ZAMBIA

Policy Analysis for the Elimination of Pediatric HIV

Elizabeth Glaser Pediatric AIDS Foundation

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ViiV Healthcare

THE CHILDREN'S INVESTMENT FUND FOUNDATION

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25 mg
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ACRONYMS

ACP	AIDS Control Program
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Dugs
CSO	Civil Society Organization
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMTCT	Elimination of Mother-to-Child Transmission
HC I–IV	Health Center I–IV
HIV	Human Immunodeficiency Virus
HSSIP	Health Sector Strategic and Investment Plan
INGO	International Nongovernmental Organization
MCH	Maternal and Child Health
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
NDP	National Development Plan
NGO	Nongovernmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PMTCT	Prevention of Mother-to-Child Transmission
UAC	Uganda AIDS Commission
UNGASS	United Nations General Assembly Special Session

Executive Summary

The "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive" (UNAIDS 2011) sets forth the ambitious goal of achieving elimination of pediatric HIV by reducing new pediatric infections by 90% by 2015. The Global Plan represents a paradigm shift from a focus on scaling up more narrow prevention of mother-to-child transmission (PMTCT) interventions to a more comprehensive approach to PMTCT that fully embraces the importance of primary prevention, family planning, and broader maternal–child health.

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), a leading global organization focused on the elimination of pediatric HIV, has launched a multicountry policy analysis effort to identify critical gaps and opportunities at the policy level that hamper efforts in achieving elimination of pediatric HIV. This report presents findings and recommendations from an analysis that was conducted in Zambia by EGPAF with the support of the Zambia Ministry of Health (MOH). The assessment included a desk review of relevant documents, interviews with key stakeholders in Zambia (in May 2012), and a systematic analysis and synthesis of that information. The report provides an assessment of the policy environment, key challenges to achieving elimination, and concrete and feasible recommendations for action in the policy realm.

Zambia has made significant progress in addressing the overall epidemic and in scaling up PMTCT across the country. Despite this success, vertical transmission remains the second leading source of HIV infections (10%) in the country, with an estimated 7,500 children newly infected each year (MOH 2012). Zambia's health care system requires significant strengthening, particularly at the lower levels, where the majority of women receive PMTCT. While the health care challenges extend beyond PMTCT, policy remedies need to be identified that can be effective in the near term for eliminating pediatric HIV.

A review of the policy environment indicates that Zambia has a comprehensive policy structure in which to pursue elimination of pediatric HIV. The policy elements, as written at the national level, track relatively closely with the vision set out by the Global Plan and form a good basis from which to pursue its goals. Furthermore, many of the necessary national structures are established, including the Cabinet Committee of Ministers on Health and HIV and AIDS; the Zambia National AIDS Council (NAC); the PMTCT Technical Working Group (TWG); the Directorate of Public Health and Research (DPHR); the Directorate of Clinical Care and Diagnostic Services (DCCS); and the newly established Ministry of Community Development, Mother and Child Health. In addition, the Zambia Ministry of Health issued in 2011 "The Joint EMTCT and ART National Strategy & Operational Plan 2011–2015: Eliminating Mother-to-Child Transmission of HIV and Scaling Up HIV Care, Treatment and Support for Children, Adolescents and Adults," with the goal of virtual elimination of mother-to-child transmission (EMTCT) and reduction of HIV morbidity and mortality among HIV-positive women and HIV-exposed and -infected infants. Based on the desk review and key informant interviews, six key policy- and systems-related issues that have the potential to challenge efforts toward elimination of pediatric HIV emerged from this analysis:

- There are different conceptions and a lack of knowledge and understanding of virtual elimination of pediatric HIV among key decision makers and implementers, which have weakened collective support for efforts to eliminate pediatric HIV.
- There is weak coordination and oversight for national efforts toward elimination of pediatric HIV and no clear plans to bring policies to fruition on the ground, which undermines the effectiveness of policies toward elimination of pediatric HIV.
- There is a lack of cohesive representation and involvement of local stakeholders, including civil society, the community, traditional healers, and religious leaders, in the policy formulation process and implementation of roll-out strategies, which limits the responsiveness of policies to the reality on the ground and the feasibility of their implementation.
- There are no policies in place to address some of the main barriers that prevent the involvement of men in efforts to eliminate pediatric HIV.
- There are no policies to mitigate the potential negative impact of customary laws on elimination of pediatric HIV efforts.
- There are insufficient human resources for health to meet the needs of the elimination of pediatric HIV agenda.

