

MEASURE Evaluation

Working Paper Series

**Know Your Response
Southern Province Zambia**

**HIV-Prevention Policies and Programs in
Government Health and Non-Health Sectors**

Mubiana Macwan'gi, Munukwayumba Munyima,
Parkie Mbozi, Tedson Simwanza, Anastasia J. Gage

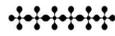
August 2014

WP-14-156



This paper has been supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00, which is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, with Futures Group, ICF International, John Snow, Inc., Management Sciences for Health, and Tulane University. The views expressed in this publication do not necessarily reflect the views of PEPFAR, USAID or the United States government. .

Carolina Population Center
University of North Carolina at Chapel Hill
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, North Carolina 27517
Phone: 919-445-9350
measure@unc.edu
www.cpc.unc.edu/measure



This working paper series is produced by MEASURE Evaluation in order to speed the dissemination of information from research studies. Working papers may be under review or awaiting journal publication, and are distributed as received from the authors with minor editing and formatting adjustments.

The series and other publications are available from the MEASURE Evaluation at:

<http://www.cpc.unc.edu/measure>



Table of Contents

List of Tables	ii
List of Figures	iii
List of Acronyms	iv
Acknowledgments.....	v
Executive Summary	vi
1. Introduction.....	1
2. Data and Methods	3
3. Policy Environment	6
3.1 HIV-Prevention Policies and Guidelines	6
3.2 Mobilization and Commitment of Resources for HIV Prevention	9
3.3 Linkages of HIV Prevention and Sexual and Reproductive Health	11
3.4 Legislative Framework	14
3.4 Summary	20
4. Strategic Information about HIV Prevention	21
4.1 Monitoring and Evaluation	21
4.2 Cross-sectional Surveys, Surveillance, and Types of Information Collected.....	21
4.3 Data Quality Assurance and Utilization	25
4.4 Summary	25
5. HIV-prevention Services and Interventions in Government Health Facilities	26
5.1 HIV-prevention Interventions	27
5.2 Populations Reached by HIV-Prevention Interventions	33
5.3 Health Worker Training.....	35
5.4 HIV Services Integration	37
5.5 Summary	38
6. HIV-prevention Programs Implemented by Government Non-Health Institutions.....	40
6.1 HIV Prevention in Public Schools and Tertiary Institutions	40
6.2 HIV Prevention Programs for Uniformed Personnel.....	41
6.2 HIV Prevention Programs for Prisoners	43
6.3 Summary and Discussion.....	45
7. References.....	47

List of Tables

Table 1 Percentage of government and all health facilities reported to offer biological/biomedical interventions that reduce HIV infection and transmission risk by type of intervention and district, Know Your HIV-Prevention Response Survey 2013...	29
Table 2 Percentage of government health facilities that offered HIV-prevention services to mitigate biological outcomes of HIV infection at the time of the survey, by type of service and district, Southern Province, Zambia 2013	31
Table 3 Percentage of government health facilities that provided standardized hybrid interventions at the time of the survey, by type of intervention and district, Southern Province, Zambia 2013	32
Table 4 Percentage of district population reached by HIV-prevention interventions and activities conducted at health facilities in the past 12 months, by district and type of intervention, Zambia 2013	33
Table 5 Priority populations specifically targeted for interpersonal HIV-prevention education and persuasion programs and face-to-face interactive dialogue at any health facility in the past 12 months by district, Zambia 2013.....	34
Table 6 Services provided directly to people living with HIV (not by referrals to other programs) by any health facilities in the district, Zambia 2013	35
Table 7 Percentage of government health facilities with at least one health worker who has, within the last 2 years, received pre-service or in-service training in specific topics, Zambia 2013	36
Table 8 Categories of health workers trained to identify and control occupational hazards that would expose them to HIV and to work with people living with HIV by district, Zambia 2013	37
Table 9 HIV services integration at various levels of the health system by district, Zambia 2013.....	38
Table 10 Estimated percentages of police officers reached by Government in various HIV- prevention interventions in the past 12 months by district, Southern Province, Zambia	42
Table 11 Estimated percentages of prison officers reached by Government in various HIV- prevention interventions in the past 12 months by district, Southern Province, Zambia 2013	43

List of Figures

Figure 1 Number of participants reporting that the National HIV M&E System includes cross-sectional surveys of behavior among key populations and other vulnerable groups, Southern Province, Zambia 2013.....	22
Figure 2 Number of participants reporting that the National HIV M&E System collects behavioral surveillance data among key populations and other vulnerable groups, Southern Province, Zambia 2013.....	23
Figure 3 Number of participants reporting that, to a large extent, the National HIV M&E System collects/track data on various HIV-related aspects, Southern Province, Zambia 2013.....	24
Figure 4 Number of participants reporting that the strategic information systems collects data on gender issues, Southern Province, Zambia 2013.....	25
Figure 5 Reported number of government and private health facilities by district surveyed, Southern Province, Zambia 2013	27
Figure 6 Percentage of public health facilities in Southern Province reported to offer specific interventions affecting knowledge, attitudes and beliefs and reducing harm, by district, Zambia, 2013	28
Figure 7 Number of public institutions of learning by district, Southern Province, Zambia 2013.....	40
Figure 8 Number of districts surveyed in which HIV-prevention programs are available in schools by type of program, Southern Province, Zambia, 2013	41
Figure 9 Number of prisons implementing specific HIV-prevention interventions, Southern Province, Zambia 2013.....	44

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
CHAZ	Churches Health Association of Zambia
CBO	Community-based Organization
CSO	Civil Society Organizations
DATF	District AIDS Task Force
DACA	District AIDS Coordination Advisor
DHS	Demographic and Health Survey
FBO	Faith-based Organization
FGD	Focus Group Discussion
FSW	Female Sex Worker
GBV	Gender-based Violence
GHI	Global Health Initiative
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
INESOR	Institute of Economic and Social Research
KYR	Know Your Response
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
NAC	National HIV/AIDS/STI/TB Council
NCC	National Constitution Conference
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan For AIDS Relief
PLWH	People Living With HIV
PWID	People Who Inject Drugs
PMTCT	Prevention of Mother-to-Child Transmission
SOP	Standard Operation Procedure
SRH	Sexual and Reproductive Health
STI	Sexually-transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VMMC	Voluntary Medical Male Circumcision
VSU	Victim Support Unit
WHO	World Health Organization
WVI	World Vision International
ZAF	Zambia Airforce

Acknowledgments

The research project upon which information in this report is based was implemented by the Government of Zambia, Ministry of Health through the National AIDS National HIV/AIDS, STI and TB Council (NAC). The research aspects of the project were conducted and managed by the Institute of Economic and Social Research at the University of Zambia and MEASURE Evaluation, in collaboration with NAC which provided leadership and valuable insights at all stages of the research. The study was funded by USAID.

Many international and national institutions and individuals contributed to the production of this report and we acknowledge and thank them individually and collectively. We appreciate the support of the UNAIDS Regional Support Team, East and Southern Africa Regional Office, especially Helen Jackson, and of Marelize Gorgens of the World Bank who provided valuable insights into early drafts of the data collection instruments. MEASURE Evaluation also wishes to thank Motlalepula Khobotlo, formerly of the Modes of Transmission Lesotho Country Team, for his invaluable support in the early stages of development of the data collection instruments.

We are also highly indebted to the numerous organisations and individuals for their valuable inputs into the research process. Our gratitude goes to the District Health Teams, Implementing Organizations, both government and non-government, and all individuals in all the study districts who participated in the pretesting of the tools and fielding of the tools and data collection. We are indebted to our Research Field Team and the Data Processing Team who did commendable job under challenging environments to collect and process the information reflected in this report. Special thanks are due to Moyern Mungwala and Masuso Nqumayo.

Executive Summary

The Know Your HIV-prevention Response Study was a situation analysis of a situation analysis of the HIV/AIDS prevention response in Zambia with the goal of identifying principle implementers in Southern Province, programmatic needs, existing policies, and opportunities for the future. The study was implemented jointly by MEASURE Evaluation and the Institute of Economic and Social Research (INESOR) at University of Zambia, in collaboration with the NAC, from September to October 2013. The study had three primary objectives:

- Determine what specific HIV-prevention interventions were being implemented
- Determine by which organizations and in which districts the interventions were being implemented
- Assess the extent to which the HIV-prevention response matched current HIV-transmission patterns, were focused on geographic areas where HIV was spreading most rapidly, and covered technical recommendations for populations at higher risk of HIV exposure.

The main findings are described below for the government health and non-health sectors, with particular attention to the policy environment, strategic information, geographic gaps in the availability of HIV-prevention interventions in public health facilities, and HIV-prevention services in the government non-health sector.

Policy Environment

- The majority of the participants were not aware of the specific policies on HIV prevention.
- The majority of the participants confirmed that in looking at gender issues they were guided by specific policies and/or laws, notably the Anti-Gender-based Violence Act. However, only few were aware about the specific provisions of the law let alone having seen a copy of the Act.
- Most of the participants noted that there few program implementers that had received copies of the HIV-prevention guidelines and the gender acts.
- There was a lack of specific policies to guide program implementers on how to deal with key populations such as sex workers and people who inject drugs that are deemed illegal in the country.
- There was a lack of specific guidelines for incarcerated populations.
- There was limited advocacy to call for amendment of various policies.
- There was inadequate participation by people living with HIV and AIDS in the formulation of policies.
- The general public was unaware of available HIV-prevention laws.
- Traditional customs were cited as a barrier in monitoring the marriage act.
- Withdrawal of cases from the Police by victims of gender violence limited the full implementation of the Anti-Gender-based Violence Act.

Strategic Information

- All the participating districts recognized strategic information as key for evidence-based planning and programming of HIV/AIDS interventions.
- All the participating districts reported that they have a monitoring and evaluation system in place which feeds into the national level systems.
- Data are collected mainly on HIV and AIDS related behaviors of the general population, HIV-related morbidity and mortality, and gender-related issues.

- Despite current efforts and achievements made so far, gaps in strategic information still existed as no data are routinely collected on some key populations and other vulnerable groups such as men who have sex with men (MSM), clients of female sex workers (FSWs) and people who inject drugs (PWID), as these behaviors are illegal.
- The main reported challenges with strategic information related to lack or inadequate policies to provide guidance on targeting of some key populations and inadequate human resources with knowledge and skills to analyze, interpret and use data from routine and special studies.

Government Health Sector

- Significant gaps occurred across and within districts in the offer of HIV-prevention services at government health facilities.
- Interventions such as diagnosis and treatment of STIs, use of gloves and protective clothing during medical procedures, family planning for the general population, in-house HIV VCT, and PMTCT were almost universally offered at government health facilities in the districts surveyed.
- Substantial variations occurred across districts in the offer of voluntary medical male circumcision, management of HIV-associated opportunistic infections, mobile counseling and testing, PLWH support groups, and breastfeeding substitutes for HIV-positive mothers.
- Gaps were also seen in the populations reached by HIV-prevention interventions, the most visible being the inability of government health facilities to reach a substantial percentage of adolescents aged 10-14 years with sex education interventions, especially in Livingstone and Mazabuka.
- No government health facilities in the district surveyed targeted clients of FSWs, MSM, transgender and PWID with HIV-prevention interpersonal education and persuasion programs and face-to-face dialogue.
- All districts surveyed except Choma had significant health staff training needs, with the greatest need occurring in Kazungula where no government health facility was reported to have staff that had been trained in the past two years on 17 out of 18 HIV-prevention topics.
- No categories of health workers in Kalomo, Mazabuka, and Sinazongwe were reported to have received sensitization training for working with PLWH and training for the identification and control of occupational hazards that would expose them to HIV.
- HIV services were not integrated with antenatal care, tuberculosis prevention and treatment services or sexual and reproductive health at the health post level in Choma, Kalomo, Mazabuka and Sinazongwe districts.

Government non-Health Sector

- None of the five districts that responded to questions on HIV-prevention in the education sector provided condoms onsite at government schools and tertiary institutions.
- In Gwembe and Mazabuka, no police officers were reported to have been reached by government-supported interpersonal HIV-prevention education and persuasion programs, male and female condom distributions programs, and condom social marketing programs in the past 12 months.
- In Mazabuka, no prison officers were reached by government-supported interpersonal HIV-prevention education and persuasion programs, male and female condom distributions programs, and condom social marketing programs in the past 12 months.

- Three out of five prisons had implemented a government-provided campaign addressing gender issues (such as gender-based violence or gender inequalities), targeted specifically to prison officers in the past 12 months.
- Three out of eight specified HIV-prevention interventions were offered to incarcerated populations in the past 12 months by all three prisons participating in the study: tuberculosis diagnosis and treatment, voluntary counseling and testing for HIV, and diagnosis and treatment of sexually-transmitted infections.

1. Introduction

According to the Demographic and Health Survey (DHS), Zambia had an adult HIV prevalence rate of 14.3 percent in 2007 (Central Statistical Office et al., 2009). In Southern Province, 14.5 percent of adult men and women aged 15-49 years were HIV positive. A district-level comparison of data from the National HIV/AIDS/STI/TB Council (NAC) showed that in 2010, HIV prevalence was highest in Livingstone (25.3 percent) followed by Mazabuka (18.4 percent). Overall, 15.7 percent of adults in the districts of Choma, Monze and Siavonga and 15.2 percent of those in Kalomo and Kazungula were HIV positive. The districts of Gwembe and Namwala had the lowest prevalence of HIV in Southern Province (6.2%). The DHS data also showed that HIV prevalence increased with wealth quintile and level of education (Central Statistical Office et al., 2009).

The Zambia Modes of Transmission Study noted that the HIV epidemic in Zambia is generalized and driven by a combination of factors, including multiple and concurrent sexual partners, low and inconsistent condom use, mobility and labor migration, low levels of male circumcision, high risk behaviors among sex workers and in male-to-male sexual relationships, and vertical transmission from mother-to-child. Other factors that increase vulnerability to HIV infection include alcohol abuse; gender inequality, gender identities and beliefs about male sexuality; intimate partner violence and sexual coercion; age-disparate relationships and transactional sex; and taboos and barriers regarding couple communication about sex (Zambia NAC, 2009). Underlying many of these factors are social and cultural norms.

The National HIV and AIDS Strategic Framework of 2011-2015 identifies four national priorities for the HIV and AIDS national response: (a) to accelerate and intensify prevention in order to reduce the annual rate of new HIV infections; (b) to accelerate the provision of universal access to comprehensive and quality treatment, care and support to people living with HIV and AIDS, their caregivers and their families, including services for tuberculosis (TB), sexually-transmitted infections (STIs) and other opportunistic infections; (c) to mitigate the socio-economic impacts of HIV and AIDS especially among the most vulnerable groups, orphans and vulnerable children, people living with HIV (PLWH) and their care givers/families; and (d) To strengthen the capacity for a well-coordinated and sustainably managed HIV and AIDS multi-sectorial response.

The overall purpose of the Know-Your-HIV-prevention- Response (KYR) toolkit is to help track the HIV-prevention response. The specific objectives are to:

- Determine what specific HIV-prevention interventions are being implemented and what resources are available to implement them.
- Determine who is doing what and where.
- Assess the extent to which the HIV-prevention response matches current HIV-transmission patterns, are focused on geographic areas where HIV is spreading most rapidly, and cover technical recommendations for key populations at higher risk of HIV exposure.

The tool kit addresses three key concepts that are critical for an improved understanding of the HIV-prevention response – location, scale, and needs – and helps provide answers to the following pertinent

questions: Who is doing what and where? Who is being reached by HIV-prevention programs? How many are being reached? Are the needs of key populations at higher risk of HIV exposure being met in settings where they are located? Thus the KYR tools permit a gap analysis, geographic mapping of the current HIV-prevention response, and provide information needed at the national and sub-national level to guide the adjustment and prioritization of HIV-prevention programs and interventions, with a view to delivering prevention services to peoples and places where they are most needed.

The HIV-prevention response analysis toolkit consists of five instruments:

- (1) Policy Questionnaire
- (2) Strategic Information Questionnaire
- (3) Program Implementers Core Questionnaire
- (4) Program Implementers Modules for Key Populations at Higher Risk of HIV Exposure (and other vulnerable populations)
- (5) District Questionnaire
 - a. Module 1: Health Facility
 - b. Module 2: Government non-Health Sector HIV-prevention Questionnaire

This report focuses on findings from the Policy Questionnaire, Strategic Information Questionnaire, and District Questionnaire. It is hoped that the data collected will provide evidence to inform the selection and prioritization of prevention interventions that are needed to have an impact on HIV incidence and prevalence.

