Objective 2:** To increase the number of male clients who believe that seeking HIV services is a sign of strength and masculinity
	Key Benefit: Treatment helps one stay healthy, enabling one to live a long life and remain a productive contributor to one's family and society.
	Supporting Points: Knowing your HIV status can give you peace of mind. When you and your partner know each other's HIV status, you can make informed decisions about your sexual behaviours and how to stay safe. If you are pregnant or planning to get pregnant, knowing your status can help protect your baby from

Adult Treatment Behavioural Objective 1	
	becoming infected. Starting and staying on treatment is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on treatment, having routine testing of how much HIV is in your blood is important to make sure your ART is working; talk to your provider to ensure you receive a viral load test. A healthy adult on treatment has a lower risk of being sick often, which reduces stress and absenteeism from work. You should start ART even if you are feeling healthy. Taking ART according to provider's direction is very important to avoid defaulting. Support is available to help you stay on treatment. When your viral load remains undetectable, you have effectively no risk of transmitting HIV.
	Strategic Approaches: • Develop "test and start" campaign tools and materials • Develop tools to support peer navigators and treatment champions to encourage treatment readiness • Improve provider counselling to support a solid foundation for treatment initiation and ongoing adherence • Ensure focused content within counselling confirms understanding and acceptance that ART is for life to minimize those lost to follow up • Develop and use disclosure tools and exercise to support PLHIV with disclosure • Apply human-centred design to diagnose barriers inhibiting access to and/or retention in care, particularly for men and those struggling on treatment • Design job aids for providers and targeted client materials to increase treatment literacy • Engage PLHIV to serve as peer supporters related to ongoing adherence • Support greater communication on the benefits of treatment to encourage men to initiate and stay on treatment • Support differentiated care models including community-based distribution to minimize the burden of travel to collect ARVs, etc. • Develop tools to increase demand for viral load testing among clients • Provide recommendations on how to strengthen community action groups • Support communication on the transition to the fixed-dose combination of tenofovir disoproxil fumarate/lamivudine/dolutegravir as the preferred first-line ART, including counselling tools for women

Adolescent and Youth Treatment Behavioural Objective 2	
Behavioural Objective: To increase the proportion of adolescents and youth living with HIV who are on treatment and virally supressed	**Priority Audience:** Adolescents and youth living with HIV
	Secondary Audience: Family members, friends, partners
	Communication Objective 1: To increase the proportion of adolescents and youth who know where treatment services are available and who understand the benefits of early treatment **Communication Objective 2:** To increase acceptance of adolescents living with HIV and adherence support to them along their treatment journey
	Key Benefit: Early treatment helps you lead a healthy life and remain someone who your friends and family admire.
	Supporting Points: Starting ART early and adhering to treatment will improve your quality of life. Even if you are on ART, you should still use condoms to prevent transmission to your partner(s). Starting ART is a life-long commitment. Starting and staying on treatment is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on treatment, routine testing of how much HIV is in your blood is important to make sure your ART is working; talk to your provider to ensure you receive a viral load test. Support is available to you to help you stay on treatment. When your viral load remains undetectable, you have effectively no risk of transmitting HIV.
	Strategic Approaches: • Design support group tools and curricula for adolescents living with HIV that cover topics related to SRH and adherence support • Strengthen adherence groups for adolescents and support them with disclosure as needed • Ensure providers and family members have the interpersonal communication and counselling skills to support adolescents living with HIV in their transition into adult services • Ensure referral mechanisms are in place for linkages to reproductive health services • Strengthen existing adolescent-friendly services and create more • Develop livelihood development programming for youth in and out of school as part of a comprehensive package of services • Design and implement activities to support the needs of adolescents living with HIV (e.g., support for transitioning into adult services, adherence support, and linkage to reproductive health services)

Paediatric Treatment Behavioural Objective 3	
Behavioural Objective: To increase the proportion of children living with HIV who are on treatment and virally supressed	**Priority Audience:** Parents, guardians, family members, and caregivers of infants and children living with HIV
	Secondary Audience: Adolescents and children who know they are living with HIV
	Communication Objective 1: To increase the proportion of caregivers who know the benefits of treatment and importance of adherence for children **Communication Objective 2:** To increase the proportion of caregivers who know where HIV-related services are available, seek testing, initiate treatment for those children and support their ongoing adherence
	Key Benefit: Early treatment will keep the child healthy and well.
	Supporting Points: Initiating ART early will enhance the child's optimal growth and survival. The child should start ART as soon as it is known they are positive to stay healthy and grow normally. It is important for the child to attend medical appointments to stay healthy. Support is available to help the child stay on treatment.
	Strategic Approaches: • Optimize index testing for children, ensuring differentiated service delivery reaches every HIV-exposed child • Promote integration with routine paediatric care, nutrition services and maternal health services, and malaria prevention and treatment • Activities to address nutritional evaluation and care of malnutrition in infants and children living with HIV • Design and implement activities to support the needs of orphans and vulnerable children (OVC) living with HIV • Conduct case management and linkages to educational support and livelihood development programming for in- and out-of-school children, and other support services to further support ongoing adherence • Conduct community strengthening and build local partnerships that support families living with children living with HIV and support them on their treatment journey • Support community-based volunteers to provide quality treatment adherence services • Ensure timely management of elevated viral loads in children due to high rates of HIV drug resistance