A summary of key recommendations toward elimination of pediatric HIV in Zambia include the following (more details in Section 4.2):

1. Enlist the government of Zambia to communicate a consistent and comprehensive message on elimination of pediatric HIV.
2. Ensure the inclusion of local stakeholders, including civil society, the community, people living with HIV and AIDS (PLWHA), traditional healers, and religious leaders, in the policymaking process and roll-out implementation strategies to make policies more responsive to the reality on the ground.
3. Strengthen the coordination of stakeholders.
4. Enhance the country's human resources for health capacity for elimination of pediatric HIV, especially in light of the forthcoming shift to option B+.
5. Restructure and improve the functioning of the body that provides coordination and oversight for the national efforts toward elimination of pediatric HIV (the National AIDS Council, or NAC).
6. Bring stakeholders together and conduct advocacy with policymakers to influence the aspects of policy relevant to the elimination agenda.

Despite these identified challenges, and in light of the strong existing policy structure, a tremendous opportunity to achieve elimination of pediatric HIV exists in Zambia. With the global and national momentum on eliminating new pediatric HIV infections, perhaps the best-ever opportunity currently exists to achieve this transformation in the fight against HIV and realize a generation free of HIV in Zambia and across the globe.

Policy Analysis for the Elimination of Pediatric HIV

1. INTRODUCTION

1.1 The Global Plan toward Elimination of Pediatric HIV

The "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive" (Global Plan, UNAIDS 2011), presented at the high-level United Nations meeting in June 2011, sets forth the ambitious goal of achieving elimination of pediatric HIV by reducing new pediatric infections by 90% by 2015. The Global Plan represents a paradigm shift from a focus on narrow prevention of mother-to-child transmission (PMTCT) interventions to a more comprehensive approach to PMTCT that fully embraces the importance of primary prevention, family planning, and broader maternal and child health. The implementation framework for achieving elimination of pediatric HIV is based on four prongs (Table 1 contains prongs and associated targets).

Virtual elimination of pediatric HIV is a realistic public health goal, with many high- and middle-income countries having already succeeded in reducing MTCT to very low levels. Effective implementation of the 2010 WHO prevention, care, and treatment guidelines in resource-limited settings could reduce MTCT to less than 5%, even in breastfeeding populations. Yet significant disparities remain, with more than 90% of the 370,000 new infections among children occurring in sub-Saharan Africa in 2009 (UNAIDS 2011). Most HIV-infected African children without access to treatment die within their first two years of life (Newell et al. 2004). Maternal morbidity and mortality from HIV also have devastating effects in countries with a high burden of HIV, and addressing these is an essential component of the global response (UNAIDS 2011).

With the momentum from the global focus on eliminating new pediatric HIV infections, perhaps the best-ever opportunity currently exists to achieve this transformation in the fight against HIV and realize a generation free of HIV.

1.2 Overview of the Report

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), a leading global organization focused on the elimination of pediatric HIV and AIDS, has launched a multicountry policy analysis effort to identify critical gaps and opportunities at the policy level that stand in the way of achieving elimination of pediatric HIV. The analysis seeks to document and describe the national policy environment and factors that are associated with the global and national goals of elimination of pediatric HIV. This approach takes into account key decision makers, decision-making processes, and decision points that are involved in making policies (and by extension, laws, regulations, and strategic plans) and translation of policies into implementation that affect access to and utilization of prevention of mother-to-child-transmission (PMTCT) and related services.

This report presents findings and recommendations from an analysis that was conducted in Zambia by EGPAF and health policy experts from the George Washington

TABLE 1: SUMMARY OF IMPLEMENTATION FRAMEWORK FOR ACHIEVING ELIMINATION OF PEDIATRIC HIV (UNAIDS 2011)

Prong	Description and Target
Prong 1	Achieve primary prevention of HIV among women of reproductive age. *Target: Reduce HIV incidence in women ages 15–49 by 50%.*
Prong 2	Reduce unmet family planning need among HIV-positive women. *Target: Reduce unmet need for family planning among women living with HIV to zero.*
Prong 3	Ensure access to HIV testing and counseling and antiretroviral drugs (ARVs) for HIV-positive pregnant women to prevent mother-to-child transmission (MTCT) during pregnancy, birth, and breastfeeding. *Target: Reduce MTCT to 5% (with 90% of mothers receiving perinatal ARV prophylaxis and 90% of breastfeeding, mother–infant pairs receiving antiretroviral therapy [ART] or prophylaxis).*
Prong 4	Provide HIV care, treatment, and support for women and children living with HIV and their families. *Target: Provide 90% of pregnant women in need of ART for their own health with lifelong ART.*

University in Washington, D.C. The review was carried out with the support of the Zambia Ministry of Health (MOH). EGPAF decided to conduct the analysis in Zambia because of strong country-level support to conduct the analysis, ongoing in-country review of elimination strategies, and Zambia's status as a leader in innovation of HIV- and maternal and child health (MCH)–related policies and programs.