2. Data and Methods

MEASURE Evaluation conducted a pilot test of the KYR toolkit from September to October, 2013 in Southern Province, Zambia, in collaboration with the Institute of Economic and Social Research at the University of Zambia, and the National HIV/AIDS/STI/TB Council. The study was funded by USAID. The specific objectives of the pilot test were to: (a) identify and eliminate problems in the KYR tools and enable corrective changes or adjustments to be made; (b) permit a thorough test of the logistical arrangements and planned statistical and analytic procedures; and (c) determine whether data collected via the tools yielded information that was needed to assess the extent to which prevention interventions were focused on geographic areas where HIV was spreading most rapidly, and covered technical recommendations for HIV-prevention among populations at higher risk of HIV exposure. An additional objective was to share the results of the pilot test with key stakeholders and data users in order to determine whether the tools provided data needed to answer policy and programmatic questions.

Policy Questionnaire: This questionnaire provided a broad view of the policy environment for HIV prevention by collecting information on decision makers on HIV-prevention policies and guidelines and linkages between HIV-prevention and sexual and reproductive health services. The Policy Questionnaire also assessed the extent to which policy actions related to HIV-prevention had taken into consideration gender and Positive Health, Dignity and Prevention principles. Information for the policy assessment came from key informant interviews (policy makers, technical and program specialists, activists, people affected by policy or its absences) as well as from published and unpublished reports from governments, researchers, and international donors. The overall questions addressed by the policy checklist were: How comprehensive are HIV-related policies, national laws, operation plans and guidelines? To what extent are HIV prevention policies and strategies responsive to populations at higher risk of HIV exposure? Prior to administering the interviews, the research team was instructed to conduct a policy text analysis to help guide the interviews and collect copies of relevant documents for reference purposes.

A qualitative method was used to gather information. An open ended policy questionnaire was administered during focus group discussions (FGDs) with between four and 12 participants in each group. The participants to the FGDs were purposively selected from among the key non-governmental organizations (NGOs) implementing HIV prevention and treatment programs and government institutions that participated in the study. The participating organizations were advised to send senior staff to the FGDs, from the level of program manager or equivalent in the case of NGOs. The sampled organizations reflected the range of activities they were involved in and type of organization – government (health and non-health), NGOs, community-based organizations (CBOs), faith-based organizations (FBOs) and private sector – in each of the sampled districts. Four of the 12 districts were purposively sampled on account of size (by population size based on the 2010 Central Statistical Office): Choma, Livingstone, Mazabuka and Monze. However, the data from Choma could not be analysed due to inaudible quality of the tapes. There were a total of 18 participants from three districts, seven of whom were female. Seven participants were from Livingstone, three were from Mazabuka, and eight were from Monze. Participants occupied a variety of positions including the following: chairperson, data entry officer, HIV and AIDS coordinator, paralegal officer, coordinator, executive director, secretary, Antiretroviral Therapy (ART) Focal Person, police constable, principal biomedical scientist, District HIV and AIDS Coordinator Advisor (DACA), director, and coordinator.

Strategic Information Questionnaire: This questionnaire assessed the extent to which the existing information system addressed three main categories of activities related to strategic information for the HIV prevention response: (a) surveillance of HIV and sexually-transmitted infections (STIs); (b) monitoring and evaluation; and (c) research. The Questionnaire included information needs relevant to assessing the degree of integration of gender and Positive Health, Dignity and Prevention principles into HIV-prevention programming. The focus was on data and information that could be used for any of the following purposes: to show which health and disease problems were significant and worthy of intervention; to detect and investigate health problems and initiate remedial action; to monitor the implementation and evaluate effectiveness of specific programs/projects; to identify high risk groups and geographical areas where HIV and associated problems are common; to identify and monitor risk factor that affect HIV prevalence and health status; to identify epidemics and ensure effective control measures are taken; to monitor timely and appropriate use of resources and identify gaps; to communicate effectively with decision makers and the public; and to decide whether to end, modify or scale-up a program. Eight key informants from 6 districts – Choma, Gwembe, Kazungula, Livingstone, Mazabuka and Monze were interviewed using an open-ended questionnaire regarding the existence and implementation of strategic information actions in Zambia.

District Questionnaire - Health Facility Module: The Health Facility Module collected information from district health officers regarding HIV-prevention interventions that were based at private and government health facilities. The objectives of this module were to assess the extent to which district-level health facilities addressed technical HIV-prevention recommendations and to determine barriers and facilitators to full implementation of technical recommendations. The module contained two sections. The first section focused on the availability of HIV-related interventions at health facilities in the district, by intervention type. It included questions on patient services and service delivery, safety, and administration. The second section comprised a health facility service checklist. This section collected data on the availability of selected interventions at each health facility in the district. Seven districts completed the health facility module: Choma, Kalomo, Kazungula, Livingstone, Mazabuka, Monze, and Sinazongwe. Two districts – Pemba and Zimba – were new districts and did not have district health offices at the time of the survey. Health facilities in these districts were likely to have been included in Monze (for Pemba) and Kazungula (for Zimba).

District Questionnaire - Government non-Health Sector Module: The purpose of this module was to determine what HIV-prevention interventions, programs and activities were implemented by the Government of Zambia in sectors other than health in a given district, with emphasis on Education, Defense, and Home Affairs. The module was subdivided into four sections:

- (a) Government/public school and tertiary institution HIV-prevention activity checklist: This section required a listing of all the government/public schools and tertiary institutions of learning in the district and the completion of a checklist of HIV-prevention activities. Six districts – Choma, Kazungula, Livingstone, Mazabuka, Namwala and Siavonga – responded to this section of the Module.
- (b) HIV Prevention/Support for Uniformed Personnel/Services: This section asked about programs and support for HIV prevention that may be provided by the government for the district's uniformed personnel. Uniformed personnel included the Zambia Army, Zambia Air-force,

Zambia National Service under the Ministry of Defence as well as Zambia Police, and Zambia Prison Services under the Ministry of Home Affairs. However, the Ministry of Defence did not participate in the study. All districts, with the exception of Siavonga, provided information on HIV-prevention programs/support for police officers while five districts (Choma, Kalomo, Kazungula, Livingstone and Mazabuka) provided information on HIV-prevention programs/support for prison officers.

- (c) HIV Programs/support for prisoners: This section asks about programs and support for HIV prevention that may be provided by the government in the district's prisons. It required listing all the prisons in the district and completing a checklist of HIV prevention activities for each one of them. Three prisons provided information on HIV programs and support for prisoners.
- (d) HIV Prevention/Support for Refugee/Displaced Populations: This section asked about programs and support for HIV prevention that may be provided by the government in the district's camps/settlements for refugees and displaced persons. There were no refugees and/or displaced persons in Southern Province and, therefore, no district responded to this section of the questionnaire.

The study was approved by the Tulane University Human Research Protection Program Biomedical Institutional Review Board, New Orleans, Louisiana. Local IRB approval was obtained from ERES Converge and authorization to conduct the study, from the Zambia NAC. Interviewers and supervisors received a one-day research ethics training based on the Family Health International 360 Research Ethics Curriculum. The data collection instruments were pretested in Chongwe District near Lusaka in July 2013.

The transcriptions of the Policy Questionnaire were analyzed qualitatively and conclusions and inferences deduced from the responses of the participants across the three districts. Quantification was done to instances where it was necessary to ascertain the number of participants who responded in a particular way. Data from the District Questionnaire Health Facility Module were analyzed using STATA version 12.0 and Microsoft Excel.

3. Policy Environment

Parkie Mbozi

This section of the study was intended to gather information from key informants on their knowledge and interpretation of relevant national HIV prevention policies and laws. Further, it sought to elicit information on how respondents were implementing programs in the province vis-à-vis existing national policies and laws. It is hoped that the results of this section of the study will be used by policymakers and stakeholders to clarify guidelines and directives, address barriers to implementation, improve resource mobilization, update implementation plans, or advocate for policy reform.

3.1 HIV-Prevention Policies and Guidelines

This section of the study focused on the respondents' awareness of availability of policies and laws and their understanding and interpretation of how these were impacting on specific population groups and structural vulnerability factors such as gender inequality, low level of engagement of men in the HIV prevention response, HIV-related stigma and discrimination, and social, legislative, policy and community attitudes towards key and other vulnerable populations. Additional questions inquired as to the extent to which the national HIV prevention policy or strategy promoted male circumcision as an additional strategy for the prevention of heterosexually-acquired HIV infection in men.

Participants noted that the NAC had provided among others, the below-listed HIV and AIDS policies/guidelines:

1. National HIV Work Policy
2. National Operational Plan
3. National STI and TB Policy
4. HIV National Prevention Framework

The participants noted that these guidelines were introduced around 2005 but the challenge has been the failure of the NAC to avail the documents to all implementers. The participants noted that very few implementers had copies of these policy guidelines. This concern was prominent in Livingstone, Monze and Mazabuka districts.

'Personally I have not seen a National HIV Prevention Policy or Strategy, if it is there maybe it's in few individuals hands, but what I can say is what I have seen is the HIV National Prevention Framework. That is all I have seen where HIV is mentioned.'

Participants also noted that these policy guidelines were not being formulated by NAC but by respective donors. As a result it had become difficult to harmonize most of them due to various factors such as finances, political will, and the language aspect.

There were mixed responses on how the national HIV policies addressed gender inequality. Overall the respondents were evenly divided between those that were aware and those not aware about how the named policies impact on addressing gender inequalities. Some knowledgeable respondents acknowledged the use of the HIV policy as a guideline for gender equality. Some noted that the policy has guidelines on the observance of human rights, which caters for both male and female clients. It was noted that the Gender Based Violence Act in particular supplements the National HIV Policy to address issues of gender inequality. Overall it was noted that the available policy frameworks do not discriminate along gender lines in HIV and AIDS prevention because the disease affects both sexes. They noted that in fact the policies have adopted a holistic approach to cater for men, women and children.

Regrettably because of various factors such as culture and ignorance, there was little involvement by men in the HIV-prevention response. The respondents observed that because men are bread winners, the role of taking children to the clinic or hospital is generally handled by women. On a positive note the participants noted that the introduction of programs for the prevention of mother-to-child transmission (PMTCT) which involve counselling couples to get tested and know their HIV status, was having a positive impact on male involvement in HIV prevention. In the same vein, pregnant women attending ante-natal clinics are mandated to go with their partners for testing. It was perceived that the issue of male circumcision has helped to involve men in the HIV-prevention response. Although no figures were given, it was perceived that men were increasingly getting circumcised as a way of minimizing the spread of HIV and AIDS. Overall, these policies had seen a minimal increment in male involvement in HIV-prevention programs.

In discussing the issue of stigma and discrimination, participants noted that while policies discouraged these vices, in reality this was difficult to control. The participants noted that at health facility level, incidents of discrimination have been minimized because people who are HIV are able to access the treatment places. Some HIV patients have joined support groups where they interact with others to discuss various challenges and also to encourage one another. And in some cases the ART clinics have been integrated to minimize incidents of discrimination.

“We have the National STI & TB Policy with me here, on page 23 of the National Policy, I read, protection of human rights prevention of stigma and discrimination, to ensure that rights of HIV affected people living with HIV is eliminated. Many people living with HIV are stigmatized, contraction of HIV/AIDS should be treated just like any other diseases, not be tagged for stigma. To this the government has done a lot of things which I can go on and on. It just shows how committed our government is to fight stigma of HIV/AIDS and discrimination treatment and care and support to those who need it.”

Youth Alive Zambia, an HIV Implementer based in Livingstone stated that they had noticed a reduction of incidents of discrimination against HIV and AIDS patients. In the past some pupils used to refuse to eat with HIV patients but this trend has improved for the better. Participants further stated that during voluntary counselling and testing (VCT), health personnel at ART centers or any other medical centers were mandated to observe the rule of confidentiality. This was aimed at protecting the integrity of the client regarding his or her HIV status. On the other hand, the participants observed that that in the event of breaching this confidentiality, there was no legal sanction as the policy did not stipulate any punitive actions against the offending medical personnel. Still on the subject of stigma, the participants observed

that the separate counselling of PLWH was itself discriminatory and created room for stigma. The creation of ART centers was also equally discriminatory as everyone knew that whoever sought treatment at the facility was presumably HIV positive.

The participants in Mazabuka raised the issue of culture as contributing to discrimination and stigma against HIV patients. They noted that in the western culture people seemingly recognized sex workers, homosexuals, lesbians and transgender people. As a result, these population groups easily opened up regarding their HIV status. However, in the Zambian context such populations were considered a taboo thereby inhibiting such people from disclosure and getting involved in HIV-prevention programs.

“I think the trouble that we have in Zambia, Africa, our culture, we are too cultured people such that things that come up we do not want to talk about them, prostitution in the Western world it’s something people don’t pay attention, let’s look at homosexuality, those areas they do not pay much attention. I will give you an example, there was this time we had a workshop and this was done by an NGO targeted at the sex workers, and were told to attend this workshop. So when they reached at the venue, a group of sex workers then this man came, did not know about the workshop he said should we help you. They said we have come for a workshop and called the man in charge, Mr. Phiri, prostitutes have come, and they just went back because of the terms used.”

Regarding social, legislative, policy and community attitudes towards key populations and other vulnerable groups, participants noted that although sex workers, people who inject drugs (PWID) and MSM are deemed illegal in the country, they are somehow covered in the HIV policy framework.

“Page 33 of the National Framework Policy provides guidelines on the support due to high risk vulnerable groups like sex workers. So the national policy provides guidelines on how they should be looked at.”

The participants also noted that because of the illegality, it was difficult to domesticate terms like sex workers, people who inject drugs and men who have sex with men. Nevertheless, medical personnel regard sex workers, men who have sex with men (MSM), and people who inject drugs (PWID) as ordinary patients regardless of their sexual orientation or drug use.

While the HIV policy framework had a holistic approach, participants said that it was seemingly a challenge to disseminate information on HIV prevention in schools which accommodated youths. They noted that the HIV policy framework needed to be simplified for youth. Regarding migrant workers, participants acknowledged that migrant populations like truck drivers and sex workers had a higher risk of exposure to HIV transmission.

“I think sex workers and migrants actually contribute to high level of HIV, I think I still want to blame the policies that are in place are not so favored, why do I say so? I think somehow we look at the imbalance of the distribution of wealth in the country. Now for instance, why do people move from one place to the other? It could be that they want to go and look for employment, I think what the government should do is to distribute wealth equally in all districts so that people in Southern Province are not forced to move to North-western Province where there are new mines to go and work from there. I think even here there can be mines that can be exploited, so

that people from here don't move, this movement is the one that puts us at risk in the area of HIV."

Although Southern Province did not have refugees, participants sympathized with their situation as oftentimes they were fleeing from war in their countries. Even in camps it was necessary to extend HIV-preventive measures to refugees. Meanwhile, the issue of culture, value and traditions were cited as a challenge in terms of attitude towards HIV prevention. The participants noted that in the Zambian context men had a larger say in sexual matters. The use of condoms was cited as an example. Even in the case of sex workers, the man has the choice to use condoms as a preventive measure or not to use them at all. To overcome this challenge, the participants proposed that the legal framework should be tightened to prevent incidents of wilful transmission of HIV. The law must have a punitive clause for those people that deliberately transmit HIV to their partners.

On the issue of male circumcision (MC), one participant stated:

"The policy has allowed the provision of MC services throughout the country including in Eastern, Northern and Southern Provinces where there are low levels of circumcision. This information we can get it from the Strategic Framework Policy. The policy also allows the male circumcision of young ones and to ensure that the traditions and capacity building are strengthened. In addition the policy provides the hygiene standards and environment in which MC will be carried out as well as HIV counselling being part of the package."

Participants observed that in the recent past the issue of MC has taken center stage in the area of HIV prevention. They noted that the involvement of among others; politicians, actors and traditional rulers on adverts promoting MC has helped to spread the importance of the practice. The component of promoting hygiene has actually boosted the need for MC.

"The strategy of male circumcision we can see some of the proof, that during holidays we have an overwhelming response, school going children go for MC in their health facilities whereby like this August holiday we have seen a good demand than any other holiday. The number is always on the increasing part, even when you see what is happening, it shows it is in line with what the National Policy says and we are seeing that it is good."

3.2 Mobilization and Commitment of Resources for HIV Prevention

The question of whether there was a costed plan for effective prevention of HIV was raised. However, there were mixed responses on this subject. The participants in Livingstone responded as follows:-

"Yes there is, we have the National Operational Plan and this plan it is costed. It provides for all levels of the community. So when we put up our plans we also use the national one which is costed."