Providers Supporting Treatment Behavioural Objective 4	
Behavioural Objective: To increase the proportion of providers who offer quality, compassionate, and responsive care to improve treatment initiation and adherence among their clients	**Priority Audience:** Health care providers, community lay counsellors
	Secondary Audience: PLHIV, other stakeholders including international NGOs who support health care workers and service delivery
	Communication Objective 1: To increase counselling and referral skills among community lay counsellors and providers for improved linkage to treatment **Communication Objective 2:** To increase community and facility linkages and coordination to provide quality differentiated service delivery **Communication Objective 3:** To clearly communicate the importance of ongoing retention in care and counsel using problem-solving techniques to ensure the client is equipped to manage challenges with adherence
	Key Benefit: Early treatment will help to eventually reduce provider workloads and personal stress as fewer clients will come back with serious illness.
	Supporting Points: Coordinating closely with community lay counsellors will help decongest facilities, reduce provider workloads, and clients will be more satisfied, given they will not have to wait as long to obtain their refills, etc. Ensuring clients know what to expect with treatment will help them manage any issues that arise. Early ordering of drugs will also make your job easier to provide high quality care and your clients will not be frustrated when they can get everything they need.
	Strategic Approaches: • Build capacity in differentiated service delivery models with a focus on supporting clients in adherence and retention regardless of the modality • Ensure treatment protocol and guideline flow charts are available and prominently placed on the walls, etc. so providers can be reminded of their responsibilities and key messages • Design and disseminate other treatment-related job aids for providers and targeted client materials to increase treatment literacy • Engage PLHIV to serve as peer supporters related to ongoing adherence • Support a system of escorted referrals from lay counsellors in the community to the facility to ensure linkage and care and treatment initiation • Design and implement activities for providers to support the needs of adolescents living with HIV (e.g., support groups, support for transitioning into adult services, adherence support, and linkage to reproductive health services) • Design and implement activities for providers to support the needs of OVC living with HIV

Providers Supporting Treatment Behavioural Objective 4	
	• Conduct case management and linkages to educational support and livelihood development programming for in and out of school youth, and other support services • Conduct community strengthening and build local partnerships between facilities and communities towards the goal of sustainability • Support the SBCC technical working group to ensure the needed SBC materials and support are provided countrywide • Empower the provincial health promotion offices to develop and/or share SBCC materials quickly • Incorporate client-centred communication techniques in pre-service training curricula

TB

Situation Analysis and Behavioural Determinants

The MOH, in its *Consolidated Guidelines for Prevention and Treatment of HIV Infection*, recommends TB screening for HIV-infected individuals, and, if positive, should be placed on TB treatment. TB is the leading cause of death for PLHIV, which predisposes a person to TB infection and progression to active disease. Testing those with presumptive TB (i.e., individuals with TB symptoms) is increasingly important as they have been shown to have higher prevalence of HIV than the general population and are more numerous than TB patients.

Based on self-report, 60.9 percent of adults aged 15–59 years who visited a TB clinic were tested for HIV during a TB clinic visit; however, 30.7 percent did not test for HIV during the visit and did not know their HIV status. Challenges continue in meeting MOH recommendations for follow-up in that all TB patients must be seen at least once monthly by a health care provider for clinical review, assessment of side-effects, and dose adjustment according to weight. Currently, challenges also include poor adherence to treatment by patients, sub-optimal dosage, incorrect management of individual cases by clinicians, poor infection prevention and control in both public and private places and use of TB drugs of unproven quality sold over the counter and on the black market.[75,76,77,78]

TB Behavioural Objective 1	
Behavioural Objective: To increase the proportion of people with TB identified,	**Priority Audience:** Anyone with symptoms of TB and PLHIV
	Secondary Audience: Family, communities, leaders, peers, workplaces, schools, prisons and other congregant settings, refugee camps and traditional healers
	Communication Objective 1: To create a clear understanding that TB is curable if it is diagnosed and treated early, regardless of HIV status

TB Behavioural Objective 1	
initiated on treatment, and tested for HIV	**Communication Objective 2:** To create awareness and understanding of the warning signs and symptoms of TB and the consequences of delay in seeking diagnosis at a recommended health facility **Communication Objective 3:** To increase the involvement of caregivers, family, and communities in ensuring adherence to TB treatment regimens **Communication Objective 4:** To create awareness on how TB spreads and the need for infection prevention and control
	Key Benefit: TB can occur in HIV-positive and HIV-negative individuals and is curable when it is diagnosed early and treated promptly.
	Supporting Points: Having TB does not mean a person has HIV. Early diagnosis and treatment can prevent the spread of TB to other family members, community members, peers, congregants, etc. Comprehensive quality TB treatment is available at government health facilities. TB treatment is available at government health facilities.
	Strategic Approaches: • Strengthen TB contact tracing, TB household investigations, and community and facility case-finding • Conduct community engagement and mobilisation activities as well as creative use of media platforms to reduce stigma and discrimination of TB • Identify presumptive TB patients through TB symptom screening in HIV settings • Ensure community-level support systems are in place to provide adherence support to TB patients on medication • Increase knowledge of TB preventive treatment for all PLHIV on ART as a routine part of HIV clinical care countrywide • Strengthen political will and social commitment to fighting TB • Strengthen TB patient–activist groups and establish linkages with PLHIV networks • Advocate for logistical support for community-based TB volunteers

Orphans, Vulnerable Children, and Adolescents

Situation Analysis and Behavioural Determinants

The early child period is considered to be the most important developmental phase throughout the lifespan and is a determinant of health and wellbeing. What happens to the child in the early years is critical for the child's developmental trajectory and life. Among HIV-unexposed children in Zambia, 17.0 percent are stunted and 11.5 percent severely stunted. Among HIV-exposed and uninfected children, however, 21.4 percent are stunted and 26.3 percent severely stunted, according to the ZAMPHIA. Community-based OVC workers and volunteers have an important role in providing case management that supports access to comprehensive services and providing regular follow-up and monitoring at the household level. OVC programmes are key to finding and ensuring that asymptomatic children living with HIV are found and initiated on ART. The goal is to reach children and adolescents before they become ill.[79,80,81]