The Zambia Ministry of Health issued "The Joint EMTCT and ART National Strategy & Operational Plan 2011–2015: Eliminating Mother-to-Child Transmission of HIV and Scaling Up HIV Care, Treatment and Support for Children, Adolescents and Adults" (herein referred to as the EMTCT Plan), which outlines an implementation framework for how Zambia will achieve elimination of mother-to-child transmission (EMTCT) of HIV. The analysis presented in this report focuses specifically on understanding the policymaking process and the policy barriers and facilitators to achieving EMTCT and complements the EMTCT Plan, which is more focused on the barriers and facilitators at the service-delivery level.

This report is intended for policymakers at the MOH, the Ministry of Community Development, the Maternal and Child Health department, the NAC, Parliament, implementing partners, civil society organizations (CSOs), local governments, the Ministry of Chiefs Affairs, and other key stakeholders to help inform planning for elimination of pediatric HIV in Zambia. While this report does not focus on barriers at the service-delivery level, it can serve to complement analysis and support work at this level.

The report is divided into the following sections: Section 1 gives background and context for elimination of pediatric HIV in Zambia, Section 2 describes the methods, Section 3 presents the key findings from the document review and stakeholder interviews, and Section 4 provides a summary and priority actionable recommendations based on the policy analysis.

1.3 Zambia Context for Elimination of Pediatric HIV

1.3.1 Key statistics

Zambia has made significant progress in addressing the HIV epidemic. As early as 2002, Zambia established an aggressive, politically led, multi-sectoral effort to reduce the rate of HIV infection. Among Zambia's strengths are its prevention efforts; the establishment of structures within the government to provide policy direction in relation to HIV and coordination for multi-sectoral HIV efforts; the rapid scale-up of HIV testing and counseling (HTC), antiretroviral therapy (ART), and prevention of mother-to-child transmission (PMTCT); and the roll-out of early infant diagnosis and strategies to improve its use, including mobile technology. Since implementation of its national program in 2002, Zambia has seen overall HIV incidence in adults

aged 15–49 years cut in half to 1.6% in 2009 (2% in women, 1.2% in men) (World Bank 2009).

In recent years, Zambia has made significant progress in the scale-up of PMTCT since the national program initiated it in 1999. By 2010, all districts offered PMTCT services; 1,200 out of 1,471 health facilities (over 80%) were implementing PMTCT services in 2010, up from 533 health facilities in 2007 (MOH 2012). Despite the efforts to scale up PMTCT and nearly universal antenatal care (ANC) coverage for at least one visit per pregnant woman, vertical HIV transmission is the second leading source of HIV infection (10%) in the country, with an estimated 7,500 children newly infected each year (MOH 2012). In 2011 about 85% of pregnant women in need of PMTCT had access to these services (MOH 2012). The unmet need for family planning services is 27% and is especially prevalent in rural and hard-to-reach areas of the country (DHS 2007). Overall, only 47% of women delivered their babies in health facilities in 2007 (DHS 2007). An estimated 88% of HIV-positive pregnant women and only 57% of HIV-exposed infants received ARVs for PMTCT in 2010 (MOH 2012), and 77.6% of ART-eligible adults and only 28% of children living with HIV were receiving ART as of 2011 (MOH 2012).

1.3.2 The health delivery system

There are three categories of health services in Zambia. Hospitals provide the largest share of PMTCT and ART services in the public sector and are divided into three categories: Level 1 hospitals at the district level, Level 2 hospitals at the provincial level, and Level 3 hospitals at the central level (largest scope of services) (Magagula 2011). Health posts and health centers, divided into urban and rural centers, have also been set up to bring health care as close to the community as possible. There are tremendous challenges associated with the health care delivery infrastructure in Zambia, including a critical shortage of health care workers, poor infrastructure and lack of equipment at health facilities, and shortages of essential drugs and supplies (MOH 2011). Despite the recent growth in public health facilities, including an increase in health posts in rural areas, Zambia faces major challenges with respect to geographical coverage and distance to health facilities in rural areas (MOH 2011). As we will explore in the findings of this analysis, the status of the health delivery system has a tremendous influence on whether policies achieve their intended outcomes on the ground, and an understanding of the health delivery system is critical throughout the policy-making process from conception to implementation.

1.3.3 Government management of elimination of pediatric HIV efforts

The National HIV/AIDS/STI/TB Policy, launched in 2003 and expanded in 2005, the 2011–2015 National AIDS Strategic Framework (NASF), and the National HIV and AIDS Operational Plan set forth guidance for the national HIV response, coordination, and management (NAC UNGASS Biennial Report 2010). The Cabinet Committee of Ministers on HIV and AIDS (established in 2000), now reconstituted to the Cabinet Committee of Ministers on Health and HIV and AIDS, works with the MOH and the National AIDS Council (NAC) to provide policy direction, supervision, and monitoring of the implementation of HIV programs in the public sector (NAC UNGASS Biennial Report 2010). The Cabinet Committee is chaired by the MOH, which is responsible for coordinating the HIV health sector response in collaboration with the NAC.