Respondents in Mazabuka gave the following response:-

“I might say no but with inverted commas; maybe I have not understood the question. This is fine to us, this is free; the donors are costed. The way it is with us that we feel it is not costed when it is. The way it was before I will just give an example. When we started giving ARVs people used to pay something then they said it is free, but someone is paying for it. No wonder we find ourselves in problems because there is no sustainability.”

And in Monze, the response was as follows:-

“I think for me there is no costed plan for HIV prevention, I don’t know how many organizations here have these funds in order for them to plan all these activities- Male Circumcision, Voluntary Counselling and Testing, PMCT whatever campaigns which are there all those plans just go to waste, why, because there are no resources to effectively do these activities. We are not actually doing them, they are good on paper. It leaves much to be desired.”

In answering this question, respondents said implementers were guided by the national policy on the need to plan for resource mobilization to carry out HIV-prevention programs. However, the major constraint was the lack of funds to carry out these activities. In Livingstone the respondents said that they collaborate under the District AIDS Task Force (DATF) to carry out HIV-prevention measures. During these meetings implementers are assigned specific tasks within their budgets so that the HIV prevention measures are undertaken.

In Monze the respondents acknowledged the element of planning but noted that some interest groups like the disabled or handicapped were seemingly left out of these HIV-prevention programs. In particular, they cited the blind and deaf communities as having difficulties in accessing information on HIV preventive measures. One respondent in Monze said that the various stakeholders had not been brought together to discuss a costed plan for resource mobilization for HIV prevention while another in Mazabuka stated:

“Whenever you are doing an activity you have to plan because you cannot just go out without anything, you need fuel that is why I said the recipients may not see anything but there are costs attached to it. It’s mandatory to report back to donors and NAC.”

Questions about the existence of a costed work plan for HIV-prevention also elicited participants’ views as to whether the plan tracked and analyzed expenditures to improve future planning cycles and allocated financial, human and technical resources to ensure gender-responsive HIV-prevention strategies. While the respondents in Monze skipped this question, their colleagues in Livingstone and Mazabuka confirmed that the available programs provide room for tracking and analyzing expenditure to improve future planning cycles. The 2011 – 2015 Strategic Plan was cited as providing room for planning and tracking purposes. The respondents said that the guidelines helped them to fall back on programs that were not done during the year due to lack of resources such as finances. In addition, the costed plan also helped implementers to track programs, such as condom distribution in their districts.

Regarding the allocation of resources in the costed plan to ensure gender-responsive HIV-prevention strategies, respondents noted that sometimes the implementation of HIV prevention strategies was segmented by gender. In this regard, financial resources had to be allocated to achieve this objective. The respondents cited the male circumcision programs targeting the male population in the country. Respondents also stated that for HIV-prevention strategies to be successful all areas including technical

support needed to be planned and budgeted for. They added that without planning for such resources then the HIV prevention strategies would not be sustained. The respondents noted the importance of human resources under HIV prevention strategies. However, like any other resource, trained personnel were sometimes scarce. The following responses were recorded:

“And on human resources to ensure gender responsive, HIV preventing strategies I think on that, something has been done like in our organization (Zambia Police Service) there has been people who have been put to look at issues of HIV/AIDS, the gender imbalances, there are people looking at that.”

“Shortages of trained personnel are there even at Ministry level. We don’t have enough manpower to handle HIV and AIDS issues. I think the ever increasing population puts health in this awkward position, when the population increases so much means we need to improve on manpower as well. Trained human resource to deal with certain fields that is another challenge, but the thing is our towns and villages are expanding. We all need resources to train health staff because with the small population it is manageable, at the moment the population has grown so much and we require more human resource to be trained.”

3.3 Linkages of HIV Prevention and Sexual and Reproductive Health

Responding to this subject, the respondents confirmed the existence of bi-directional linkages between HIV prevention and sexual and reproductive health (SRH) in the country. For example, there was a direct link between maternal and child health (MCH) and PMTCT programs.

“Yes there is, one I can bring out is the issue of PMTCT which is offered, it is productive health, we have incorporated it, there is also the issue of family planning which is used as a prevention measure, in that very few women who are HIV positive fall pregnant.”

“I think as my colleague has mentioned even in the communities where we do implementation, the issue of reproductive health where they are linked to HIV prevention, we talk about family planning and other things.”

Still on the same subject, the respondents noted the existence of policies and procedures that facilitated the linkage between HIV prevention and SRH. The AIDS policy compels all pregnant mothers to undergo testing to prevent the transmission of HIV to children. It was mentioned that under the same policy, medical personnel are guided to seek the consent of the client that wishes to have an HIV test. The respondents also listed the ART protocol of 2010 and the Family Planning Policy. In the area of joint planning mechanisms between HIV and SRH departments, the respondents said this was already stipulated in the policy. Every activity required planning before it could be undertaken. The Standard Operation Procedure and couple testing for HIV were perceived as two of the most important policies in place to facilitate the strengthening of the linkage between HIV-prevention and SRH services.

“On this one, the procedures which are there first you must have guidelines, we have the Standard Operation Procedures (SOP) and the people that are offering the service, they undergo training because the guidelines will say before offering those services one needs to be trained.”

“In addition that policy of testing a couple when a women is pregnant, it’s one of the most important policy and procedure, because when they are found positive they will be told how to make sure that before the child is born is not infected, there was one time just in case one partner is negative and the other is positive, they will be told how to do sex health related issue condoms, to me that procedure is one of the most important one.”

Participants affirmed that line items for SRH commodities (female and male condoms, other contraceptives, STI medication, and safer delivery kits) were included on the HIV-prevention budget.

“The budgets which we make at the end of each quarter they look at HIV prevention and also reproductive health, all these which have been mentioned are budgeted for.”

The respondents said they budgeted for contraceptives such as male and female condoms because of their importance in HIV prevention. However, in practice it was observed that male condoms had been accepted as a tool in HIV prevention and tended to move faster than the female condoms which were slowly being accepted. It was also agreed that there was joint planning of HIV-prevention and SRH programs between the government and other stakeholders. This was done during planning meetings involving all stakeholders at district level. Such meetings were guided by the National HIV Policy guideline.

“I think we agree that there is joint planning because we have stakeholders meet and look at certain areas even if they don’t look at how they should put their work together issues that are there, we are talking about the referral systems that are there between the NGOs and the government. Normally there is joint planning they have to come together to make sure they deal with the issues because HIV issues are related sexually reproductive issues.”

The respondents also said that they had introduced youth-friendly PMTCT activities which were promoting, among other things, STI medication to minimize infections. In the area of family planning, the respondents said that because people in Southern Province had generally accepted polygamy as a way of life, changing their attitude was proving to be difficult and had a negative effect on HIV prevention.

“I think in the communities where we do implementation, the issue of reproductive health where they are linked to HIV prevention, we talk about family planning and sex education to ensure reduction in HIV.”

Concerning the prevention and management of STI infections, respondents said the government has provided guidelines in the treatment of STI infections. Each health facility should be able to treat STI’s whether there is a laboratory or not. Health facilities that do not have laboratories use a chart which guides the medical personnel to identify the type of STI and later provide the patient with medicine. But where there are laboratory services, the patient can be referred for such testing. Meanwhile, patients with STI are counselled and given sufficient information before subjecting them to an HIV test.

Maternal and newborn health care was perceived as an important area in minimizing HIV infections. This response was provided by one participant:

Although we have talked a bit on maternal through sexual reproductive health, the issue we have been talking about is the issue of PMTCT, maternal health, so like in Livingstone, most of the sites you go to where we offer MCH, we are also offering PMTCT, but we have gone further, instead of referring those positive mothers who are eligible to start full ART treatment, we have created the sites or centers that although it may not offer ART to all the general public it would only offer for the pregnant mothers and would be able to access the ART at the clinic. So we have integrated so that mothers would be accessing all the services from one particular clinic. So they will have to access until they deliver and even when they deliver they have to confirm because we have to follow them up and the baby at 18 months. When we do the test, and the baby is tested negative we would know that we have successfully prevented HIV infection to the baby and they will be discharged as long as the baby has stopped breastfeeding.”

Participants were also asked: “To what extent have the following essential sexual and reproductive health services been integrated into HIV-prevention and response programs?” In general, participants felt that at the national level the Government had taken a prominent role in preventing and managing gender-based violence (GBV). This has seen the creation of the Victim Support Unit (VSU) under the Police Department and it currently collaborates well with the Ministry of Health (MOH). The respondents said that once victims report any violent cases to the Police, they are given a medical report for presentation to the nearest medical center for commencement of treatment. The respondents also said that at community level, various NGO’s are currently undertaking sensitization programs on the dangers of GBV and direct victims to places where they can access help.

“I think the prevention of GBV in the communities, because we deal with the communities, for community sensitization, the dangers of gender based violence, and direct them where they can access help.”

In addition, the respondents said that in Monze the traditional rulers were equally involved in educating the local people on the danger of GBV. Respondents however, expressed concern that some survivors of GBV were undermining the program by withdrawing cases before going to court. The YMCA revealed that Police in Livingstone arrested 650 cases of GBV but only one suspect was successfully convicted. The rest of the victims withdrew their cases thereby undermining the fight against GBV. Still on GBV, the respondents brought out the issue of sexual assault which medical personnel are handling.

“I also want to look at cases of sexual assault which the Ministry of Health handles. Let me give an example, issues of rape, when they come to the MOH in Livingstone, we have a special unit where they don’t have to pay and officers who they will find at that clinic they also understand the law, trained by the police, so that person whom they find will be able to assist them. We have added another component if the victims test HIV negative but the perpetrator is HIV positive, within 3 days we are able to offer post exposure prophylaxis to the victim to prevent the virus.”

On the topic of prevention of unsafe abortions and post-abortion care, respondents stated that the country allowed abortion on medical grounds and any other reasons are deemed as criminal and therefore illegal.

“From what I know abortion is not legal in Zambia unless you have a medical problem and usually safe abortions are done from the hospitals and when this happens you are assigned to three doctors, there has to be consent from 3 doctors, generally it is illegal.”

As a result, implementers have been carrying out sensitization campaigns on the danger of abortion. As a preventive measure implementers are encouraging family planning as a way of minimizing unwanted pregnancies. And the Ministry of Health has created clinics which handle cases of post abortion. These clinics have additional services aimed at saving the lives of mothers. Participants also stated that, although members of the public are given education through SRH on the danger of abortion, the girl child has proved to be a weak link in minimizing illegal abortions. It has been established that some young girls that get pregnant, resort to unsafe abortion which sometimes results in death.

“So I think much as Sexual Reproductive Health is there to educate the women, I think at the end of the day safe abortion is still a problem because there are two types of abortions, there is inevitable abortion and there is abortion that is wilful, when we look at inevitable abortion, the time to go and consult the doctors for them to say ABC; I think here, we must look at wilful abortion where people feel she is pregnant and is not ready for this pregnancy, therefore the information which people receive is for those women to be given this information so that they do not fall into this issue of having unnecessary abortions and they should learn to protect these pregnancies by means of using condoms, contraceptives so that they don't fall pregnant. However, that information is given in areas of Sexual Reproductive Health that is given to women.”

3.4 Legislative Framework

Gender-based Violence

This section began by inquiring about the existence of laws and policies that prevent or respond to GBV, perceptions about the degree to which the laws/policies have been enforced, the extent to which the public was well informed about the laws/policies against gender-based violence, and whether there had been an observable change in the reporting of cases of gender-based violence since the implementation of the laws/policies. Questions were also asked about the extent to which the country (e.g., government, NGOs, donors, FBOs, CSOs, etc.) had built public awareness and demand to amend legislation and policies that created barriers to the reporting of and response to gender-based violence. All the respondents confirmed that they were laws against gender based violence and cited the following laws:

- Chapter 37 of the Penal Code; and
- The Anti-Gender Based Violence Act which was enacted in April 2013
- The National Child Policy

The respondents said that due to many sensitization programs on radio, television, drama groups, church forums, schools and workshops added that members of the public in especially urban areas know about these laws that are aimed at arresting GBV cases. Furthermore, this information on GBV had been translated in local languages. Armed with this knowledge victims of GBV have managed to report cases to the Police VSU and YWCA for action. The YWCA in Livingstone said in 2012 it had 650 cases of reported cases of GBV clearly indicating that members of the public are sensitized on this topic.

Although the Anti-Gender Based Violence Act was enacted to protect both men and women, few men

that are abused report cases of violence to the Police or the YWCA. The reason is that such men fear to be ridiculed by society and even the Police. Because of this gap, the Police handle more cases of women being abused by their partners.

The Anti-Gender Based Violence Act was perceived to have also helped to minimize the abuse of children by some parents. Some children have rushed to the Police to report cases of abuses. Unfortunately, participants did not provide figures on such cases. For various reasons such as victims' fears of losing one's marriage and the bread winner of the family, the Police have not managed to convict men that have been reported for violence by their spouses. Many victims have ended up withdrawing such cases before the matter is pushed to the courts. That aside, there is a slow change of attitude towards engaging in GBV as the perpetrators fear that they could end up being convicted the next time they are reported to the Police.

Concerning public awareness of GBV, respondents said that they were many organizations and individuals involved in the dissemination of information discouraging GBV. These organizations include the Ministry of Health, the Police, SNV, World Vision International (WVI) and Churches Health Association of Zambia (CHAZ). Traditional rulers, Members of Parliament and various community leaders have been lobbying government to stiffen the punishment against perpetrators of GBV. In fact the more the media reported about cases of GBV, the more have NGO's pushed for tightened legislation to negate the vice.

Marriage Laws

The policy questionnaire also enquired about respondents' awareness of marriage laws and perceptions as to the extent to which they are respected or enforced. Respondents stated that, according to customary law there is no specific age for marriage. For a girl, this depends on her attaining puberty at the age of 12, 13, 14 or 15 years. As for a boy, as long as he is capable of looking after a wife, he can marry at the age of 17, 18, 19, and upwards. And according to statutory law, men and women as long as they are 21 years and above they can get into marriage even without the consent of parents. According to respondents, in both customary and statutory marriages the age limit is supposed to be respected because the institution of marriage requires serious responsibility. Although a girl attains puberty at say 14 years, it is not mandatory for her to get married because she still has to go to school. Even if she drops out of school, marriage only becomes a reality when there is a suitor. However, because of changes in attitudes the general public has started protesting the culture of early marriages under both the customary and statutory law. Today, traditional rulers have been strongly campaigning against early marriages in villages to allow both girls and boys to concentrate on their education. Regardless of the age, the institution of marriage is respected under both customary and statutory law.

“Yes you have to be 21 on statutory law, but customary law, you know how those people behave in the village, I don't know, you can go in the bush, field and other places, so you can marry even at 17 in the villages. It's different from the statutory 21 years and above.”

“Adherence is very difficult in our society. There is a difference between the rural areas and the urban areas. The urban areas people are aware and would avoid to go and get a minor below the age of 16 and marry them off, but it is very common in the rural areas. They only come and report when they have a difference, but in town because of a minimum sentence of 15 years, who would want to marry a girl of that age and go to jail for 15 years?”

As there is no specific age limit for marriage under customary law, respondents felt that it was difficult to monitor the legal minimum age under customary law. Fortunately, the inclusion of the law of defilement (sleeping with a girl below the age of 16) has brought in the element of monitoring of the minimum age under customary law. And respective parents do monitor the ages of their children as they have the right to accept or reject any marriage proposal for their daughter under customary law. Under statutory law most of these marriages are registered by the Registrar of Marriage thereby allowing scrutiny of one's age before tying the marital knots.

“The aspect of monitoring, I think it's done under statutory law, the Registrar of Marriages and makes sure that before the marriage certificate is offered both parties are over 21 years. If they are younger they should have permission from their parents, have you seen now? It turns back, even those who are below 21 can still marry under statutory, with consent from their parents, if there is no consent from the parents then they cannot marry. This consent is not applicable if the partners are widowed.”

Regarding the amendment, enactment or enforcement of the legal minimum age at marriage, respondents explained that in the last three (years) stakeholders Contributed to the National Constitution Conference (NCC) drafting the Draft Republican Constitution to amend the legal minimum age. For now the stakeholders are only waiting for the government to complete discussing the draft constitution.

“I think the country is moving in that direction, you are aware that we are trying to come up with the new constitution and with regard to marriage, the draft constitution says a person shall marry another person of the opposite sex at the age of 18. The steps are there, it is just the procedure. The draft constitution is very clear on that.”