OVC Behavioural Objective 1	
Behavioural Objective: To increase of OVC and adolescent case finding, access to services, and primary prevention	**Priority Audience:** Parents, caregivers, and other family members
	Secondary Audience: OVC and adolescents
	Communication Objective 1: To increase awareness on the availability of services and referral systems for OVC **Communication Objective 2:** To increase the proportion of OVC and their caregivers who are found and linked with a comprehensive set of services and ensure they receive social support and ongoing case management through community-based approaches
	Key Benefit: Children at risk of HIV or living with HIV can be supported to live long healthy lives and are eligible for additional services.
	Supporting Points: Services, including food and nutrition services and social cash transfers, are frequently available to families with OVC to support them in preventing HIV and, if positive, start and stay on treatment to ensure the child remains healthy. HIV testing and initiating ART early will enhance the child's optimal growth and survival. The child should start ART as soon as it is known they are positive to stay healthy and grow normally. It is important for the child to attend medical appointments to stay healthy. Staying in school will help a child/young person reach their potential and have the skills to prevent HIV.
	Strategic Approaches: • Conduct guided community consultations and identification of OVC using vulnerability index tools • Facilitate testing for HIV through index testing and among OVC beneficiaries as appropriate

OVC Behavioural Objective 1	
	• Develop and implement family-centred, strengths-based case management (closely coordinated with clinical facilities), including routine monitoring of child and family case plan achievement and progress towards outcomes associated with health, stability, safety, and schooling • Provide comprehensive prevention and treatment support to OVC with particular focus on girls • Promote access to adolescent-friendly services and services to prevent HIV infection among adolescents, particularly girls • Support age-appropriate protection skills training/schools-based GBV curriculum as part of comprehensive youth sexuality education • Implement psychosocial interventions that emphasize problem solving and social and emotional skills in adolescents • Support early childhood development through the development and use of tools and resources to encourage physical, social/emotional, and language/cognitive domains of development • Training and curriculum development focused on community-based outreach workers and peer counsellors to enhance their ability to carry out OVC-specific assessments, counselling, violence prevention, etc. • Use mobile tracking on tablets for HIV-related service referrals • Facilitate communities to provide other social support to ensure children living with HIV are retained in care • Support improved community-facility linkages to ensure OVC and their families are linked and retained in PMTCT, paediatric and adult treatment and care, home-based care, support groups, VMMC for male partners, GBV services, etc. to reduce loss to follow-up • Ensure that children and adolescents, as well as pregnant AGYW, have access to socioeconomic and psychosocial services • Focus parenting interventions on nurturing, positive discipline, and understanding of developmental stages • Provide education assistance to facilitate enrolment and progression in primary and secondary education • Coordinate with programmes providing food and nutrition assistance as well as social cash transfers

Key Populations

Situation Analysis and Behavioural Determinants

The NASF 2017–2021 acknowledges the neglect of key populations in the national response and calls on opinion leaders and other gatekeepers to urgently recognize the implications of key population risk to the general population in crafting, implementing, and delivering the related prevention and treatment services. The policy and legal framework doesn't always fully provide an environment in which key populations—female sex workers

(FSW), men who have sex with men (MSM), people who inject drugs (PWID), transgender people, and inmates—can easily access HIV prevention services free from stigma and discrimination. There is also inadequate population data on people of diverse sexual orientation and gender identity or lesbian, gay, bisexual, transgender, and intersex people in Zambia though plans are underway for further size estimation at the time of this writing.[82]

According to the WHO, the global response to HIV largely neglects key populations because governments and donors fail to adequately fund research, prevention, treatment and care for them. However, the National AIDS Fast Track Strategy 2015–2020 specifies a target that 90 percent of key populations should have access to HIV combination prevention services. Further, the preamble to the Constitution of Zambia (Amendment) Act 2 of 2016 articulates the commitment to "uphold the human rights and fundamental freedoms of every person."83,84,85,86

This call within the NASF is imperative because FSWs are extremely affected by HIV with odds of infection 12.4 times higher than the general population of reproductive age women in sub-Saharan Africa. Sex work is illegal in Zambia with provisions stating that living off earnings from sex work, encouraging others to become sex workers, and using premises for sex work are illegal. Vagrancy and public disorder offenses are often applied against sex workers operating in public with arrests made based on appearance, even if they have not committed an offense. FSWs face stigma and discrimination when trying to access health services including STI screening and treatment, HIV testing, ART, ANC, and access to condoms. The Zambia Sex Workers Alliance and NAC acknowledge that although key populations have been recognised, policy and legal frameworks have not changed to provide an enabling environment or address structural issues affecting key populations such as GBV among sex workers. Members of key populations in Zambia live in constant fear of arbitrary detention; discrimination in education, employment, housing, and access to services; and extortion encouraged by the existence of sections 155–157 of the Zambia Penal Code in which MSM sexual acts are prohibited. The maximum penalty for unnatural sex was increased from 14 years to life imprisonment in 2005.[87,88,89,90]