The MOH is responsible for the management of delivery of services related to elimination of pediatric HIV through the Directorate of Public Health and Research (DPHR) and the Directorate of Clinical Care and Diagnostic Services (DCCS) (2011–2013 Virtual Elim Scale-up Plan 2010). A PMTCT specialist in the DPHR coordinates the national PMTCT efforts; pediatric ART services are jointly coordinated by a pediatric ART program officer in DCCS and a pediatric HIV program officer in DPHR. Provincial medical offices (PMO) manage district medical offices (DMO) that oversee implementation of PMTCT services, which are integrated into maternal, neonatal, and child health (MNCH) services, in the districts. District medical officers manage program officers, including the clinical care expert and the MCH coordinator. Implementation of services for elimination of pediatric HIV is supported by various partners on the ground (2011–2013 Virtual Elim Scale-up Plan 2010).

In September 2011 the government of Zambia established a new Ministry of Community Development, Mother and Child Health (MCDMCH) as one of Zambia's key social sector ministries contributing significantly to reduction in poverty, improvement in the living standards of vulnerable individuals, and promotion of the health of mothers and children. There is a possibility that in the near future PMTCT and elimination efforts will become the responsibility of the new ministry.

1.3.4 The policy and legal environment

In Zambia policies and laws are generally conducive or neutral to efforts toward elimination of pediatric HIV. However, there are some key challenges with legislation pertaining to the health sector more broadly, customary laws, and adoption and implementation of commitments under international agreements that could potentially also hinder efforts toward elimination of pediatric HIV.

The EMTCT Plan is the central policy focused on elimination of pediatric HIV in Zambia. The plan includes all four prongs of the comprehensive approach to elimination of pediatric HIV and has well-defined goals, aims, objectives, and national targets that are consistent with the Global Plan. This policy, as well as various other HIV and health sector policies that are more directly related to elimination of pediatric HIV, will be explored in greater detail in Section 3.4. These policies generally provide a positive environment to facilitate efforts toward elimination of pediatric HIV.

There are some challenges with current legislation related to delivery of health services in Zambia that also impact efforts toward elimination of pediatric HIV. In 2005, the 1995 National Health Services Act, which had approved the establishment of the Central Board of Health, was repealed without replacement. According to the Sixth National Development Plan, the country plans to develop a new Health Services Act to replace the repealed 1995 Act before 2015 (SNDP 2011–2015). Since the Health Services Act was repealed, much effort has been directed toward developing specific policies in the health sector. Yet without a strong framework to monitor the impact of new policies and legislation and ensure harmonization and alignment among all health policies and legislation, there are challenges with linking policy formulation and implementation (UNDP 2011).

In Zambia statutory bodies are responsible for regulation of the health sector. The dissolving of the Central Board of Health, along with few financial, human, and logistical resources, has challenged the operation of statutory bodies and their regulation of health sector institutions (UNDP 2011).

Zambia's laws are drawn from multiple sources, including the Constitution, legislation, common law, judicial precedent, customary law, and authoritative texts (Magagula 2011). Although the laws within Zambia's formal legal code are generally conducive to facilitating elimination of pediatric HIV, there are some aspects of customary law that could serve as barriers; these will be discussed in a subsequent section. Courts that employ customary law have few formal rules of procedure. The presiding judges are usually prominent members of the community who have the power to apply customary law and give judgments, which do not usually adhere to the penal code, on marriages, divorces, inheritances, and other civil proceedings (Magagula 2011). These judgments have been seen to discriminate against women, and certain practices associated with customary law perpetuate women's vulnerability to HIV and their unequal place in society (Magagula 2011).

Zambia is a signatory to many global and regional agreements and declarations, including the Millennium Development Goals, the Paris Declaration, the UNGASS Declaration, Universal Access, the Abuja Declaration, the African Union Maseru/Maputo Declaration, and the Southern African Development Community SADC Protocols (UNGASS 2010). Although Zambia's status as a signatory to these international instruments is conducive to facilitating efforts toward elimination of pediatric HIV, implementation of the commitments under these agreements and declarations is slow or does not always happen, creating barriers to elimination.

2. METHODS

The analysis was submitted to the Biomedical Research Ethics Committee at the University of Zambia for ethical review and received approval on March 23, 2012. The analysis utilized a qualitative case study methodology that included a desk review of relevant documents, interviews with key stakeholders in country in May 2012, and analysis and synthesis of information.