Legal age of Consent to Sexual Intercourse

Participants affirmed that under statutory law it was established that the legal age for sexual consent/debut is 16 years but under customary law there is no specified age for sexual consent/debut. The ideal situation is that sex is a preserve for married couples. But because people have the power of choice, they can choose to indulge in sex outside marriage. In this regard the element of consent before indulging in marital or pre-marital sex is still left in the hands of individuals. As for respect, the respondents noted that society expects couples that are married to engage in sexual intercourse. The couples may be married under customary or statutory law.

The respondents said that regardless of the law this was a difficult situation to monitor because sexual activities were a private arrangement. It is the wish of every parent to marry off virgins but in reality this is not possible as some youths are involved in pre-marital sex. Several reasons were given which prompted some youths to engage in pre-marital sex. These include peer pressure and access to technology such as internet which enable youth access to pornographic sites. The films/movies which some youths watched also tempted some to engage in pre-marital sex. And in all these situations the parents/guardians were not there to prevent pre-marital sex. The results of pre-marital sex are only noticed when one becomes pregnant. In certain situations parents only come to learn when their girl child has been involved in an abortion attempt. Because of these gaps, society is often reactionary to the outcomes of pre-marital sex.

In the past three years, stakeholders (government, NGOs, donors, FBO, CSO, etc.) have intensified campaigns to warn the general public on the dangers of pre-marital sex. This has included promotion of programs like Virgin Power among youth. These messages have been taken to schools, on television, radio and drama groups. Furthermore, the stakeholders have been warning society on the consequences of defilement. Adults have been warned not to have sex with youth below the age of 16 years as adults risk being arrested. Both of these programs are targeting the legal age of consent for sexual intercourse.

“In the recent past, some NGO’s have tried to protect the girl child, although this is not to put the age but trying to look at the marriage point of view, I think in a way it tries to look at the issues of sexual intercourse, when they say who is a child then, you say a child is one who is 16 years and below.”

Legal age for HIV Testing

The respondents gave two different ages as the legal age for HIV testing independent of a parent or caretaker. Ages 16 and 18 years were mentioned as the legal age at which a youth can access Voluntary Counselling and Testing (VCT) services without the consent of the parents or guardians. And the respondents said, youth below the age of 16 were always instructed to come with their parents or guardians for HIV VCT. The respondents explained that consent from parents/caretakers was necessary because it helped to minimize incidents of depression if a youth tested positive after the HIV test. On the other hand, it was observed that while parental or caretaker consent was necessary, in certain cases it was a hindrance as youths are delayed from knowing about their HIV status. This means that a child can only know about his or her HIV status once the parent or guardian is ready to escort them for VCT.

“The parental consent is quiet negative, because it prevents young people in accessing ART. Imagine my son who is 10 years goes to a clinic and says I want to have an HIV test. Then the people at the clinic say no, go and call your parents, maybe this child did not want the parents to know about it, this would block the child. In my view the parental consent is not helping.”

The legal age of HIV testing was perceived by respondents to have a positive impact in terms of VCT among the youths.

“We have had a number of youths especially those that are still in school, to have an HIV testing and we have had no experience of a negative impact, whereby maybe the child gets disappointed, but they have been able to receive results as they come out and being able to move on or accept the results as they come out.”

However, the respondents noted the following challenges:-

“I think one of the barriers we have experienced as an organization in relation to HIV prevention, is in terms of those minors who are on HIV treatment, the barrier is from the parents, they are not able to disclose the status to the child. So the child will be taking medication without knowing why, and they are growing becoming sexually active and it’s a girl and she gets to be interested in a boy or vice-versa and have no information on why they are on that medication, there is no HIV prevention there, that is what we have found in the communities, parents are not able to disclose the status to the children and why they are taking medication.”

“The other problem we found is that those that are adopted being raised by probably relatives, they do not disclose to their guardians their HIV status for fear of rejection/stigma in the family, the feel if they do that they will be thrown out of the houses. The challenge is those minors that still need help as they cannot look at themselves.”

Legislation and Policies that Create Barriers to HIV prevention

On the issue of reviewing and amending legislation and policies that create barriers to HIV prevention and response in minors, respondent number one from Mazabuka said that government has not done much on this subject. He added that the status quo has remained the same under the current HIV guidelines. On laws and policies affecting women and girls, about 75 percent of the respondents across the three districts were aware of at least one specific law or policy and noted two important documents: Anti-Gender Based Violence Act and the Girl Re-entry Policy which allows young mothers to return to school. In looking at the impact of laws and policies on HIV prevention for women and girls, some respondents noted that the Gender policy promoted equity between male and females. A female respondent stated that because of this policy, women were able to contribute to decision making in homes. Although our culture seemingly prohibits women from taking a leading role in sexual matters, with this policy women are quite free to discuss some protective measures for HIV prevention. Commenting on the re-entry education policy, she said that young girls that stopped school after getting pregnant were now allowed to return to continue with their studies. In the past, pregnant girls were barred from continuing with their education while the boys were not expelled from school for causing a pregnancy.

Public Awareness and Amendment of Laws/Policies that Discriminate Against Women and Girls

Commenting on the subject of public awareness, amendment of laws and policies that discriminate against women and girls, the respondents noted that a lot of work had been done in this area. For example, since the Ministry of Health introduced compulsory PMTCT during ante-natal, it has helped women to be counselled with their male partners. This is an advantage as it minimizes HIV infections. Furthermore, the respondents noted increased advocacy on the need to strengthen the Gender Violence Act to protect women and girls from abuse by their male partners. The government, NGOS, CSO's and members of the general public have been in the forefront lobbying for advocacy whenever the media carries stories of victims having been battered by their male/female partners. One respondent from Mazabuka district said there are serious steps being taken under the new draft republican constitution to insert laws protecting women and girls. These laws include social and economic rights. In addition there is a proposal for women to have the right to change the names of children if the partner fails to support them financially and materially.

Laws and Policies affecting Prisoners

In discussing laws and policies affecting prisoners, all the respondents agreed that there were no specific laws for the prison population. However, prisoners were covered under the National HIV Policy of universal access to treatment for all vulnerable groups including sex workers and truck drivers. The impact of this National HIV Policy has seen prisoners having access to information, VCT and treatment (ART). On the issue of reviewing and amending legislation to benefit the prison population, very little has been done. The respondents noted that prisons are detention centers to punish those that have offended society. As a result, sexual activity is one right which the prisoners forego. In view of this situation,

Implementers cannot take contraceptives to the prisoners. In fact the Commissioner of Prisons stressed that condoms and other contraceptives were not allowed in prisons. Nevertheless, program implementers are allowed to provide information on the dangers of HIV and prisoners who are living with HIV are given treatment within the prison premises. In the same vein, female prisoners that entered prison while pregnant are given the necessary care and treatment.

Anti-discrimination Laws and Policies that protect People Living with HIV

Looking at this subject, the respondents said the law protected HIV patients from discrimination and stigma. They referred to the following laws:-

- a) The National HIV Policy clearly stipulates that no one is supposed to be discriminated on the basis of his or her HIV status;
- b) The HIV Work Policy – Under this policy employers and fellow employees are mandated not to discriminate against any colleague who is HIV positive. In addition each organization is supposed to have an HIV Focal person to provide guidance and counselling; and
- c) The GBV Act also has a provision to punish anyone who wilfully infects his or her partner with HIV

On the issue of PLWH taking legal action against their employers the respondents cited the case of three Zambia Airforce (ZAF) employees that were dismissed on grounds of testing positive with HIV. It is important to note that these ZAF employees won their case in court and the employer was directed to re-employ the officers in the year 2011. This example clearly demonstrates that employees are free to take legal action against their employers once discriminated for testing HIV positive. On the topic of law enforcement officers and judiciary officials being trained in anti-discriminatory laws, the respondents said these officials were often kept abreast with changes in various aspects of the law. This was done through trainings such as workshops and in-house training. In addition, the media also played a role in disseminating respective changes in law.

Regarding public awareness and amending legislation of polices that discriminate against HIV status, the respondents said that this was an ongoing process. They said the National HIV Policy was born out of frequent lobbying by members of the general public, NGO's, CSO's, and FBO's. On the availability of laws that criminalize HIV transmission, the respondents cited the Anti-Gender Based Violence and National HIV Acts. Following continues sensitization by Implementers many members of the public were aware of these anti-discrimination laws that protect PLWH.

Laws that Promote Gender Equality

As mentioned earlier, all cases of gender-based violence fall under the GBV Act and the Gender Policy. The effectiveness of these laws has seen an increase in the number of victims that report their cases of violence to the YWCA and the VSU. Regarding the property and inheritance rights, respondents stated that this is covered Cap 59 of the Laws of Zambia. This law stipulates what is entitled to the spouse, the children and dependents when the head of the house dies. In terms of effectiveness, it was observed that many people were aware of this law which prohibits property grabbing from surviving spouse, children and dependents. This is based on the number of Administrators of Estates that have been taken to court

for violating the property and inheritance rights. As a result there has been a reduction of cases of property grabbing especially in urban areas. Concerning access to education, the law encourages education for all. In fact the government has placed this as a priority under the Millennium Development Goals from 2006 to 2015. There is commitment on the part of government to encourage everyone access to school as there are no fees from grade one to grade 7. Furthermore, the Government has allowed young mothers to return to school after nursing their children.

3.4 Summary

Overall the research established that Zambia has laws and policies that which promote HIV prevention measures among the various population groupings. Most of the policy makers are fully aware of these laws and policies which include the National HIV Policy, the GBV Act, and the Gender Policy. The involvement of law enforcement officers also brought out additional laws under the Penal Code which promoted HIV prevention. The study also established that there were no specific laws supporting prisoners, sex workers, MSM, transgender people and PWID. These groups were covered under the universal access for treatment. The respondents acknowledged that while sex workers, MSM and transgender people, and PWID were part of the general population it was difficult to attend to their specific needs because of the legal environment.

In addition there is no law to support abortion and the distribution of contraceptives to schools and prisons. The research further established that there was political will on the part of government to minimize incidents of HIV. This was evident by the formation of the National Aids Council (NAC) and the enactment of various laws being pushed by NGOs, CSOs and FBOs. The research further established that using these laws, the various program implementers in Choma, Livingstone, Monze and Mazabuka districts were able to carry out their objectives. The research also established that the available laws were universal as they touched on education, health and sensitization on the danger of HIV and AIDS. As a result of networking and regular meetings at district level, the program implementers were able to catch up with changes in the various laws. The media has also played a major role in sensitizing Implementers on new changes in the law. Meanwhile, the research noted that one major shortcoming was the failure by NAC to deliver sufficient copies of the various laws to the Implementers at district level. Other shortcomings included the lack of resources, awareness of policies, weak implementation and people's negative beliefs. Other challenges include lack of capacity among some policy makers at district level and limited coordination in some districts where policy makers rarely meet at DATF level.

4. Strategic Information about HIV Prevention

Mubiana Macwan'gi and Tedson Simwanza

The data for this section were drawn from the strategic information questionnaire, the objective of which was to determine whether strategic information actions were in place and assess the extent to which they were being implemented. The focus was on data and information that could be used for any of the following purposes: to show which health and disease problems are significant and worthy of intervention; to detect and investigate health problems and initiate remedial action; to monitor the implementation and evaluate effectiveness of specific programs/projects; to identify high risk groups and geographical areas where HIV and associated problems are common; to identify and monitor risk factor that affect HIV prevalence and health status; to identify epidemics and ensure effective control measures are taken; to monitor timely and appropriate use of resources and identify gaps; to communicate effectively with decision makers and the public; and to decide whether to end, modify or scale-up a program. It is hoped that the results of the situation analysis will be used by program managers, policymakers and stakeholders to make recommendations to improve the strategic information system and promote improvements to current HIV programs and projects based on evidence.

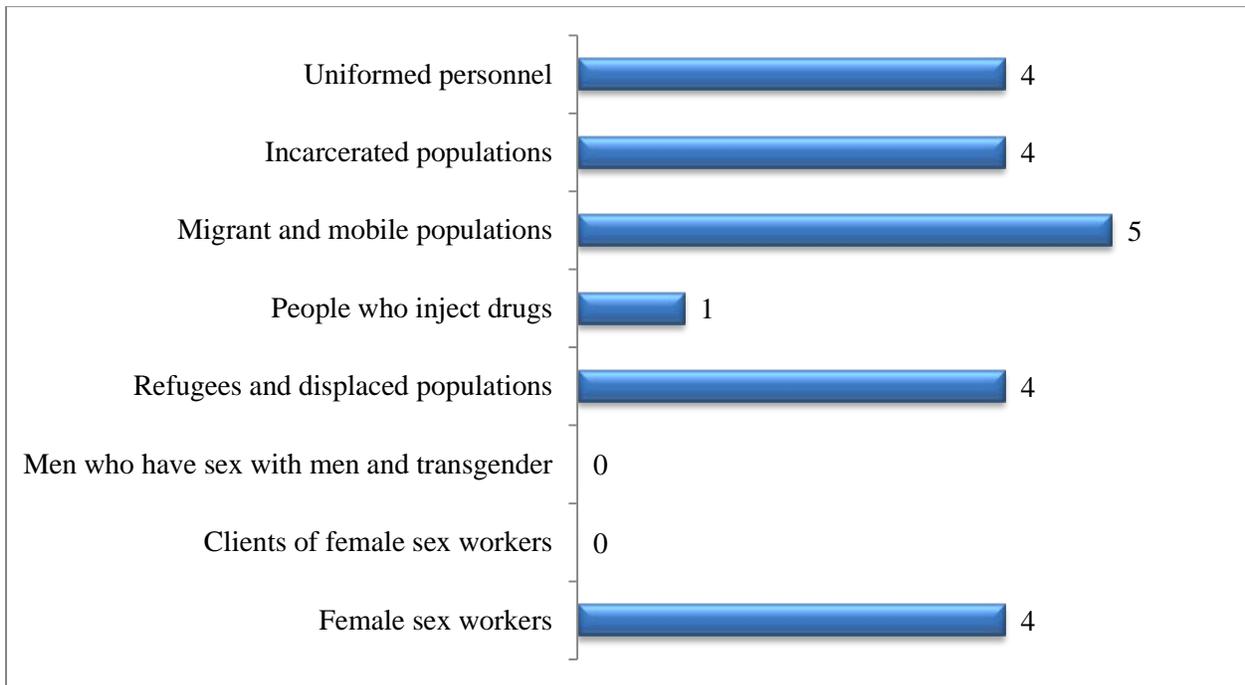
4.1 Monitoring and Evaluation

Eight (8) participants from six districts responded to the Strategic Information Questionnaire. All reported that there was a national HIV and AIDS monitoring and evaluation (M&E) system in place and that the districts followed the policies and guidelines that had been established by the NAC. The Health Management Information System and SMARTCARE System under the Ministry of Health (MOH) were cited as part of the national M&E system. Further, respondents indicated that the NAC is responsible for overseeing HIV and AIDS activities in all the districts. Five out of the eight respondents stated that there was an imbalance between urban and rural areas in the way information was collected from pregnant women, with more information being collected from urban areas. Some of the reasons provided for this reported imbalance were (a) urban areas had more health facilities which were easily accessible whereas in the rural areas, facilities were few and distances covered were long, and (b) inadequate resources. The districts that reported that there were no imbalances stated that all the communities have put in place counsellors and staff both in rural and urban areas who report through smart phones with Mwana160 interface and that the National M&E system was designed to cover all the rural and urban health centers.