Perception of criminal laws interfere with health providers' medical and ethical obligations to their clients as they regard lesbian, gay, bisexual, transgender, and intersex people as criminals and think that providing health services to them is sometimes seen as promoting homosexuality and thus unacceptable or even illegal. Article 27 of the Bill of Rights provides that a person shall not be "discriminated against, except under a law that provides for affirmative action" thus guaranteeing the rights of all including people of diverse sexual orientation and gender identity. Most health care providers are inadequately oriented to serve sex workers, MSM, transgender persons, and other sexual minorities and often lack the training to identify and address their risk factors. Further, breaches in confidentiality relating to health status and issues of sexual orientation and gender identity are persistent as are verbal humiliations and poor treatment in general. Many of these behaviours stem from a negative perception of key populations and lack of awareness.[91,92]

Social stigma and the criminalization of same-sex practices combined with ignorance about the key population community further perpetuates negative stigma and stereotypes. Those who do not conform to male gender norms and may identify as a third gender or transgender are also subject to increased violence which complicates their access to needed HIV prevention and treatment services.[93]

The NASF (2017–2021) acknowledges that the proportion of PWID is estimated to be increasing, and NAC recognizes the need to articulate guidance and suggest a comprehensive package of services given their high risk of HIV exposure because of sharing needles and injection equipment. PWID are often unable to access health services in Zambia due to the criminalized nature of drug use, the fear of arrest, and the stigma and discrimination they experience when accessing health services. The most common risk-taking behaviours tend to include sharing needles, reusing needles and other unhygienic injecting practices, using tainted drugs, and performing sexual favours for drugs. The Narcotic Drugs and Psychotropic Substances Act Chapter 96 of the laws of Zambia is a substantial barrier for PWIDs in accessing health service because health service providers have reported that the legal framework bound them to not provide health services and that people who use drugs avoided services for fear of arrest. [94,95]

Correctional facilities remain a high-risk environment for HIV transmission because drug use and needle sharing, tattooing with homemade unsterile equipment, anal sex without a condom, sex bartering, and rape commonly occur. In addition, condoms cannot be freely distributed in Zambian correctional facilities due to the provisions in sections 155–157 of the Zambian Penal Code that does not acknowledge sex among men. Young people are even more vulnerable to HIV in this environment given sexual exploitation by adults, a practice confirmed to be prevalent in Zambian prisons as youth are frequently forced into sexual relationships constituting rape, particularly when they are held with adult inmates. Although this practice violates both Zambia laws and international guidelines, it still occurs. Health care is provided at prison health centres, yet anecdotally, service providers offer some resistance to visit the prisons and service provision may be inconsistent. Small cells further exacerbate problems and gaps remain in many preventive services.

Some cultural, social, policy, and legal factors contribute to HIV vulnerability among migrants. These factors include language barriers, marginalisation, and legal obstacles. Cultural attitudes, religious beliefs, and fear of discrimination can increase vulnerability. Further, negative attitudes towards migrants may also inhibit their use of services.

Likewise, persons with disabilities are at higher risk of exposure to HIV. PLHIV may also develop impairments and may be considered to have a disability that hinders their full and effective participation in society on an equal basis with others. The NASF recognizes that despite the 2005 National HIV/AIDS/STI/TB Policy being in place explicitly indicating the need for HIV interventions for persons with disabilities, there have been few tangible actions for persons with disabilities.[96,97,98,99,100,101]

<table>
<tr><th colspan="2">Sex Worker Behavioural Objective 1</th></tr>
<tr><td rowspan="5">Behavioural Objective:

To increase the proportion of sex workers who test for HIV, start and adhere to treatment, and practice preventive behaviours</td><td>Priority Audience: FSW</td></tr>
<tr><td>Secondary Audience: Clients and regular sexual partners</td></tr>
<tr><td>Communication Objective 1: To increase the proportion who know the benefits of testing and treatment, know where to obtain HIV-related services, and feel safe accessing them

Communication Objective 2: To increase the proportion of FSW who test for HIV and if positive, start and stay on treatment

Communication Objective 3: To increase risk perception of FSW and practice of safe sexual practices including condom use</td></tr>
<tr><td>Key Benefit: Getting tested, starting ART if positive, and adhering to treatment and safe sexual practices will help maintain your good health and allow you to live a long productive healthy life.</td></tr>
<tr><td>Supporting Points: Getting tested for HIV is the first step to getting lifesaving ART. Starting and staying on ART is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on ART, having routine viral load testing of how much HIV is in your blood is important to make sure your ART is working and reduce the risk of onward HIV transmission. Starting and staying on ART will ensure you are there to support your child/ren in the future. By developing an adherence plan that takes your lifestyle into consideration, you can be successful. Make sure you reduce your intake of alcohol and drugs, so you remember to take your treatment. Take your ART even if you have been drinking. Having a support partner or group enhances your treatment adherence and can help you with any challenges you might have.</td></tr>
<tr><td>Strategic Approaches:

• Collaborate closely with sex workers to ensure approaches are meeting their needs
• Promote sex worker peer support groups
• Enhance interpersonal communication sessions focused on prevention and treatment, supporting SBCC materials and psychosocial support
• Build the capacity of key population community outreach workers, ideally sex workers themselves, and develop the skills of peer navigators to support testing and treatment uptake
• Strengthen community engagement for mobile outreach service delivery
• Provide mobile services at locations convenient to sex workers that include PrEP, HIV testing, treatment, PMTCT, screening and management of STIs, prevention, diagnosis and treatment of TB, FP, SRH care</td></tr>
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Sex Worker Behavioural Objective 1	
	• Conduct training and skills-building activities of sex workers in small groups • Promote, demonstrate, and distribute male and female condoms and water-based lubricants • Conduct screening and treatment for drugs and alcohol abuse • Use mobile phones to disseminate messages • Mobilise community to increase awareness on health rights, risks of HIV/STI and GBV, gather collective sex worker community solutions, and thereby enhance social support through sex workers groups and networks • Build capacity among sex workers for leadership and ownership to build their agency in preventing HIV within their community • Mitigating and managing sexual and GBV • Economic empowerment for alternative livelihood assistance if interested to expand choices beyond sex work • Focused demand generation for use of PrEP • Establish key population friendly clinics across the country