2.1 Document Review

A desk review was conducted prior to in-country interviews and used documents that were publicly available as well as those provided by the Ministry of Health (MOH) and other organizations. Examples of documents reviewed include the National Constitution; multilateral and bilateral agreements related to HIV, health, and child welfare; national and subnational laws, regulations, executive orders, and administrative decrees; national strategic plans; health provider self-regulation and code of ethics; and policy research reports and analyses. Appendix 1 lists all documents reviewed.

The desk review provided information about the political, legal, sociocultural, and health system context of Zambia. In addition, the desk review included analysis of the content of laws and policies related to elimination of pediatric HIV. Data from the document review were collected as detailed notes. Upon completion, detailed notes from the document review were compiled and theme analysis of the documents reviewed was conducted.

2.2 Stakeholder Interviews

Interviews with 26 different key stakeholders in Zambia took place May 14–24, 2012. Key informants were identified based on the desk review and from discussions with the MOH and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Zambia team. Interviewees included senior MOH officials, Parliamentarians, HIV program implementing partners, international nongovernmental organizations (INGOs), domestic NGOs, donors and development partners, and civil society organizations. The names of the individual interviewees and organizations were kept confidential to encourage candid responses.

A semi-structured interview guide was developed for discussions with key stakeholders in country. The interview guide examined the following dimensions of policies and laws related to elimination of pediatric HIV: 1) stakeholders' understanding of the concept of elimination of pediatric HIV and its programmatic components; 2) perspectives of the government's prioritization and political will in relation to elimination of pediatric HIV; 3) key factors in agenda setting of policies and laws related to elimination of pediatric HIV; 4) processes associated with policy initiation, formulation, and adoption; 5) perspectives on existing policies that either facilitate or hinder efforts toward elimination of pediatric HIV; and 6) perspectives on implementation, monitoring, and evaluation of policies.

2.3 Analysis

Interviews were transcribed verbatim and reviewed the same day by the interview teams to identify gaps or additional information needs. Follow-up requests for additional information were made as needed. Following the country visit, the team compiled and systematically analyzed notes from the interviews to identify similarities and differences in responses across different stakeholders and to identify key themes. Three reviewers (two who attended the country visit and one who did not) reviewed the notes independently and identified key themes with supporting evidence from the notes. The team collectively discussed the reviews. Information from the interviews was triangulated with data collected from the document review. The findings from the interviews and document review were discussed with the EGPAF-Zambia team and Zambia MOH to develop key recommendations.

2.4 Potential Limitations

There are several potential limitations to this analysis. This analysis was conducted in the context of Zambia, and while there may be some universal lessons to be drawn from this analysis, they cannot necessarily be applied to other contexts. It was done in collaboration with the MOH of Zambia. Although working with the MOH was beneficial in gaining access to some of the stakeholders, this may have influenced the responses of some of the stakeholders to questions in the interview guide. Efforts were made to conduct a comprehensive document review. However, there may have been relevant documents that were not included in the document review. Finally, there was variability in the seniority and position of the people interviewed from stakeholder organizations. Stakeholders were identified to participate in interviews at the discretion of their organizations. It must be considered that organizational responses were dependent on the person who participated in the interview.

3. RESULTS/KEY FINDINGS

3.1 Understanding of Elimination of Pediatric HIV

Having a common understanding of the four key program components to achieve elimination of pediatric HIV is critical to identifying appropriate national goals and mobilizing resources and support to achieve those goals. The analysis pointed to a gap between the comprehensive approach to elimination of pediatric HIV articulated in the EMTCT Plan and stakeholders' limited and inconsistent understanding of this concept.

The EMTCT Plan articulates a comprehensive approach to elimination of pediatric HIV that includes the four prongs of the Global Plan's implementation framework (MOH 2012).[1] In contrast to the broad approach set forth in the EMTCT Plan, stakeholders defined the goals associated with elimination more narrowly. The majority of stakeholders explained the goal of elimination of pediatric HIV in terms of preventing HIV transmission from mothers to their babies. While the Global Plan specifically emphasizes the importance of keeping mothers alive, only one stakeholder independently brought this up and only in the context of keeping mothers alive so that children can complete their education. Multiple stakeholders mentioned mandatory HIV testing of pregnant women as a key component of a program to achieve elimination of pediatric HIV.

In describing the program components involved in achieving elimination of pediatric HIV, the majority of stakeholders focused on prong 3 of the comprehensive approach to PMTCT defined in the Global Plan and the EMTCT Plan: delivery of PMTCT services. Of the targets articulated in the Global Plan, the target associated with prong 3 of reducing MTCT was the only target mentioned among all stakeholders. According to multiple stakeholders, the differences between PMTCT, virtual elimination, and elimination are not well understood in Zambia. When several of the stakeholders were asked follow-up questions regarding prongs 1 and 2 and why these components were not mentioned, stakeholders consistently alluded to weaknesses in addressing these prongs. According to stakeholders, work on these prongs is weak because it is more complex to measure and attribute the work associated with prongs 1 and 2 than, for example, delivery of ARVs or HIV testing of pregnant women, in a context that emphasizes quantifiable results that can be attributed to specific organizations. Stakeholders also expressed that the focus on prong 3 was due to the fact that this prong was seen as the most urgent.