4.2 Cross-sectional Surveys, Surveillance, and Types of Information Collected

Participants were asked whether the national HIV M&E system included cross-sectional surveys of behavior in specific priority populations. Figure 1 indicates that PWID (6), and mobile and migrant population (5) were considered the most-covered populations followed by refugees and displaced population, incarcerated populations, and uniformed personnel (4 each). MSM and transgender population and clients of FSWs are not currently covered by the National HIV M&E System

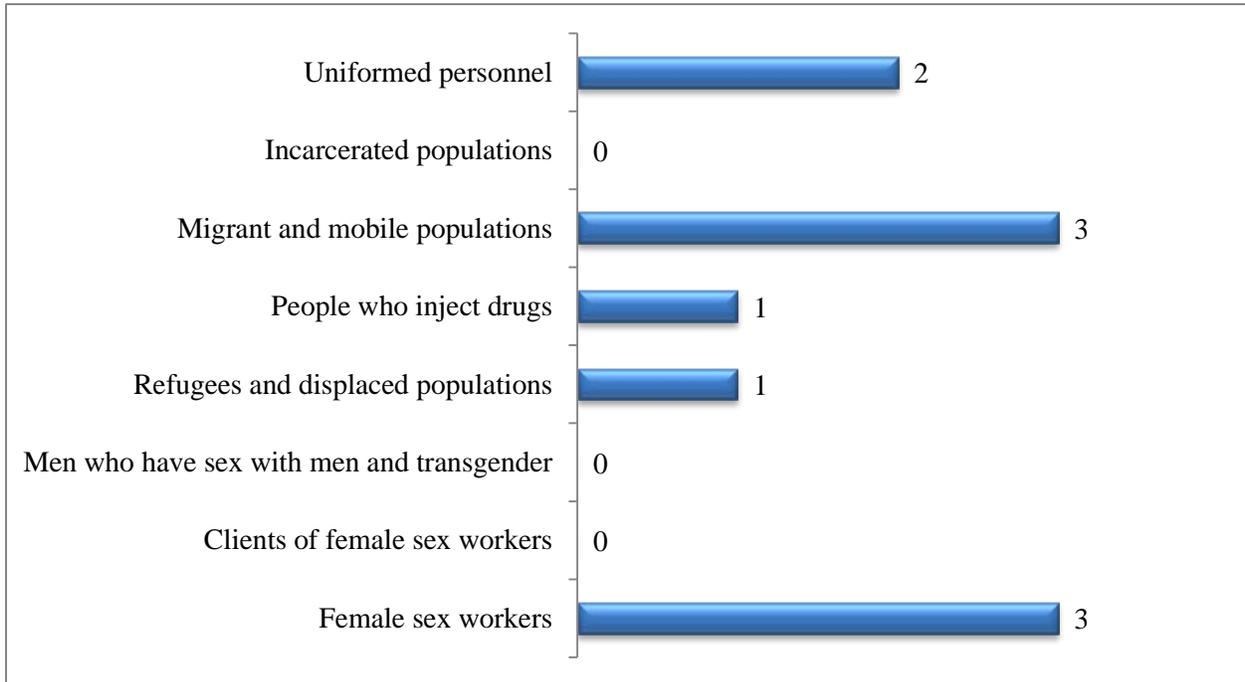
Figure 1 Number of participants reporting that the National HIV M&E System includes cross-sectional surveys of behavior among key populations and other vulnerable groups, Southern Province, Zambia 2013



It was reported that data on most key and other vulnerable populations are collected by the MOH and in rare occasions by Corridors of Hope. However, there are no data collected on MSM, FSWs, clients of FSWs and transgender people as some these acts are considered to be illegal. Participants talked about FSWs' fear of being arrested as a major challenge to the implementation of cross-sectional surveys among this group.

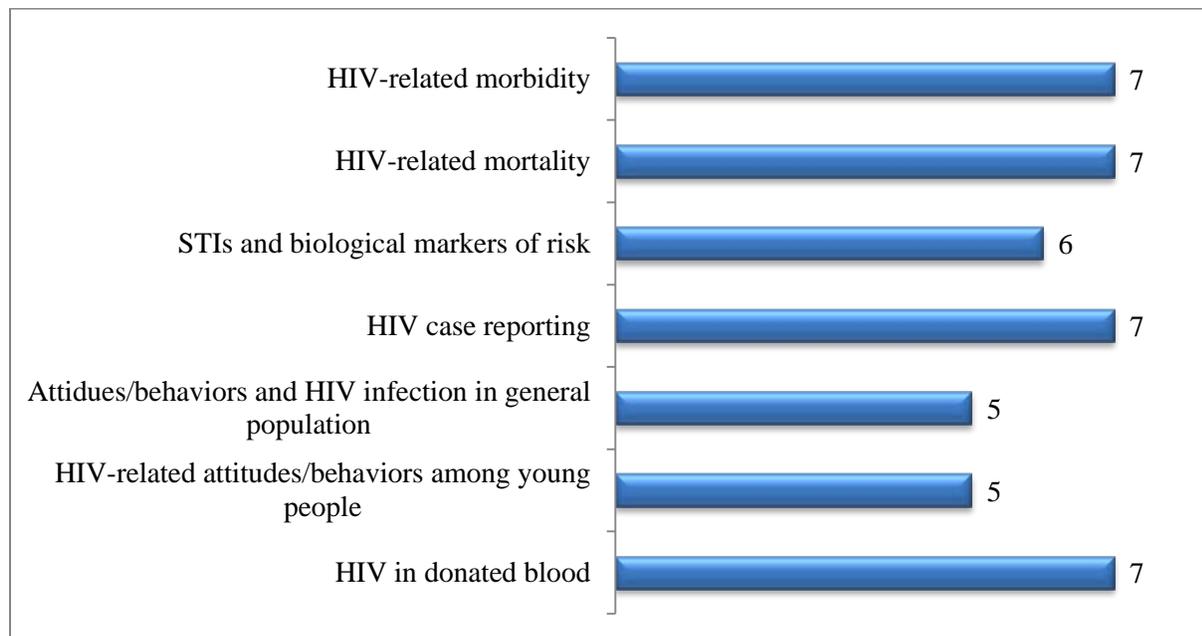
Figure 2, shows that in general, participants reported that to a large extent National M&E system does not collect behavioral surveillance data among key populations. For example, all participants reported that behavioral surveillance data are not collected on MSM and seven reported that no surveillance behavior data is collected on incarcerated population and clients of FSWs. It was mentioned that FSWs, MSMs, and PWID were included in the general population in the National HIV M&E System. The MOH and Corridors of Hope were reported as conducting behavioral surveillance on mobile and migrant populations, with fishing camps in Namwala being singled out as areas where intensive M&E systems are being established.

Figure 2 Number of participants reporting that the National HIV M&E System collects behavioral surveillance data among key populations and other vulnerable groups, Southern Province, Zambia 2013



Most participants reported that to a large extent, the National HIV M&E system tracked HIV in donated blood, HIV case reporting, STIs, and other biological markers of risk. VCT data were reported as being collected monthly through the Health Management Information System (HMIS) and Smart Care and PMTCT data, quarterly through the HMIS reporting system. Five participants stated that to a large extent, HIV-related attitudes and behaviors among young people, and attitudes and behaviors and HIV infection in the general population are also tracked by the System. All but one participant reported that the system collects data on HIV-related mortality and morbidity. Regarding the tracking of HIV in donated blood, it was reported that blood is centrally screened in Lusaka and that there were no blood banks in Mazabuka.

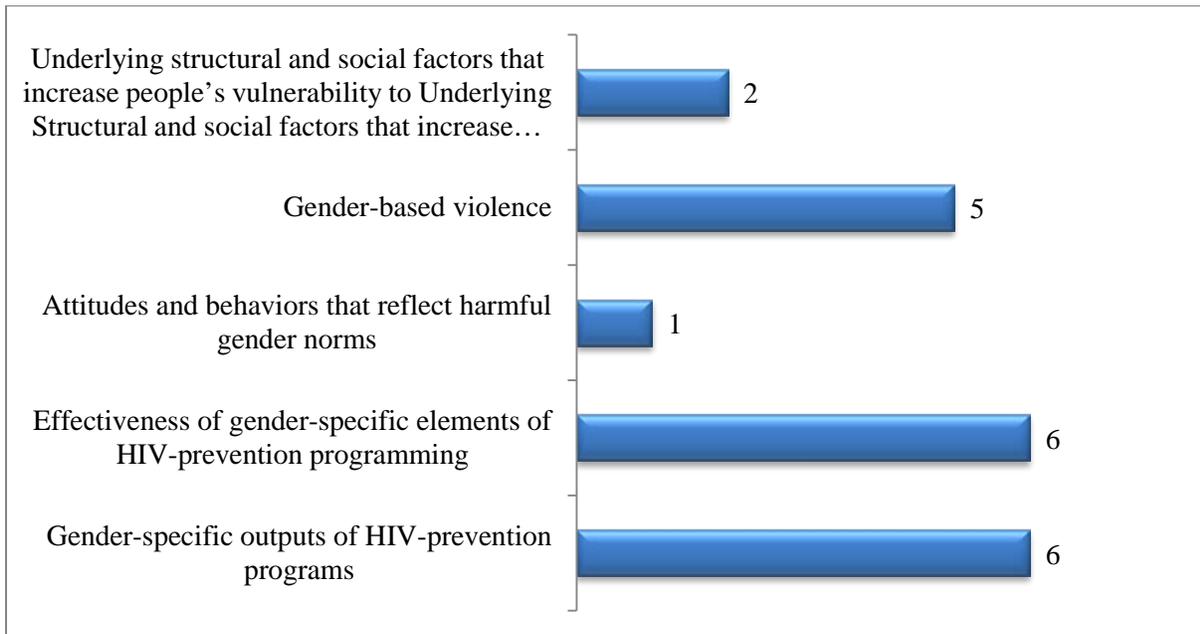
Figure 3 Number of participants reporting that, to a large extent, the National HIV M&E System collects/track data on various HIV-related aspects, Southern Province, Zambia 2013



Participants reported that information collected about clients living with HIV included (a) personal information such as name, address, and marital status; (b) diagnostic results such as results of routine tests and CD4 Count, prophylaxis given; (c) referral related information to health facilities and/or support group. In general the office of the DACA was reported to be accountable for all operations. One of the districts stated that the financial information is supposed to be availed to the offices of the DATF/NAC but it is not being captured because most of the implementing partners are donor funded and they have confidentiality issues to protect. Knowledge about monitoring of adverse events of ART was generally low. However, respondents reported that since Zambia does not manufacture its own antiretroviral drugs (ARVs), sometimes it faced shortages of ARVs.

Figure 4 shows that the number of districts that reported that data are collected on specific gender-related issues. All districts reported that they collected data on the effectiveness of gender-specific and outputs of HIV-prevention programming. Data on GBV were collected by 5 of the 6 participating districts. In one instance it was reported that data on GBV were collected by the DAFT through the Police VSU and in one district, this reporting has been facilitated by the formation of a district committee to coordinate all issues of GBV. Another district reported using an improvised tool to collect data on all gender issues including property grabbing, rape cases, and defilement. Only two districts reported collecting data on underlying structural and social factors that increase people’s vulnerability to HIV and, in one instance, such data were reported to include orphans and vulnerable children and homes provided with food by NGOs.

Figure 4 Number of participants reporting that the strategic information systems collects data on gender issues, Southern Province, Zambia 2013



4.3 Data Quality Assurance and Utilization

Participants reported that to ensure data quality, data collected are verified and the reports are checked by stakeholders for uniformity and consistency. HIV-prevention data are shared with stakeholders and other people through meetings at different levels such as the district, provincial and national levels as well as during the National VCT and World AIDS Days. Routine data collected from the HIV strategic information system were generally reported to inform the planning and programming of HIV and AIDS-related activities. Specifically the data was reported to be used for planning for female and male condom distribution; providing checks and balances on how well issues of gender are incorporated in HIV programming and; and monitoring and evaluating how effective the previous HIV prevention programs have been in terms of reducing infections and re-infections. Four out of six districts stated that there were no participatory national assessments of the HIV-prevention response in the past three years.

4.4 Summary

Strategic information is pivotal for evidence-based planning and programming of HIV/AIDS interventions. All the participating districts reported that they have an M&E system in place. However there are gaps in strategic information collected. Generally no data are collected on MSM, clients of FSWs, and PWID, the main reason being that these behaviors are illegal in Zambia. Knowledge about the whole information system (i.e., collection, processing and reporting) was low. The reported main source of information was the MOH. Data collected by research institutions and NGOs were not well known.

5. HIV-prevention Services and Interventions in Government Health Facilities

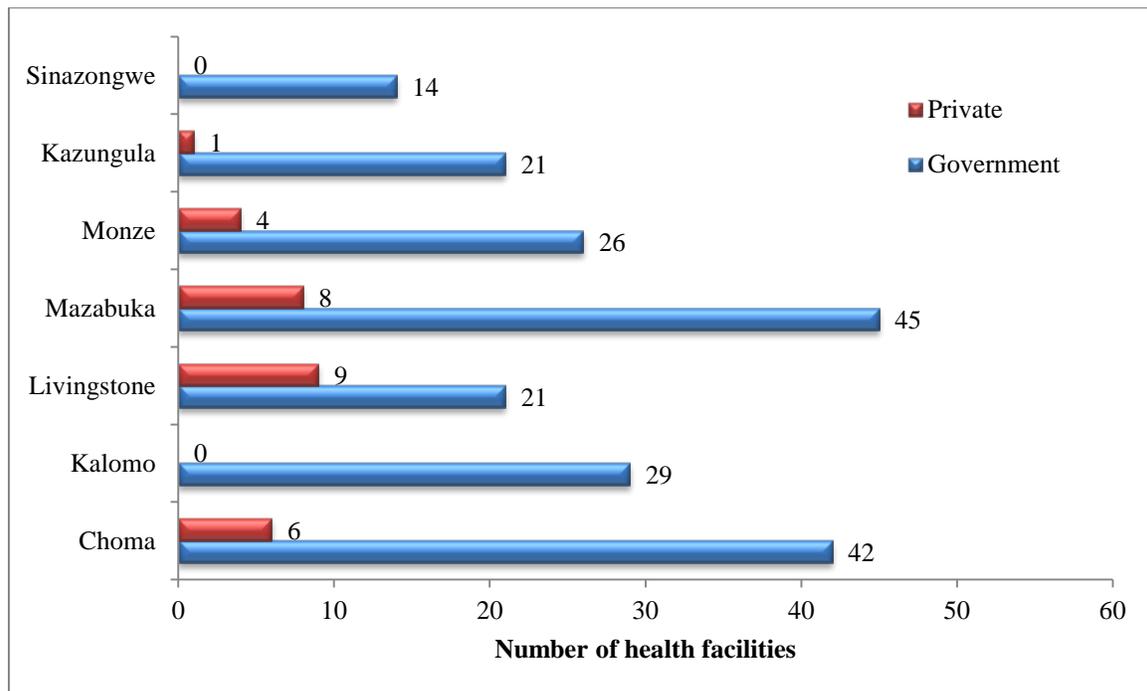
Anastasia J. Gage

The data for this section of the report were derived from interviews with district health officers regarding HIV interventions that were based at private and government health facilities. The objective of the district questionnaire – health facility module was to assess the extent to which district-level health facilities addressed technical HIV-prevention recommendations and to determine barriers and facilitators to full implementation of technical recommendations. It was hoped that this information could help districts in Southern Province plan for HIV-prevention programming and coordination. Seven out of twelve districts completed the district questionnaire health facility module. This section focuses on government health facilities, although data are sometimes presented for all health facilities regardless of type. Data are presented on the availability in government health facilities of:

- Interventions affecting knowledge, attitudes & beliefs & influencing psychological & social risk correlates (e.g., percentage of the district’s adolescent population reached by sexual education by health facility staff in the past 12 months)
- Harm reduction interventions (e.g., percentage of the district’s health facilities that have equipment required for universal precautions)
- Biological/biomedical interventions that reduce HIV-infection & transmission risk (e.g., percentage of health facilities that offer services to diagnose and treat STIs)
- Interventions for mitigation of biological outcomes of HIV infection (e.g., percentage of health facilities that provide management of HIV-associated opportunistic infections) and
- Standardized hybrid interventions commonly used (e.g., percentage of health facilities providing in-house client-initiated HIV counseling and testing)

Data are also presented on the reported reach of various HIV-prevention interventions, services targeted at priority populations, availability of trained health workers, and HIV services integration at various levels of the health system. As Figure 5 shows, the reported number of government health facilities varied widely across districts from 45 in Mazabuka to 14 in Sinazongwe, in part a reflection of population size and density. There were few private health facilities (less than 10 in any given district).