MSM Behavioural Objective 2	
Behavioural Objective: To increase the proportion of MSM who test for HIV, start and adhere to treatment, and practice preventive behaviours	**Priority Audience:** MSM
	Secondary Audience: Sexual partners, peers
	Communication Objective 1: To increase the proportion of MSM who know the benefits of treatment, know where to obtain services, and feel safe accessing them **Communication Objective 2:** To increase the proportion of MSM who test for HIV and if positive, start and stay on treatment **Communication Objective 3:** To increased risk perception and practice of safe sexual practices including condom use
	Key Benefit: Getting tested, starting ART if positive, and adhering to treatment and safe sexual practices will help maintain your good health and allow you to live a long productive healthy life.
	Supporting Points: Starting and staying on ART is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on ART, having routine viral load testing is important to make sure your ART is working; talk to your provider to ensure you receive a viral load test. Starting ART immediately and maintaining viral suppression through treatment adherence will improve your quality of life and reduce the risk of HIV transmission to your

MSM Behavioural Objective 2	
	partner(s). ART is a life-long commitment. Go to key population-friendly clinics for quality treatment services provided by trained providers. Support is available to you to help you stay on treatment.
	Strategic Approaches: • Establish safe spaces with MSM • Collaborate closely with MSM to ensure appropriate programming and SBCC interventions • Build the capacity of key population community outreach workers, ideally MSM themselves who understand the needs of their community • Develop the skills of peer navigators to support MSM in testing and treatment uptake • Encourage MSM peer support groups incorporating training, counselling, and additional support as needed • Develop and provide interpersonal communication sessions focused on prevention and treatment, supporting SBCC materials and psychosocial support • Conduct community engagement for mobile outreach service delivery • Strengthen referral systems between MSM service providers and health service systems • Provision of mobile services at locations convenient to MSM that include PrEP, HIV testing, treatment, screening and management of STIs, prevention, diagnosis and treatment of TB, and psychosocial support • Promote, demonstrate, and distribute male condoms and water-based lubricants • Strengthen the capacity of service providers to ensure high-quality key population-friendly services • Design, develop, and disseminate MSM-specific SBCC materials which may include posters in MSM hotspots, pocket size booklets or brochures, peer education job aids, branded condoms and lubricant with HIV messages, online campaign materials and tools, documentaries with key messages, etc. • Use mobile phones and online communities to disseminate messages including online MSM sites and chat groups, social media including Facebook, WhatsApp, etc. that also support community building and social networking • Mobilise community to increase awareness on health rights, risks of HIV/STI and GBV, gather collective MSM community solutions, and thereby enhance social support through MSM groups and networks • Build capacity among MSM for leadership and ownership to build their agency in preventing HIV within their community • Mitigate and manage sexual and GBV • Conduct media sensitization and trainings on key population issues to create a more enabling environment that include MSM themselves • Provide focused demand generation for using PrEP

Transgender Behavioural Objective 3	
Behavioural Objective: To increase the proportion of transgender women and men who test for HIV, start and adhere to treatment, and practice preventive behaviours	**Priority Audience:** Transgender people
	Secondary Audience: Partners, peers
	Communication Objective 1: To increase the proportion who know the benefits of treatment, know where to obtain services, and feel safe accessing them **Communication Objective 2:** To increase the proportion who test for HIV and if positive, start and stay on treatment **Communication Objective 3:** To increased risk perception and practice of safe sexual practices including condom use
	Key Benefit: Getting tested, starting ART if positive, adhering to treatment and safe sexual practices will help maintain your good health and allow you to live a long productive healthy life.
	Supporting Points: Starting and staying on ART is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on ART, having routine viral load testing is important to make sure your ART is working; talk to your provider to ensure you receive a viral load test. Starting ART immediately and maintaining viral suppression through treatment adherence will improve your quality of life and reduce the risk of HIV transmission to your partner(s). ART is a life-long commitment. Go to key population-friendly clinics for quality treatment services provided by trained providers. Support is available to help you stay on treatment.
	Strategic Approaches: • Collaborate closely with transgender people to ensure appropriate programming and SBCC interventions • Establish safe spaces for transgender peer support groups incorporating training, counselling, and additional support as needed • Build the capacity of key population community outreach workers, ideally transgender people themselves who understand the needs of their community • Develop and provide interpersonal communication sessions including a focus on prevention and treatment, supporting materials, and psychosocial support • Develop the skills of peer navigators to support testing and treatment uptake • Conduct community engagement for mobile outreach service delivery • Provide mobile services at locations convenient to transgender people that include PrEP, HIV testing, treatment, screening and management of STIs, prevention, diagnosis and treatment of (TB), and psychosocial support

Transgender Behavioural Objective 3	
	• Strengthen referral systems between key population service providers and health service systems • Promote, demonstrate, and distribute condoms and water-based lubricants • Design, develop, and disseminate trans-specific SBCC materials may include pocket size booklets or brochures, peer education job aids, online campaign materials and tools, etc. • Use mobile phones and online communities to disseminate messages including online transgender sites and chat groups, social media including Facebook, WhatsApp, etc. that also support community building and social networking • Mobilise community to increase awareness on health rights, risks of HIV/STI and GBV, and gather collective transgender community solutions • Build capacity among transgender people for leadership and ownership • Mitigate and manage sexual and gender-based violence • Provide focused demand generation for using PrEP