3.2 Perspectives on the Government's Prioritization of Virtual Elimination of Pediatric HIV and Political Will

Leadership and governance are generally seen as critical to achieving desired outcomes in efforts to systematically address the HIV epidemic and to strengthen health care (UNAIDS 2006, WHO 2008). This sentiment is shared in Zambia, where there was a widespread belief among those interviewed that leadership and political will at the highest levels of government could help mobilize and galvanize support to eliminate pediatric HIV. Although the document review supports that there is political will for elimination given the existence of the EMTCT Plan and the fact that PMTCT is mentioned as a priority prevention activity in multiple high-level health policy documents, stakeholders had mixed opinions on this.

Multiple stakeholders suggested that increasing leadership and political will are important facilitators in achieving elimination of pediatric HIV. Most stakeholders felt that leadership for elimination needs to start at the highest levels of government. There were mixed responses from stakeholders about whether the elimination of pediatric HIV is a top priority for political and health leadership in Zambia.

Stakeholders provided various examples to substantiate their opinions that political will and high-level commitment for elimination of pediatric HIV are present. Stakeholders noted that PMTCT is always featured prominently in the National Health Policy and the National AIDS Framework. According to stakeholders, the minister of health has been vocal about the promising possibility of elimination of pediatric HIV and has consistently spoken about the need to act to reduce new infections among children. In addition, elimination is seen as an achievable goal, and there are data to monitor its progress as a result of the commitment to this issue.

Stakeholders also discussed various examples of government commitment to health and HIV in general that they feel demonstrate political will for elimination of pediatric HIV. Stakeholders described a recent increase

1. The Zambia elimination plan includes slightly different targets than the Global Plan. It also includes an additional objective to reduce the number of new HIV infections among children by 90% by 2015.

in budgetary allocation to the MOH in 2012 from 8% to about 9% and the likelihood that this would have a positive impact on elimination. Some stakeholders felt that the fact that the government allows partners to work in the provinces and provide HIV services is a demonstration of political will through which the government is ensuring provision of services it is not able to marshal on its own. Finally, some stakeholders felt that the establishment of a dedicated body to coordinate HIV and AIDS response (NAC) exemplifies the government's dedication and commitment to HIV and elimination of pediatric HIV.

Stakeholders also presented multiple reasons why they perceive that there is insufficient political will for elimination of pediatric HIV. The government does not consistently equip clinics to offer the services necessary to achieve elimination, and therefore clinics rely on partners to provide support to deliver these services. Stakeholders felt that if the government viewed elimination as a key priority for the country, it would find a way to allocate the resources necessary to finance the programs. Some respondents felt that increased support from State House would have significant impact on elimination of pediatric HIV to give it the push required to place it at the forefront. Some stakeholders discussed how the MOH did not propel elimination efforts forward with the momentum created by the Global Plan in June 2011; they felt the push came from outside the MOH, and this showed that elimination was not a priority.

Although there is relatively strong political will to support the elimination agenda, resources are key constraints in translating that political will into tangible actions. The elimination of new pediatric infections is well understood at the MOH, and they provide guidance to the political leadership to ensure that appropriate policy solutions are created. They also share this understanding with other national institutions and partners that support the implementation of programs. However, there was a perceived need to do more to ensure that the resources to implement identified policy solutions are provided at all the levels so that the goals are reached.

3.3 Formulation and Adoption of Policies Related to Elimination of Pediatric HIV

The document review and stakeholder interviews explored the structures, processes, and key influences associated with policies related to elimination of pediatric HIV. Although the documents point to a particular process for policy formulation and adoption, the stakeholders identified key influences that they feel are necessary to driving the processes in practice, including the PMTCT Technical Working Group (TWG), donors; data/evidence; international guidance from WHO; and involvement of civil society, community, and traditional leaders. In addition, stakeholders discussed the lack of involvement of civil society, community, and traditional leaders in the formulation of policies.