Figure 5 Reported number of government and private health facilities by district surveyed, Southern Province, Zambia 2013



5.1 HIV-prevention Interventions

Interventions affecting knowledge, attitudes & beliefs and reducing harm

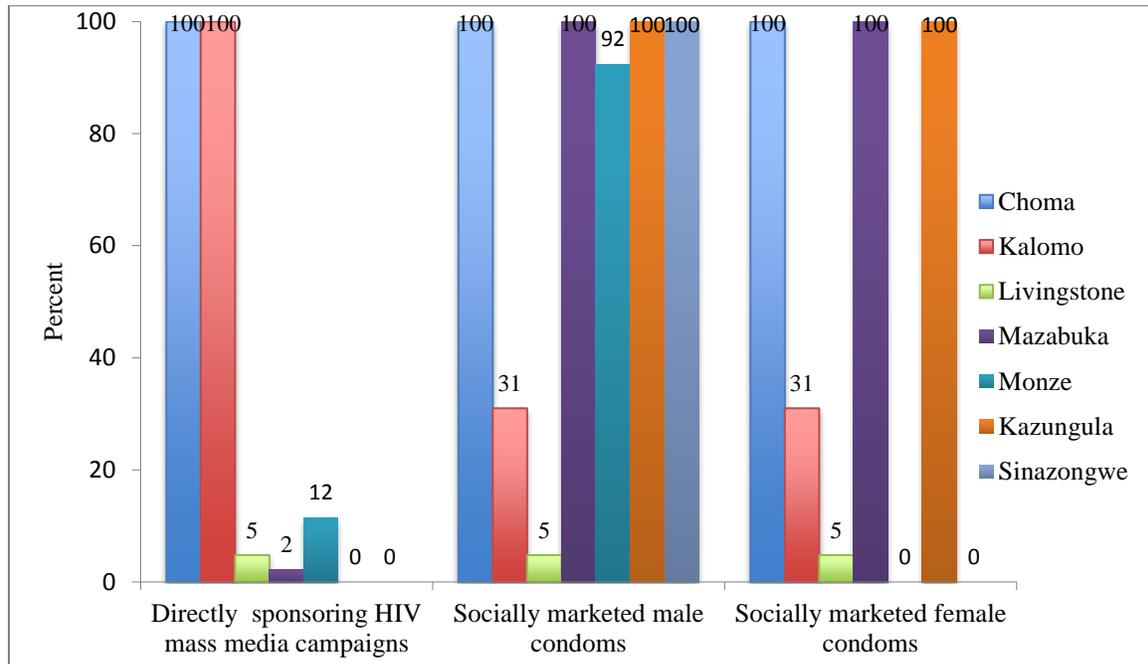
As Figure 6 shows, the percent of government health facilities that directly sponsored HIV mass media campaigns in the past 12 months varied tremendously from 100 percent in Choma and Kaloma to none in Kazungula and Sinazongwe. Substantially fewer government health facilities were reported to offer socially-marketed male condoms in Kalomo and Livingstone compared to other districts. No government health facilities were reported to offer socially-marketed female condoms in Kazungula and Sinazongwe. Ownership of equipment required for universal precautions was reported as being universal in government health facilities in all districts (not shown).

Biological/biomedical interventions that reduce HIV-infection & transmission risk

Services to diagnose and treat STIs and the availability of post-exposure prophylaxis protocols were reported as being available in all government health facilities in districts surveyed (see Table 2). Three districts – Kazungula, Livingstone and Monze – were reported to not offer family planning services specifically for men and women living with HIV on a routine basis. In four of the seven districts surveyed, less than 20 percent of government health facilities were reported to offer voluntary medical male circumcision services (VMMC). No government health facilities were reported to offer breastfeeding substitutes for HIV-positive mothers in Kalomo, Livingstone, Monze and Sinazongwe. Few government health facilities were reported to offer

both blood donation and transfusion services in the districts surveyed. No government health facilities offered sperm donation services in the districts surveyed. PMTCT services were available in 90-100 percent of government health facilities in the districts surveyed.

Figure 6 Percentage of public health facilities in Southern Province reported to offer specific interventions affecting knowledge, attitudes and beliefs and reducing harm, by district, Zambia, 2013



While all government health facilities were reported as routinely able to use gloves and protective clothing during all medical procedures in the districts surveyed, in Kaloma, regular and adequate disinfection of medical equipment were not reported as universal. It is difficult to determine whether there was uniformity in the criteria used by district health officers to determine whether a given health facility could be classified as meeting a given standard of care. No health facility (government or private) was reported as offering drug treatment, including drug substitution therapy for people who inject drugs except in Choma, where all government health facilities were reported as providing this service (which could reflect differences in respondent’s understanding of the term “drug substitution therapy”). This issue warrants further investigation. Only half of government health care facilities in Sinazongwe were reported to completely follow a strategy or protocol for injection safety compared to 100 percent in all other districts surveyed. In Sinazongwe, only 7 percent of government health facilities were reported to provide safe medical waste management compared to 100 percent in all other districts for which data are available.

Mitigation of biological outcomes of HIV infection

Data from the health facility listing revealed that there were wide variations across districts in the reported percentage of health facilities that offered services to mitigate biological outcomes of HIV infection (see Table 2). Note that the data for Choma and Mazabuka were incomplete.

Table 1 Percentage of government and all health facilities reported to offer biological/biomedical interventions that reduce HIV infection and transmission risk by type of intervention and district, Know Your HIV-Prevention Response Survey 2013

District Surveyed	Offer Services to Diagnose and Treat Sexually-transmitted Infections		Have Post-Exposure Prophylaxis Protocol		Routinely Offer Family Planning Services Specifically for HIV+ Men and Women		Medical Male Circumcision Services		PMTCT Services	
	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total
Choma	100.0	100.0	100.0	100.0	100.0	95.8	19.0	18.8	100.0	87.5
Kalomo	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Kazungula	100.0	100.0	100.0	100.0	95.2	95.5	33.3	36.4	100.0	100.0
Livingstone	100.0	100.0	100.0	100.0	0.0	0.0	9.5	16.7	90.5	63.3
Mazabuka	100.0	100.0	100.0	100.0	0.0	0.0	11.1	11.3	93.3	90.6
Monze	100.0	100.0	100.0	86.7	0.0	0.0	100.0	96.7	100.0	86.7
Sinazongwe	100.0	100.0	100.0	100.0	0.0	0.0	7.1	7.1	100.0	100.0

District Surveyed	Offer Breast-feeding Substitutes for HIV+ Mothers		Offer Both Blood Donation and Transfusion Services		Offer Blood Donation Services Only		Offer Blood Transfusion Services Only		Offer Sperm Donation Services	
	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total
Choma	100.0	87.5	2.4	2.1	0.0	0.0	4.8	4.2	0.0	0.0
Kalomo	0.0	0.0	3.4	3.4	3.4	3.4	0.0	0.0	0.0	0.0
Kazungula	0.0	0.0	4.8	4.5	0.0	0.0	0.0	0.0	0.0	0.0
Livingstone	0.0	0.0	4.8	3.3	4.8	3.3	4.8	3.3	0.0	0.0
Mazabuka	93.3	90.6	2.2	1.9	0.0	0.0	0.0	0.0	0.0	0.0
Monze	100.0	100.0	3.8	3.3	100.0	86.7	3.8	3.3	0.0	0.0
Sinazongwe	0.0	0.0	7.1	7.1	0.0	0.0	0.0	0.0	0.0	0.0

Table 1 contd. Percentage of government. and all health facilities reported to offer biological/biomedical interventions that reduce HIV infection and transmission risk by type of intervention and district, Know Your HIV-Prevention Response Survey 2013

District Surveyed	Routinely Able to Use Gloves and Protective Clothing During Medical Procedures		Offer Drug Treatment, including Drug Substitution Therapy for People Who Inject Drugs		Regularly and Adequately Disinfecting Medical Equipment		Completely Follow District Strategy/Protocol for Injection Safety		Provide Safe Medical Waste management	
	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total	Govt.	Total
	Choma	100.0	100.0	100.0	100.0	100.0	100.0	ns	ns	100.0
Kalomo	100.0	100.0	0.0	0.0	69.0	69.0	100.0	100.0	100.0	100.0
Kazungula	100.0	100.0	0.0	0.0	100.0	100.0	100.0	100.0	100.0	95.5
Livingstone	100.0	100.0	0.0	0.0	100.0	100.0	100.0	83.3	100.0	83.3
Mazabuka	100.0	100.0	0.0	0.0	ns	ns	100.0	100.0	ns	ns
Monze	100.0	100.0	0.0	0.0	100.0	100.0	100.0	100.0	100.0	100.0
Sinazongwe	100.0	100.0	0.0	0.0	100.0	100.0	50.0	50.0	7.1	7.1

ns Not stated

Less than 20 percent of government health facilities offered cesarean delivery and this percentage did not vary significantly across districts. The offer of family planning services ranged from 100 percent in Choma to 56 percent in Monze. Less than one in every four government health facilities were reported to provide antiretroviral therapy except in Mazabuka and Kazungula and an even lower percentage was reported as providing in-house CD4 counts. In-house laboratory tuberculosis (TB) testing was reported to be provided by less than 20 percent of government health facilities, except in Monze (44 percent) and Sinazongwe (35 percent). Few facilities were reported by district health officers to provide in-house malaria microscopy, with the percentage ranging from 9 percent in Kazungula to 93 percent in Kalomo. TB treatment was reported to be provided by all government health facilities in Choma and Kazungula. Only 21 percent of government health facilities in Kalomo were reported to provide this service. Significant variations were seen in the provision of illness- prevention treatment for PLWH, availability of PLWH support groups, and management of HIV-associated opportunistic infections. Support groups for PLWH were more prevalent in government health facilities in Monze, Sinazongwe, and Mazabuka than in the other districts surveyed. More than 70 percent of government health facilities provided home-based care and outreach in Kazungula, Monze, and Sinazongwe, compared to less than 10 percent in Choma and Livingstone, and 29 percent in Kalomo. No government health facilities were reported to provide food and nutrition support for PLWH in the districts surveyed (not shown).

Table 2 Percentage of government health facilities that offered HIV-prevention services to mitigate biological outcomes of HIV infection at the time of the survey, by type of service and district, Southern Province, Zambia 2013

Intervention	Choma (a)	Kalomo	Kazungula	Livingstone (a)	Mazabuka	Monze	Sinazongwe
Cesarean delivery	8.0	3.4	4.6	ns	8.0	8.0	15.0
Family planning ***	100.0	96.4	95.5	81.0	80.0	56.0	90.0
Antiretroviral Therapy ***	20.0	32.1	72.7	23.8	48.0	24.0	20.0
In-house CD4 counts	8.0	32.1	13.6	14.3	16.0	16.0	20.0
In-house laboratory TB testing	20.0	21.4	13.6	14.3	20.0	44.0	35.0
In-house malaria microscopy ***	16.0	92.9	9.1	14.3	24.0	28.0	35.0
TB treatment ***	100.0	21.4	100.0	71.4	56.0	36.0	70.0
PLWH illness-prevention treatment ***	52.0	50.0	100.0	71.4	80.0	80.0	20.0
PLWH support groups ***	16.0	28.6	13.6	28.6	72.0	84.0	75.0
Management of HIV-associated opportunistic infections ***	24.0	71.4	100.0	85.7	48.0	96.0	20.0
Home-based care/outreach ***	8.0	28.6	100.0	4.8	20.0	96.0	70.0
N	25	28	21	21	25	25	20

*** p<.001 ns Not stated

As supplemental sheets were not used by interviewers and respondents for the health facility listing in Choma and Mazabuka, the data for these two districts are incomplete.

Standardized hybrid interventions commonly used

As Table 3 shows, the provision of in-house client-initiated, provider-initiated and couple-based VCT was near universal in government health facilities in all districts, with the exception of Livingstone and Sinazongwe where 86 percent and 75 percent of government health facilities were reported to offer these services, respectively. Less than 25 percent of health facilities provided mobile counseling and testing in Livingstone and Mazabuka. Monze was the only district with more than 10 percent of government health facilities reported as providing in-house blood donor HIV testing and counseling services. Condom use education and support were reported to be offered by all government health facilities in four of the six districts surveyed, with similar percentages being seen for in-house STI/HIV risk reduction education and counseling. In Monze, substantially fewer government health facilities offered the latter service (64 percent) as compared to condom use education, promotion and support (100 percent).

Table 3 Percentage of government health facilities that provided standardized hybrid interventions at the time of the survey, by type of intervention and district, Southern Province, Zambia 2013

Intervention	Choma (a)	Kalomo	Kazungula	Livingstone (a)	Mazabuka	Monze	Sinazongwe
In-house client-initiated HIV testing and counseling ***	100.0	100.0	100.0	85.7	92.0	100.0	75.0
In-house provider-initiated HIV testing and counseling ***	1000.0	100.0	100.0	85.7	92.0	100.0	75.0
In-house couple-based voluntary counseling and testing ***	100.0	100.0	100.0	85.7	92.0	100.0	75.0
Mobile counseling and testing unit ***	100.0	ns	86.4	4.8	24.0	100.0	10.0
In-house blood donor HIV testing and counseling ***	0.0	3.6	4.6	4.8	0.0	84.0	10.0
Condom use education, promotion and support	100.0	100.0	100.0	90.5	96.0	100.0	95.0
In-house STI/HIV risk reduction education and counseling ***	100.0	100.0	100.0	90.5	84.0	64.0	95.0
N	25	28	21	21	25	25	20

*** p<.001 ns Not stated

As supplemental sheets were not used by interviewers and respondents for the health facility listing in Choma and Mazabuka, the data for these two districts are incomplete.

5.2 Populations Reached by HIV-Prevention Interventions

District health officers were asked to provide estimates of the percentage of the district population reached by various HIV-prevention interventions in the past 12 months. These data are presented in Table 4. In districts in which health facilities directly sponsored mass media campaigns in the past 12 months, 75-100 percent of the population was estimated to have been reached by these campaigns. Similar percentages of the population were reported to have been reached by health-facility based interpersonal HIV-prevention education and persuasion programs in Choma, Mazabuka and Sinazonga. Less than a quarter of the populations in Kazungula, Livingstone and Monze were reported to have been reached by the latter group of interventions. Sex education by health facility staff was reported to have reached less than 25 percent of young people aged 15-24 years in Kalomo, Mazabuka and Sinazongwe and roughly two to three times as many in Livingstone and Monze. While the reach of sex education programs by health facility staff was reportedly similar for youth aged 15-24 years and adolescents aged 10-14 years in four of the seven districts, in Livingstone and Mazabuka, these programs were reported as not reaching any young adolescents. HI-prevention counseling at health facilities was reported as reaching none of the district populations in Mazabuka and Monze and the majority of the populations in Choma and Kazungula.

Table 4 Percentage of district population reached by HIV-prevention interventions and activities conducted at health facilities in the past 12 months, by district and type of intervention, Zambia 2013

District	District Population Reached By:				
	Health-facility sponsored HIV-prevention mass media campaigns	Health-facility based Interpersonal HIV-prevention education and persuasion programs	Youth aged 15-24 years reached by sexual education by health facility staff	Youth aged 10-14 years reached by sexual education by health facility staff	HIV-prevention counseling at health facilities
Choma	75-100	75-100	75-100	75-100	75-100
Kalomo	75-100	50-74	1-24	1-24	25-49
Kazungula	75-100	1-24	25-49	25-49	75-100
Livingstone	75-100	1-24	50-74	None	25-49
Mazabuka	75-100	75-100	1-24	None	None
Monze	None	1-24	50-74	50-74	None
Sinazongwe	None	75-100	1-24	1-24	50-74

Table 5 shows which population sub-groups were specifically targeted for interpersonal HIV-prevention education and persuasion programs and face-to-face interactive dialogue at district health facilities in the past 12 months. No priority populations were targeted in Choma and Kazungula. No district participating in the study were reported to have health facilities that targeted clients of FSWs, MSM, transgender people, PWID (probably as a result of the criminalization of these behaviors in Zambia), refugees and displaced persons (as these populations are not found in Southern Province), and uniformed personnel. While four districts were reported to have health facilities that targeted youth aged 15-24, only half as many districts – Kalomo and Monze – had health facilities that targeted children aged 5-14 years.

Choma and Kazungula were the only districts that reported the absence of health facilities that targeted male circumcision clients.

Table 5 Priority populations specifically targeted for interpersonal HIV-prevention education and persuasion programs and face-to-face interactive dialogue at any health facility in the past 12 months by district, Zambia 2013

Priority Population	Choma	Kalomo	Livingstone	Mazabuka	Monze	Kazungula	Sinazongwe
Female sex workers	No	No	Yes	Yes	No	No	No
Clients of female sex workers	No	No	No	No	No	No	No
Men who have sex with men	No	No	No	No	No	No	No
Transgender people	No	No	No	No	No	No	No
Youth aged 15-24 years	No	Yes	Yes	Yes	Yes	No	No
Children aged 5-14 years	No	Yes	No	No	Yes	No	No
People living with HIV/AIDS	No	Yes	Yes	Yes	Yes	No	No
Refugee and displaced populations	No	No	No	No	No	No	No
Mobile and migrant populations	No	No	No	Yes	No	No	No
People who inject drugs	No	No	No	No	No	No	No
Prisoners/people in closed settings	No	Yes	No	No	No	No	No
Uniformed personnel	No	No	No	No	No	No	No
Male circumcision clients	No	Yes	Yes	Yes	Yes	No	Yes
Number of subgroups targeted	0	5	4	5	4	0	1

District health officers were also asked whether any health facilities in the district provided specific services directly (not by referrals to other programs) to PLWH. The data showed that all districts surveyed, with the exception of Mazabuka, had at least one health facility provided home-based care for PLWH and their families. Support groups for PLWH were reported as being offered in all districts surveyed except for Choma and Sinazongwe. Fee exemptions for PLWH and their families were not common and were reported only by one district (Livingstone) as were specialized services for OVC. All districts surveyed except Livingstone were reported to have at least one health facility providing HIV care for patients and their families (see Table 6). Legal services for PLWH were not provided in health facility settings in any district.