PWID Behavioural Objective 4	
Behavioural Objective:	**Priority Audience:** PWID
To increase the	**Secondary Audience:** Spouse/partner and other family members of PWIDs,

PWID Behavioural Objective 4	
	developing an adherence plan that takes your lifestyle into consideration, you can be successful. Make sure you reduce your intake of alcohol and drugs, so you remember to take your treatment. Take your ART even if you have been drinking or taking drugs. Having a support partner or group enhances your treatment adherence and can help you with any challenges you might have. Use condoms consistently.
	Strategic Approaches: • Advocate for the formation of PWID peer-support groups • Focus interpersonal communication sessions on prevention and treatment, supporting materials, and psychosocial support at drop-in centres • Focus PWID outreach workers on hotspots • Encourage peer navigators to support PWID in testing and treatment among other things • Engage community for mobile outreach service delivery • Provide mobile services at locations convenient to PWIDs that include HIV testing, treatment, screening and management of STIs, prevention, diagnosis and treatment of TB, and psychosocial support • Conduct training and skills-building activities in small groups • Promote, demonstrate, and distribute male and female condoms and water-based lubricants • Conduct screening and treatment for drugs and alcohol abuse • Use SBCC materials including pocket size booklets or brochures, counselling cards and other peer education job aids for peers and outreach workers as well as fliers/brochures, small information booklets for PWID providing information on various services and health issues and locations of services • Mobilise community to increase awareness on health rights, risks of HIV/STI and GBV, gather collective PWID community solutions, and thereby enhance social support through PWID groups and networks • Mitigate and manage sexual and GBV • Provide family and social services to support PWID to start and remain on treatment • Encourage viewing of interactive video documentaries at drop-in centres • Implement needle and syringe programmes as well as medically assisted therapy • Ensure the provision of opioid substitution therapy

Migrant and Displaced Persons Behavioural Objective 6	
Behavioural Objective: To increase the proportion of migrants and displaced persons who test for HIV, start and adhere to treatment, and practice preventive behaviours	**Priority Audience:** Migrants and displaced persons
	Secondary Audience: Law enforcement officials, health care providers who serve them, their family members
	Communication Objective 1: To increase the proportion who understand their increased risk of HIV infection, know the benefits of testing and treatment, and feel safe accessing them
	Key Benefit: Getting tested, starting ART, and adhering to treatment will maintain your health.
	Supporting Points: Getting tested for HIV is the first step to getting lifesaving ART. Starting and staying on ART is key to lowering the amount of HIV in your body and allowing your immune system to stay healthy. Once on ART, having routine testing of how much HIV is in your blood is important to make sure your ART is working; talk to your provider to ensure you receive a viral load test.
	Strategic Approaches: • Develop and disseminate culturally appropriate materials and interventions • Develop interpersonal communication and counselling materials for use in training of health care providers and community workers in a culturally sensitive manner • Improve provider-client communication by working with an independent interpreter who has been trained on the importance of maintaining confidentiality • Encourage the involvement of migrant communities in designing program activities and service delivery • Support provider-initiated testing and counselling and treatment initiation for those found positive • Provide TB and STI prevention, screening, and treatment • Support peer education training and outreach • Provide SBCC materials including pocket size booklets or brochures, counselling cards and other peer education job aids • Partner with businesses who employ migrants to ensure they are meeting their health needs and see the return on investment of providing HIV-related services to their workforce • Strengthen the capacity of patient groups and their leadership, including PLHIV, to advocate for their own rights • Consider supporting the client with a health travel card in different languages during service provision to minimize breaks in treatment given their mobility

Service Providers Assisting Key Populations Behavioural Objective 8	
Behavioural Objective: To increase the proportion of service providers who willingly provide friendly HIV services to key populations without judgment	**Priority Audience:** Health care providers
	Secondary Audience: Others working in health facilities, community health workers, and outreach workers
	Communication Objective 1: To increase the number of providers who understand key population health needs and the unique challenges they face **Communication Objective 2:** To increase the number of providers who use key population-friendly tailored counselling techniques to facilitate compassionate care in the provision of the minimum package including prevention, STI screening, HIV testing, immediate treatment initiation and ongoing adherence
	Key Benefit: Initiating testing and early treatment will help reduce your workload over time, as fewer clients will come back sick
	Supporting Points: You have the ability to welcome key populations and provide much-needed services to people in need and feel valued by those when you serve them well. It is your legal obligation to provide quality services to each person. All PLHIV, regardless of their sexual practices or behaviours, have the right to be treated with respect and receive HIV-related services. HIV testing is the first step to early ART initiation, which improves the health of PLHIV and reduces the risk of HIV transmission to their sexual partners. Clients empowered with accurate ART information can make informed decisions about their health and their family's health.
	Strategic Approaches: • Ongoing key population-specific training and sensitization of health workers to better serve all people free of stigma and discrimination and deliver key population-friendly services for prevention, STIs, HIV testing, treatment, FP, and linkages to GBV-related services, among others • Build empathy and compassion among providers, so that even if not a designated key population provider, they have opportunities to interact with key populations • Provide community/mobile service outreach to key populations to reach them with HIV-related services at times and days that are convenient for key populations and in places where they may feel more comfortable receiving services • Encourage dialogue and coordination with key populations to determine what days and times they may want to access services to ensure differentiated care if offered and supported with key population in the ways that will work best for them