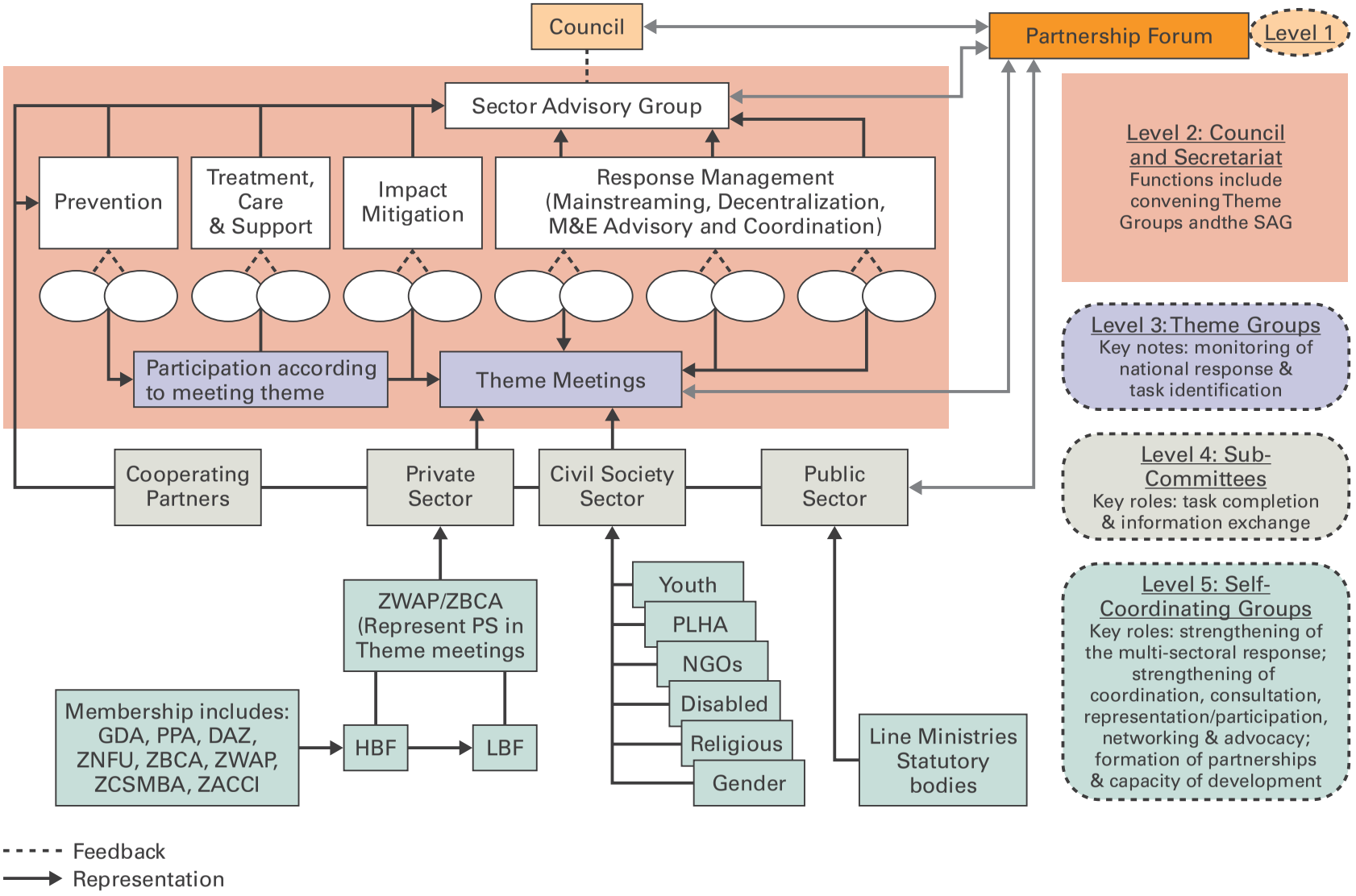
3.3.1 HIV/elimination of pediatric HIV policymaking institutional structure

Figure 1 (taken from the NASF 2011–2015, p. 53) depicts the institutional structure for the coordination of the national HIV and AIDS multi-sectoral response. The Cabinet Committee of Ministers on HIV and AIDS (established in 2000) and reconstituted to the Cabinet Committee of Ministers on Health and HIV and AIDS, chaired by the minister of health, is the highest level HIV policymaking body. The MOH is responsible for coordinating the health sector response in collaboration with NAC. NAC is designated as the national coordinating body for HIV in Zambia. The Cabinet Committee appoints the NAC board chairman and supervises NAC's activities. The MOH represents NAC in Parliament and the MOH's permanent secretary is the controlling officer for NAC's income and expenditures (NASF 2011–2015). NAC includes a Sector Advisory Group with representation to cover prevention, treatment, care and support, impact mitigation, and response management. In addition, a number of technical working groups exist, including the PMTCT TWG, which provides technical expertise on various aspects of the HIV response to NAC. The PMTCT TWG also provides expertise in relation to elimination of pediatric HIV.

NAC's coordination takes place at four levels (national, provincial, district, and community), and coordinating structures at each level include representation from the government, civil society organizations, development partners, and the private sector. NAC convenes quarterly meetings with the cooperating partners, civil society organizations, private sector, and faith-based organizations' self-coordinating groups/forums to facilitate partnership building, consultation, participation, and information exchange.