Table 6 Services provided directly to people living with HIV (not by referrals to other programs) by any health facilities in the district, Zambia 2013

Service	Choma	Kalomo	Livingstone	Mazabuka	Monze	Kazungula	Sinazongwe
Home-based care for PLWH and their families	Yes	Yes	Yes	No	Yes	Yes	Yes
Support groups for PLWH	No	Yes	Yes	Yes	Yes	Yes	No
Fee exemptions for PLWH and their families	No	No	Yes	No	No	No	No
Legal services for PLWH	No	No	No	No	No	No	No
Counseling or health education for prevention of transmission of HIV	No	No	No	No	No	No	No
Specialized services for OVC	No	Yes	No	No	No	No	No
Education on HIV care for patients and their families	Yes	Yes	No	Yes	Yes	Yes	Yes
Other	No	Yes	No	No	No	No	No

5.3 Health Worker Training on HIV Prevention

Data were collected on the estimated number of government and private health facilities with at least one health worker trained in the last two years on specific topics. Percentages were calculated based on the reported number of health facilities by type in a given district. This section focuses on the availability of recently trained health workers in government health facilities. In Choma, it was reported that all government health facilities had at least one health worker who had, within the last 2 years, received pre-service or in-service training on all topics listed in Table 7, with the exception of TB diagnosis and treatment for which no data were provided. All other districts had significant staff training needs, which for the purpose of this report, were defined as having less than 50 percent of health facilities with at least one health worker who had received pre-service or in-service training in a given topic in the past two years. In Kalomo, it was reported that no government health facility had a health worker who had recently been trained on adolescent sexual and reproductive health (ASRH), nutrition counseling for PLWH and for newborns of HIV-positive mothers, and GBV prevention and treatment.

The greatest need for staff training in HIV prevention-related topics was seen in Kazungula where no government health facility was reported as having a health worker who had been recently trained in 17 of the 18 topics presented in Table 7. Livingstone was second in terms of staff training needs. Fewer than 20 percent of government health facilities in Livingstone were reported to have a recently trained health worker for each of the topics presented. In Mazabuka, the greatest staff training needs were reported for gender-based violence (2 percent), diagnosis and treatment of TB (20 percent), ART (36 percent), and opportunistic infection and care (36 percent). In Monze, less than 50 percent of government health facilities had a health worker who had been recently trained in ASRH, opportunistic infection treatment and care, ART adherence counseling, and diagnosis and treatment of TB. In Sinazongwe, no health facility was reported to have a health worker who had been recently trained in the following topics: prevention with HIV positives, general HIV-prevention education, waste management including safe waste disposal, safe injection practices, family planning for HIV-positive people and their partners, GBV,

and confidentiality, rights and non-discrimination practices for working with clients living with HIV (see Table 7).

Table 7 Percentage of government health facilities with at least one health worker who has, within the last 2 years, received pre-service or in-service training in specific topics, Zambia 2013

Topic	Choma	Kalomo	Kazungula	Livingstone	Mazabuka	Monze	Sinazongwe
Adolescent Sexual and Reproductive Health	100.0	0.0	0.0	9.5	93.3	23.1	64.3
Opportunistic Infection Treatment and Care	100.0	100.0	0.0	19.0	35.6	38.5	64.3
HIV/AIDS Counseling Only	100.0	0.0	0.0	19.0	0.0	100.0	0.0
HIV/AIDS Counseling and Testing	100.0	100.0	0.0	19.0	93.3	100.0	64.3
Antiretroviral therapy adherence counseling	100.0	31.0	0.0	9.5	35.6	38.5	64.3
PMTCT	100.0	100.0	0.0	19.0	93.3	100.0	64.3
Prevention with HIV Positives	100.0	100.0	0.0	9.5	93.3	100.0	0.0
General HIV Prevention Education	100.0	100.0	0.0	19.0	100.0	100.0	0.0
Infection Control/ Universal Precautions	100.0	100.0	0.0	19.0	100.0	100.0	64.3
Waste Management Including Safe Waste Disposal	100.0	100.0	0.0	19.0	100.0	100.0	0.0
Safe Injection Practices	100.0	100.0	19.0	19.0	100.0	100.0	0.0
Family Planning for HIV+ People and their Partners	100.0	100.0	0.0	19.0	93.3	100.0	0.0
Health Services/Case Management	100.0	100.0	0.0	9.5	100.0	100.0	ns
Drugs and Supplies Management, Diagnosis and Treatment of TB	ns	100.0	0.0	19.0	20.0	19.2	64.3
Nutrition Counseling for PLWH	100.0	0.0	0.0	9.5	100.0	100.0	64.3
Nutrition Counseling for Newborns of HIV+ Mothers	100.0	0.0	0.0	9.5	93.3	100.0	64.3
Gender-based Violence Prevention and Treatment	100.0	0.0	0.0	9.5	2.2	100.0	0.0
Confidentiality, Rights and Non-Discrimination Practices for Working with Clients Living with HIV	100.0	100.0	0.0	9.5	100.0	100.0	0.0

ns Not stated

Questions were also asked about the categories of health workers that were trained to identify and control occupational hazards that would expose them to HIV and to work with people living with HIV. These

data are presented in Table 8. District health officers reported that no categories of health workers have received this type of training in Kalomo, Livingstone, Mazabuka, and Sinazongwe. Choma and Kazungula were the only two districts in which it was reported that most categories of health workers had been trained. Social workers in Choma and community health workers in Monze were reported as not having received training of the identification and control of occupational hazards that would expose them to HIV. Questions were also asked as to whether health care workers in the district receive sensitization training for working with people living with HIV and if so, which categories of health workers receive this training. As shown in Table 8, only one of the seven districts responding to the health facility module – Livingstone – reported that any of its health workers had received sensitization training for working with PLWH. All categories of health workers in Livingstone were reported as having received this training, except for social workers.

Table 8 Categories of health workers trained to identify and control occupational hazards that would expose them to HIV and to work with people living with HIV by district, Zambia 2013

Category	Choma	Kalomo	Livingstone	Mazabuka	Monze	Kazungula	Sinazongwe
TRAINED TO IDENTIFY AND CONTROL OCCUPATIONAL HAZARDS							
Nurses	Yes	No	No	No	Yes	Yes	No
Doctors	Yes	No	No	No	Yes	Yes	No
Clinical/Assistant Officers	Yes	No	No	No	Yes	Yes	No
Managers	No	No	No	No	No	Yes	No
Pharmacist/Dispensers	Yes	No	No	No	No	Yes	No
HIV counselors	Yes	No	No	No	Yes	Yes	No
Laboratory technicians	Yes	No	No	No	Yes	Yes	No
HMIS staff	No	No	No	No	No	Yes	No
Community health workers	Yes	No	No	No	No	Yes	No
Social workers	No	No	No	No	Yes	Yes	No
Other	No	No	No	No	No	No	No
RECEIVED SENSITIZATION TRAINING FOR WORKING WITH PLWH							
Nurses	No	No	Yes	No	No	No	No
Doctors	No	No	Yes	No	No	No	No
Clinical/Assistant Officers	No	No	Yes	No	No	No	No
Managers	No	No	Yes	No	No	No	No
Pharmacist/Dispensers	No	No	Yes	No	No	No	No
HIV counselors	No	No	Yes	No	No	No	No
Laboratory technicians	No	No	Yes	No	No	No	No
HMIS staff	No	No	Yes	No	No	No	No
Community health workers	No	No	Yes	No	No	No	No
Social workers	No	No	No	No	No	No	No
Other	No	No	No	No	No	No	No

5.4 HIV Services Integration

Questions were also asked to determine at which levels of the health system service provision for HIV/AIDS was integrated with antenatal care (ANC), TB prevention and treatment, SRH services in the district. Illustrative examples were provided for each type of integration (e. g., “An example of HIV-ANC integration would be a patient being able to receive services for both voluntary counseling and testing (VCT) and ANC from the same health care worker or team of health care workers”). As Table 9 shows, it was reported that there the provision of HIV services was not integrated with ANC, TB

prevention and treatment services or SRH services at any level of the health systems in Mazabuka. In Choma and Kalomo, HIV-ANC integration was reported to not occur at the health post level. In all districts surveyed except Livingstone and Monze, respondents reported that no HIV-TB integration occurred at the health post level.

Regarding HIV-SRH integration, there were variations between districts in the level of the health system at which integration occurred. In Livingstone, HIV-SRH integration occurred at all levels of the health system whereas in Choma, HIV services provision was reported to be integrated with SRH services only at the level of urban health centers. In Kalomo, HIV-SRH integration occurred in all levels of the health system except at health posts, while in Kazungula, this type of integration occurred only at rural health centers. In Sinazongwe, HIV-SRH integration occurred only at the level of the district hospital.

Table 9 HIV services integration at various levels of the health system by district, Zambia 2013

Type of Integration	Choma	Kalomo	Kazungula	Livingstone	Mazabuka	Monze	Sinazongwe
HIV-ANC Integration							
District hospital	Yes	Yes	No	Yes	No	Yes	Yes
Urban health center	Yes	Yes	No	Yes	No	Yes	Yes
Rural health center	Yes	Yes	Yes	Yes	No	Yes	Yes
Health post	No	No	Yes	Yes	No	Yes	No
Other	No	No	No	No	No	No	No
HIV-TB Integration							
District hospital	Yes	Yes	No	Yes	No	Yes	Yes
Urban health center	Yes	Yes	No	Yes	No	Yes	Yes
Rural health center	Yes	Yes	Yes	Yes	No	Yes	Yes
Health post	No	No	No	Yes	No	Yes	No
Other	No	No	No	No	No	No	No
HIV-SRH Integration							
District hospital	No	Yes	No	Yes	No	Yes	Yes
Urban health center	Yes	Yes	No	Yes	No	Yes	No
Rural health center	No	Yes	Yes	Yes	No	Yes	No
Health post	No	No	No	Yes	No	No	No
Other	No	No	No	No	No	No	No

5.5 Summary

The data showed significant gaps across and within districts in the offer of HIV-prevention services at government health facilities. Interventions such as diagnosis and treatment of STIs, use of gloves and protective clothing during medical procedures, family planning for the general population, in-house HIV VCT, and PMTCT were almost universally offered by government health facilities in the districts surveyed. Other services/interventions such as blood donation and transfusion, in-house blood donor HIV testing and counseling and drug treatment including drug substitution therapy were unavailable in most government health facilities in each district surveyed, with one or two exceptions. Substantial variations occurred across districts in the offer of VMMC, management of HIV-associated opportunistic infections, mobile counseling and testing units, PLWH support groups, and breastfeeding substitutes for HIV-positive mothers.

Gaps were also seen in the populations reached by HIV-prevention interventions. One of the most visible gaps was the inability of government health facilities to reach a substantial percentage of adolescents aged 10-14 years with sex education interventions, especially in Livingstone and Mazabuka. No government health facilities in the district surveyed targeted clients of FSWs, MSM, transgender and PWID with HIV-prevention interpersonal education and persuasion programs and face-to-face dialogue. Similarly, no legal services were reported as provided directly to PLWH in any health facility. The data also showed that all districts except Choma had significant health staff training needs with the greatest need occurring in Kazungula where no government health facility was reported to have staff that had been trained in the past two years on 17 out of 18 HIV-prevention topics. It was also reported that no categories of health workers in Kalomo, Mazabuka, and Sinazongwe have received sensitization training for working with PLWH and for the identification and control of occupational hazards that would expose them to HIV. Finally, the data showed that HIV services were not integrated with ANC, TB, or SRH at the health post level in Choma, Kalomo, Mazabuka and Sinazongwe.

6. HIV-prevention Programs Implemented by Government Non-Health Institutions

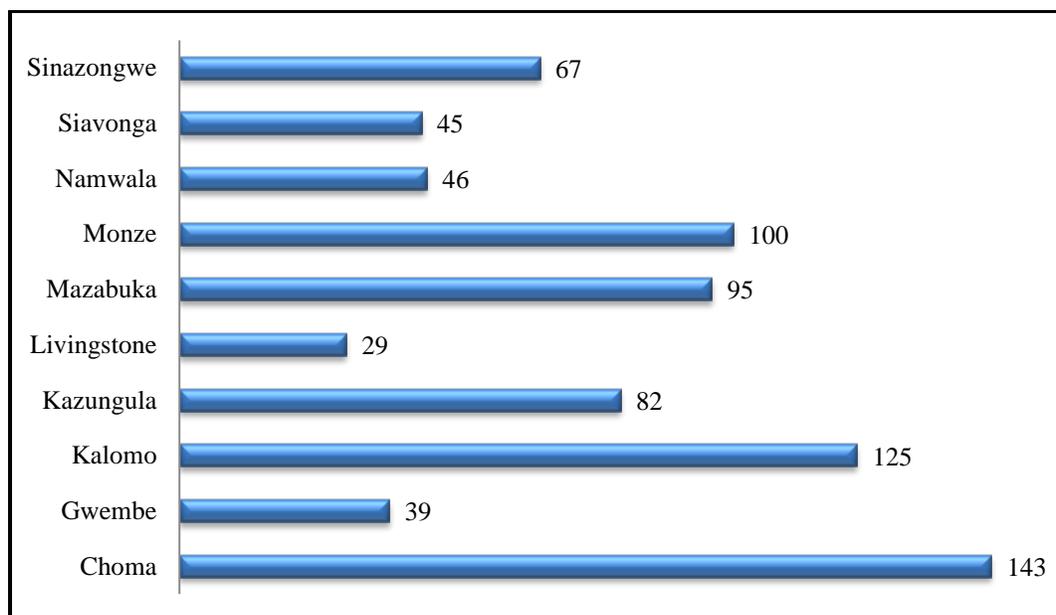
Munukayumbwa Munyima

This section of the study presents information regarding HIV-prevention programs that were implemented by government non-health institutions for schools and tertiary institutions, uniformed personnel, and prisoners in the 12 months prior to the study. Uniformed personnel included in this section are police officers and prison officers. The data were derived from the District Questionnaire - Government non-Health Sector Module.

6.1 HIV Prevention in Public Schools and Tertiary Institutions

Six districts namely, Choma, Kazungula, Livingstone, Mazabuka, Namwala and Siavonga responded to the section of the Government Non-health sector Module that collected data on HIV-prevention activities in the education sector. To supplement information from the six districts, records on government schools and tertiary institutions in Southern Province were obtained from the Provincial Education office. These revealed the number and distribution of public institutions of learning as well as the number and distribution of enrolments. The records revealed that the province had 773 public institutions of learning which include 743 primary schools, 28 secondary schools and 2 tertiary education centers. Choma followed by Kalomo had the largest number of schools (143 and 125, respectively) and Livingstone has the smallest (Figure 7).

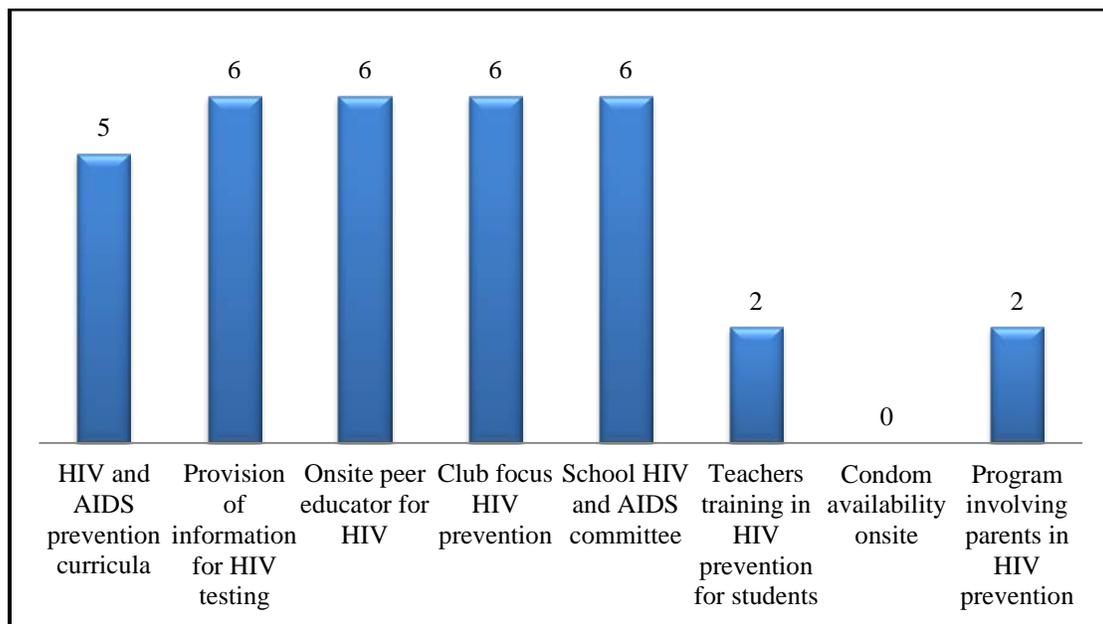
Figure 7 Number of public institutions of learning by district, Southern Province, Zambia 2013.