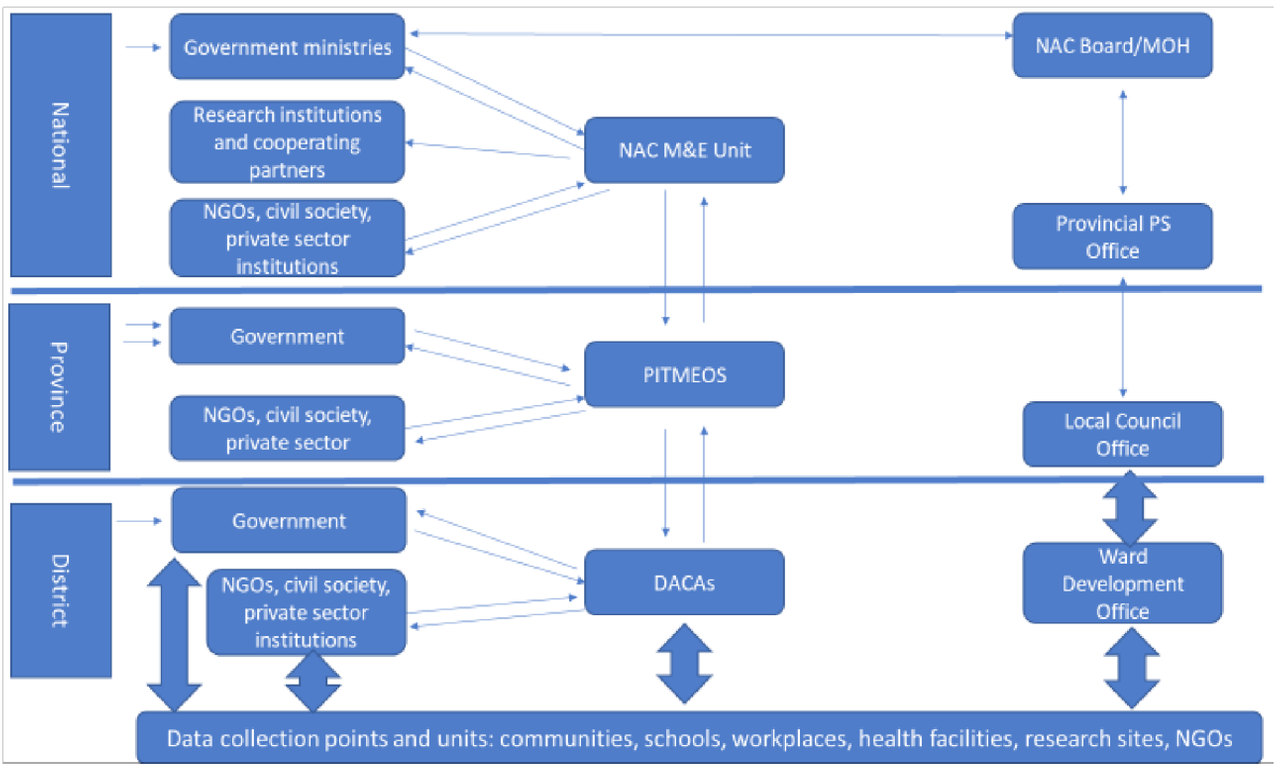
Policy Makers Behavioural Objective 9	
	• Work closely with the media to ensure unbiased news coverage of key populations • Identify lawyers who can help champion and protect key population under existing laws and policies

Law Enforcement Behavioural Objective 10	
Behavioural Objective: To increase the proportion of law enforcement who recognize key population rights	**Priority Audience:** Judiciary and law enforcement personnel
	Secondary Audience: Village headmen and other community leaders who oversee disputes
	Communication Objective 1: To increase the number of law enforcement personnel who understand key population health needs and intervene to end key population harassment and discrimination.
	Key Benefit: When key population rights are protected, they are better able to access much-needed health services to prevent ongoing transmission of HIV.
	Supporting Points: All PLHIV, regardless of their sexual practices or behaviours, have the right to be treated with respect and receive HIV-related services.
	Strategic Approaches: • Conduct sensitization workshops with the police that raise their awareness of laws related to key population and their rights • Gain support at senior levels in the police hierarchy to get and sustain support from police lower down and hold them accountable for their actions • Meet regularly with police as well as those responsible for law enforcement to reduce police harassment of key population and community outreach workers; letters of support from the police for key population-outreach workers, for example, may be explored to ensure the commitment of frontline officers to the trainings • Build institutional accountability with police to uphold the key population rights, which may include a circular to police stations requiring them to follow the rule of law and ensure due process when arresting key population • Disseminate information or tips about safety to key population (e.g., inform friends where they are going, keep numbers to call in case they are in dangerous situations) • Engage or link with lawyers who can help negotiate with legal and judicial authorities about incidents of violence and facilitate access to justice through legal services

Reporting

Reporting the results of the implementation of the Zambia National and AIDS Communication Strategy will align to that of the NASF through standardized reporting tools. Data flow at all levels (district, provincial, and national) is guided as follows in Figure 3.