Source: Ministry of Education, Science, Vocational Training & Early Education, Southern Province

Figure 8 reveals that all the six districts that participated in the study had schools and tertiary institutions that provided information on HIV testing, conducted on site peer education, and had clubs focusing on HIV prevention and HIV and AIDS committees. The figure further reveals that five districts had HIV and AIDS curricula in schools and tertiary institutions while teachers training in HIV prevention for students and programs involving parents in HIV prevention were available in two districts only. None of the districts reported condom availability on site in any school or tertiary institution and this could be attributed to government policy not to allow distribution of condoms in schools.

Figure 8 Number of districts surveyed in which HIV-prevention programs are available in schools by type of program, Southern Province, Zambia, 2013



6.2 HIV Prevention Programs for Uniformed Personnel

To assess the involvement of the Zambia Police and Zambia Prison Services in government-supported HIV-prevention programs, questions were asked about two categories of interventions. The first category was intended to establish the percentage of uniformed officers that were reached by through interpersonal HIV-prevention education and persuasion programs that involved face-to-face or interactive dialogue, male and female condom distribution, as well as condom social marketing. The second category sought to find out the extent to which uniformed personnel were involved in government-supported care and treatment activities that include VCT, support groups for PLWH, treatment for alcohol abuse, as well as campaigns against GBV.

Eleven districts responded to the Government Non-health questionnaire regarding HIV programs and/or support for police officers. Table 10 reveals that 8 districts had at least one HIV-prevention program running in the 12 months prior to this study, while two districts had none at all. Livingstone district reported having reached 75-100 percent of police officers with interpersonal HIV- prevention education

and persuasion programs. Choma, Monze and Zimba had only reached 1-24 percent while Gwembe Mazabuka and Sinazongwe had reached none. The highest percentage of police officers reached by distribution of male and female condoms was reported by Kalomo, Kazungula, and Livingstone districts while the lowest of 1-24 percent was reported in Sinazongwe district. Condom social marketing was reported a high of 75-100 percent of police officers in Kazungula and Livingstone districts and a low of , 1-24 percent of police officers in Sinazongwe.

Table 10 Estimated percentages of police officers reached by Government in various HIV-prevention interventions in the past 12 months by district, Southern Province, Zambia

District	Interpersonal Education and Persuasion Programs	Male and Female Condom Distribution	Condom Social Marketing
Choma	1-24	None	None
Gwembe	None	None	None
Kalomo	50-74	75-100	25-49
Kazungula	25-49	75-100	75-100
Livingstone	75-100	75-100	75-100
Mazabuka	None	None	None
Monze	1-24	None	None
Namwala	25-49	50-74	25-49
Pemba	ns	ns	Ns
Sinazongwe	None	1-24	1-24
Zimba	1-24	50-74	50-74

ns Not stated

Out of the 11 districts that responded to the Government Non-health questionnaire on HIV programs and/or support for police officers, two reported that they had implemented VCT, three had established support groups for police officers living with HIV and a majority (eight districts) responded that they did not have government-provided alcohol abuse treatment programs specifically targeting police officers (not shown). The data further revealed that five districts reported that they had implemented a government-provided campaign against GBV including gender inequalities specifically targeting police officers (not shown).

Table 11 reveals that five prisons responded to the Government Non-health questionnaire on HIV programs and/or support for prison officers. Four prisons – Choma, Kalomo, Kazungula and Livingstone – responded that they had implemented government-supported HIV-prevention programs in the 12 months preceding the study while Mazabuka prison reported not having any such programs. Study findings further revealed that the four prisons that reported having a government-supported HIV-prevention program also had an interpersonal HIV-prevention education and persuasion program, a male and female condom distribution program, as well as a condom social marketing program. Katombola prison in Kazungula district reported having reached the highest percentage of prison officers (50-74 percent) with interpersonal HIV-prevention education and persuasion and condom social marketing (75-

100 percent). The second highest was Livingstone prison which had reached 50-74 percent of officers with all the three interventions. The least was Kalomo prison which had only 1-24 percent of prison officers reached with all the three interventions (Table 2).

Table 11 Estimated percentages of prison officers reached by Government in various HIV-prevention interventions in the past 12 months by district, Southern Province, Zambia 2013

District	Interpersonal Education and Persuasion Program	Male and Female Condom Distribution	Condom Social Marketing
Choma	1-24	1-24	25-49
Kalomo	1-24	1-24	1-24
Kazungula	50-74	50-74	75-100
Livingstone	50-74	50-74	50-74
Mazabuka	None	None	None

Three out of five prisons reported that they implemented a VCT program specifically targeting prison officers while one prison did not. Mazabuka was the only prison that reported not having implemented any HIV-prevention interventions for its officers in the 12 months prior to the study. The data further showed that only two prisons reported that they had established support groups for prison officers living with HIV, while three prisons, including Mazabuka, did not implement this program. The study also revealed that only two prisons had implemented the alcohol abuse treatment program during the period under review (not shown).

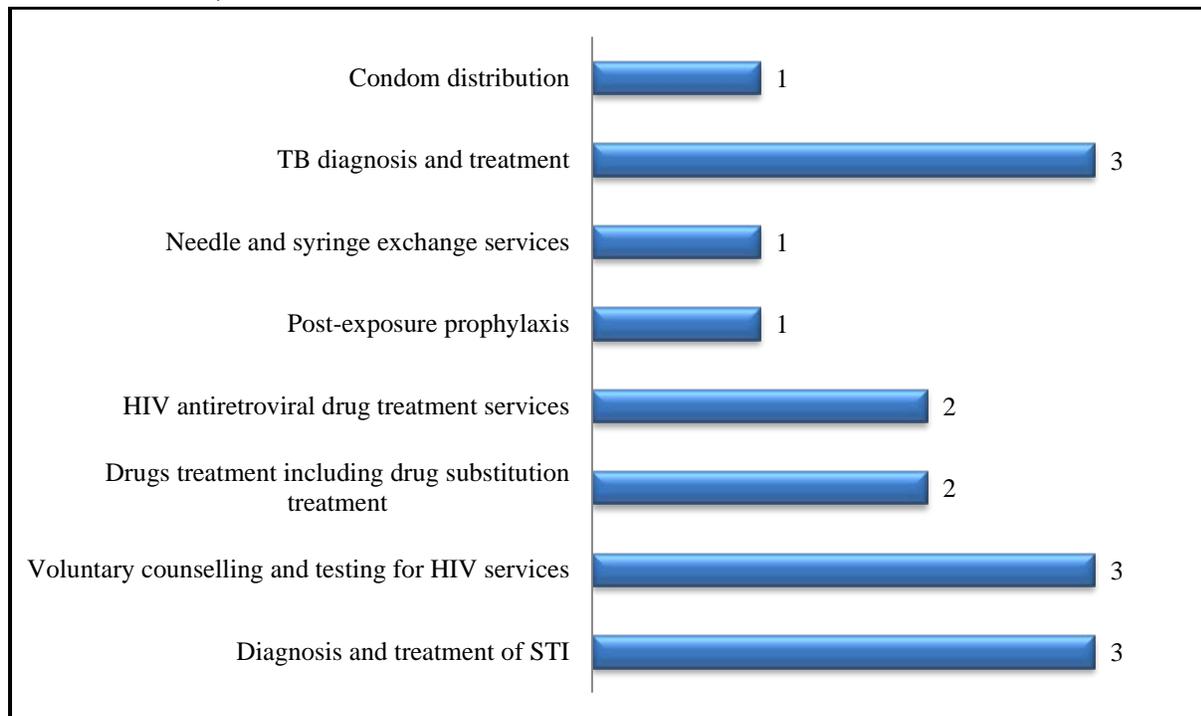
GBV, including gender inequality at places of work, has the potential to render marginalized individuals vulnerable to HIV infections through unsafe sex with those in authority. To prevent this, the Government of Zambia has mainstreamed campaigns against GBV in all institutions and levels of governance. Despite the good intention of government, the study reveals that not all prisons surveyed implemented the campaign against GBV. Three out of five prisons that responded to the questionnaire reported that they had implemented a campaign against GBV specifically targeting prison officers (not shown).

6.2 HIV Prevention Programs for Prisoners

The study sought to find out if there were any government offices working with prisoners on HIV prevention, care and/or treatment in Southern Province. Only three prisons authorities code-named (for ethical reasons) X, Y and Z could provide information regarding HIV prevention, care and/or treatment for prisoners. The three prisons that participated in the study had a combined prisoner population of 934, of which 23 were female. Prisons X and Y that reported relatively smaller prisoner populations had reached a higher proportion (75-100%) of the prisoners with HIV-prevention and support programs in the 12 months prior to this study. On the other hand Prison Z that reported the largest prisoner population had reached less than 50% of its prisoners during the same period.

Figure 9 reveals that only three out of eight identified interventions were offered by the three prison authorities that responded to this section of the question. The three interventions included: TB diagnosis and treatment, VCT, and diagnosis and treatment of STIs. Figure 9 further reveals two interventions, namely ART services and drug treatment including drug substitution for PWID were implemented in two districts. In Zambia, it is illegal to distribute condoms among prisoners and debate on whether to legalize this or not still rages on. However, this study revealed that one of the prisons reported that they had distributed condoms to prisoners during the 12 months period prior to this study.

Figure 9 Number of prisons implementing specific HIV-prevention interventions, Southern Province, Zambia 2013



The study revealed that each of the three districts independently offered a set of HIV prevention, care and/or treatment interventions. Prison X offered four out of the eight identified interventions, which included diagnosis and treatment of STI; VCT; drug treatment, including drug substitution for PWID; and TB diagnosis and treatment. Prison Y offered five of the identified interventions as follows: diagnosis and treatment of STIs; HIV VCT; HIV ARV treatment services; drug treatment including drug substitution treatment for PWID; and TB diagnosis and treatment. Prison Z reported seven out of the eight interventions shown: STI diagnosis and treatment; HIV VCT; HIV ARV treatment services; post-exposure prophylaxis; needle and syringe exchange services; TB diagnosis and treatment; and condom distribution.

6.3 Summary and Discussion

The study shows that many government non-health institutions in the Southern Province are actively involved in HIV-prevention programs. This could be the result of Government acknowledging that the initial responses to HIV and AIDS were inadequate to contain a problem that was more than just medical in nature. To address this challenge, the subsequent integrated HIV programs were designed to foster political commitment at the highest level to develop inter-sectorial approaches encompassing all Government ministries, the private sector and civil society as well as to fully involve people living with AIDS and develop effective AIDS impact mitigation strategies (MoH, 2002 & GRZ, 2010).

The fact that none of the districts reported that they provided condoms on site in schools and tertiary institutions could be evidence that debate on whether or not government should distribute condoms at institutions of learning has not been conclusive. On the other hand, HIV awareness creation activities such as peer and interpersonal education that have been widely publicized and accepted in all parts of the country have been implemented by all government non-health institutions in almost all districts that participated in the study. Although only four districts have implemented the three HIV prevention interventions, namely education and persuasion programs, male and female condom distribution as well as condom social marketing for police officers, the national appeal of these interventions has resulted in implementation of at least one of them in the majority (eight out of 11) districts that participated in the study. All prisons that had HIV prevention programs had implemented all three interventions.

While it is illegal to distribute condoms in prison, a question mark remains on whether one prison had in fact distributed condoms among prisoners. This is because a number of groups, including the World Health Organization (WHO) have lobbied government and justified why condoms should be made available to prisoners. For example WHO have cited research that has consistently found that it is feasible to make condoms available in prison, that condom distribution programs are unobtrusive to the prison routine, and that existing models of condom distribution could easily be replicated in other prisons in which condoms are not yet made available (WHO, UNODC & UNAIDS, 2007). Local pressure groups such *In But Free* an organization that has been advocating for improvement in the welfare of prisoners have also used research findings to support condom distribution in prisons. A recent study carried out in Zambia found out that a total of 609 (27 percent) prisoners who participated in the survey were HIV seropositive and was of the view that giving protection to prisoners is in the long run giving protection to the broader community (Simooya et al. 2014).

Among the four social support services provided to police officers, only prevention of GBV was implemented by a majority of the districts. This could be attributed to the massive campaign by civil society and the resultant seriousness with which government has treated issues of GBV to an extent of establishing a dedicated section within the police service. To facilitate implementation of the fight against GBV, every police station in the country has an office dedicated to this program.

While the existing HIV prevention interventions provided at non-health government institutions are a good start, a lot more effort is required to strengthen the capacity of these institutions to effectively implement these programs. Given the more than half a million student population in the province who

represent the future of this country, more focus needs to be placed in strengthening the capacity of public schools and tertiary institutions to effectively implement HIV prevention programs and social support services. Government through the National HIV/AIDS/STI/TB Council should galvanize the efforts of all stakeholders to support the Ministry responsible education in this fight.

7. References

Government of the Republic of Zambia (2010) National AIDS Strategic Framework, 2010-2015': Towards Improving the Quality of Life for the Zambian People. Lusaka, Zambia: Government of the Republic of Zambia.

Mbozi, P. (2010) Leadership in HIV and AIDS in Zambia: A Situation Analysis of Public Perceptions of the Role of Parliament in National Response to HIV/AIDS: the case of CAPAH-Z and the Zambian Media. Lusaka, SHARE.

Ministry of Education, Science, Vocational Training & Early Education, Southern Province (unpub) Primary Schools as at November 2013.

Ministry of Education, Science, Vocational Training & Early Education, Southern Province (unpub) Secondary Schools as at November 2013.

Ministry of Health (2002) National HIV/AIDS/STI/TB Policy. Lusaka, Zambia: Government of the Republic of Zambia.

National AIDS Council (2011). National HIV & AIDS Communication and Advocacy Strategy (2011-2015). Lusaka, Zambia: National HIV/AIDS/STI/TB Council.

National HIV/AIDS/STI/TB Council (no date) Briefing Notes on National HIV Prevention Presented to the HIV convention conference, 5-6th OCTOBER, 2009. Mulungushi International Conference Centre, Lusaka.

National AIDS Council (2010): *NAC Strategic Plan (2011-2015)*.

National AIDS Council (2010): *National HIV/AIDS/STI/TB Strategic Framework*.

National AIDS Council (2010): *Zambia Country Report: Monitoring the Declaration and Commitment on HIV and AIDS Declaration of Commitment*.

National AIDS Council (2009): *Support for the HIV/AIDS Response in Zambia (2009)*. Project briefing notes.

Simooya o.o, Sanjobo N, Mulenga C, Mwakazanga D, Tailoka F, Betha E, Kaetano L & Witola H (2014) 'Aggressive Awareness Campaigns May Not be Enough for HIV Prevention in Prisons-Studies in Zambia Suggest Time for Evidence- Based Interventions', *The Open Infectious Diseases Journal*, 2014, 8, 1-7.

WHO, UNODC & UNAIDS (2007) Evidence for Action Technical Papers, Effectiveness of Interventions to Manage HIV in Prisons – Provision of condoms and other measures to decrease sexual transmission.

Joint United Nations Programme on HIV/AIDS (1999) Handbook for Legislators on HIV/AIDS, Law and Human Rights Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact. Geneva, Switzerland: UNAIDS.

Joint United Nations Programme on HIV/AIDS (no date) Mainstreaming HIV and AIDS in sectors & programmes: An implementation guide for National Responses. Geneva, Switzerland: UNAIDS.

Joint United Nations Programme on HIV/AIDS (2009) Status of HIV/AIDS pandemic: sub-Saharan Africa. Geneva, Switzerland: UNAIDS.

MEASURE Evaluation

Carolina Population Center
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, NC 27517

<http://www.cpc.unc.edu/measure/>