Figure 3. Illustration of data flow



APPENDIX A: LAWS, POLICIES, AND GUIDELINES

Below are some of the health policies relevant for the success of the National HIV and AIDS Communication and Advocacy Strategy 2019–2023:

- The National AIDS Strategic Framework 2017–2021 is a multisectoral, multilayer, and decentralised response to HIV and AIDS in Zambia for government, communities, civil society organisations, private sector, and development partners (bilateral and multilateral agencies) to actively participate in implementing evidence-based HIV and AIDS programmes.
- The 2017–2021 National Health Strategic Plan is aimed at reducing the disease burden and accelerating the attainment of the sustainable development goals and other national priorities. The plan includes four major priority areas: human resources, health service delivery interventions, clinical care, and diagnostic service priority interventions, and priority integrated support systems. The document also highlights Ministry of Health priorities related to HIV/AIDS for 2017–2021.
- The National HIV/AIDS Policy of 2005 provides policy direction for the national response by setting the parameters for coordination and interventions including legal provisions.
- The Health Policy 2012 sets out the government's commitment to provide equitable access to costeffective and quality health services as close to the family as possible in a caring, competent, and clean environment. This also applies health services related to HIV and AIDS.
- Zambia Consolidated Guidelines for Prevention and Treatment of HIV Infection (2018) provides a reference tool to health care providers and support staff on new trends in the national HIV and AIDS response.
- The National Population Policy 2007, amongst other things, integrates population variables, reproductive health, gender, and HIV into development planning and programme implementation processes, especially in education, health, and agriculture. It provides a framework for integrating population dynamics in the national HIV response.
- HIV Testing Services National Guidelines (2016) provide guidance on how to deliver quality, accessible, and expanded HIV testing and counselling services in Zambia.
- The Zambia National Guidelines for HIV Counselling & Testing of Children (2011) outlines the counselling and testing needs of children up to the age of 16 years.
- The Zambia Family Planning Guidelines and Protocols (2006) provides updated and client-centred guidelines to health care providers in Zambia to guide them in providing appropriate family planning information, services, and methods to men and women including people living with HIV.
- The National Standards for SRH, HIV and AIDS Peer Education Programmes (2010) is a framework to enhance, harmonize, and strengthen existing peer education programmes while providing strategic guidance for new HIV, AIDS, and sexual and reproductive health and rights-based peer education programmes in Zambia.
- The National Mobile HIV Services Guidelines (2009) describes guidance related to mobile/outreach services including mobile counselling and testing, prevention of mother-to-child transmission, and antiretroviral therapy services.
- The National Reproductive Health Policy 2008 aims to achieve the highest possible level of integrated reproductive health of all Zambians as close to the family as possible so as to promote quality of life including integration of HIV and sexual and reproductive health and rights and services.
- The National HIV/AIDS Policy for the Education Sector provides the framework for responding to concerns and needs of those infected with and affected by HIV in the education sector.

- The National Youth Policy (2015) aims to ensure the development of young people and deals with various issues, including gender issues, health, HIV, and AIDS.
- The National Gender Policy (2014) is aimed at ensuring the attainment of gender equality in the development process by redressing the existing gender imbalances that also impact vulnerability to HIV.
- National Referral Guidelines for HIV & AIDS Related Services guides all referrals for HIV and AIDS services in Zambia.
- Implementation Framework and Guidance for Pre-Exposure Prophylaxis of HIV Infection 2018 that provides direction for the positioning and implementation of the pre-exposure prophylaxis programme in Zambia.
- National HIV Self-Testing Strategic Framework (2018) provides strategic direction for implementing the HIV self-testing programme in Zambia.

APPENDIX B: PARTICIPANT LIST

	Participant Name	Organization
1	Peter Ndemena	National AIDS Council (NAC)
2	Chisenga Mwombela	NAC
3	Shambala Diangamo	NAC
4	Rita Kalamatila	NAC
5	Jean N Simalonda	NAC
6	Steve Sichone	Breakthrough ACTION
7	Emmanuel Chama	Eastern Provincial Health Office (PHO)
8	Jessy Goma	NAC – Muchinga
9	Kelvin Chishala	MOH
10	Shinzala Deputy	MOH – Senior Health Promotion Officer
11	Akufuna Mistshele	Zambia Centre for Communications Programmes
12	Thomas Tembo	PHO – Luapula
13	Enock Kebeke	PHO – Northern
14	Rosemary Masuku	NAC – Southern Province
15	Dothine C Nkatya	PHO – Southern Province
16	Ringoh Chileshe	MOH
17	Imonda Zulu	CR – PHO
18	John Chisha	NAC – Northern
19	Hillary Sakala	NAC – North Western
20	Justine Mwiinga	NAC – Lusaka
21	Nathan Kabwe	NAC – Luapula
22	Tilandile Kabota	NAC – Copperbelt
23	Nickson Kapansa	STC – Central
24	Arlene Phiri	United States Agency for International Development
25	Andrew Chanda	NAC – Eastern
26	William Sikazwe	NAC
27	Lester Nambale	NAC 28
28	Gibson Mizinga	NAC
29	Fred Chungu	Network of Zambian People Living with HIV
30	Christine Shawa	LPHO

	Participant Name	Organization
31	Alice Chembe	Planned Parenthood of Zambia
32	Miver Malawo	Network of Zambian People Living with HIV NZP+
33	Answell Chipukuma	USAID | DISCOVER
34	Theophista Mumba	Breakthrough ACTION
35	Harvey Ngwale	Zambia Disability and Health Research Programme
36	Mwangala Situmbeko	Western PHO – Mongu
37	Elizabeth Maliwa	PATH
38	Charity Banda	Ministry of General Education Headquarters
39	Lynn Van Lith	Breakthrough ACTION
40	Hilda Dhliwayo	Breakthrough ACTION
41	Fayyaz Khan	Breakthrough ACTION
42	Sara Miner	USAID/Zambia

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