Development partners interact at all levels of this structure and include bilateral and multilateral partners as well as INGOs and are coordinated through the Partnership Forum, the Cooperating Partners Forum, and the Joint United National Program on HIV and AIDS. Different UN agencies cooperate using their competitive advantage to support implementation

Figure 1: **Cabinet Committee of Ministers on HIV & AIDS**



of priority activities. Development partners support the implementation of the NASF on the basis of the Joint Assistance Strategy for Zambia (JASZ), which represents the mutual commitment of the government and partners and has tried to align donor funding and reporting with NAC systems.

3.3.2 The policymaking process

The steps in Table 2 summarize the process for an MOH policy that becomes an act or a law (Guide to Preparing National Policy Documents and Cabinet Memorandum 2010).

TABLE 2: PROCESS FOR MOH POLICY THAT BECOMES AN ACT OR LAW

1. **Policy Formulation** • Issue/problem is identified and defined within the relevant ministry. • Consultation and analysis of the problem is undertaken by key stakeholders. • Policy options are determined and a preferred course of action is recommended to the cabinet for consideration. • Key players in this process include different ministries, the Policy Analysis and Coordination Division, and other stakeholders.
2. **Policy Adoption** • Recommended course of action or approach is presented before a decision-making body for approval. • A final memorandum is submitted once agreed upon by the Policy Analysis and Coordination Division. • The cabinet secretary processes the issue/problem for the agenda, informs the chairperson of the cabinet on the need to convene a meeting, issues a notice, dispatches documents to various members, and records the proceedings during the meeting. • The initiating minister presents the proposed recommendations to the cabinet/cabinet committees, which are the first to discuss proposals before final recommendations are presented to the cabinet for consideration. • The cabinet approves recommendations before they are implemented. • When necessary documentation is ready, a cabinet meeting is convened to consider the recommendations presented by the initiating minister.
3. **Policy Implementation** • A set of activities is undertaken to ensure that the decision made on the recommended course of action is implemented according to the approved implementation plan. • Once a decision is made, the cabinet secretary conveys the decision and indicates who should lead implementation to the permanent secretary of the initiating ministry and other concerned institutions. • The relevant ministry ensures the decisions of the cabinet are implemented. • The relevant ministry creates draft implementation plans.
4. **Monitoring and Evaluation** • A continuous process of checking progress is undertaken to make sure planned activities are being implemented within the approved timeframe. • The impact of the policy being implemented is evaluated. • The relevant ministry submits to the Policy Analysis and Coordination Division progress reports on the implementation of the policy for which they are responsible.

3.3.3 Key influences on policy decisions

Stakeholders shared different observations about what they see in practice as influencing agenda setting, policy formulation, and adoption of policies related to elimination of pediatric HIV. These observations focused on the PMTCT Technical Working Group (TWG), donors; data/evidence; international guidance from WHO; and involvement of civil society, community, and traditional leaders.

3.3.3.1 The PMTCT Technical Working Group

Stakeholders emphasized the critical role of the PMTCT TWG in setting the agenda, initiating policies, shaping the content of policies, and ultimately adopting policies related to elimination of pediatric HIV. While stakeholders felt that the MOH leads in agenda setting within the PMTCT TWG, they noted the powerful influence of certain members of this working group, including UN agencies (WHO, UNICEF, UNAIDS), CIDRZ, Boston University, and EGPAF, that exert influence on which issues become a priority. Stakeholders felt that the range of partners that participate in the PMTCT TWG position it to have multiple important perspectives. According to stakeholders, virtually all key decisions related to elimination of pediatric HIV are brought to the TWG for validation, and ultimately the content that this group proposes is in most cases passed into policy. Stakeholders attributed the influence of the PMTCT TWG to its evidence-based proposals that provide compelling arguments for change. There were some challenges associated with the PMTCT TWG driving policies raised by stakeholders. For example, stakeholders expressed that the TWG is not always cognizant of the reality and feasibility of implementation of policies on the ground.

3.3.3.2 Donors in an environment of limited resources

Several stakeholders highlighted the issue of resources and how an environment of scarce resources elevates the influence of donors in setting the agenda and influencing policy decision making. The fact that there are limited resources is substantiated by the fact that the government health budget was 10.4% of the national budget between 2000 and 2009 (UNDP 2011) and the domestic total health expenditure is only around $25–$30 USD per capita (Magagula 2011). The document review also provides evidence that Zambia is heavily reliant on external donor funding for HIV (DFID, CIDA, EC, GTZ, Ireland AID, JICA, Netherlands, DANIDA, NORAD, SIDA, USAID, CDC, and GFATM). Documents reveal that the country grapples with efficient utilization of the significant resources it receives from outside sources (MOH 2010, Global Fund 2010).

According to stakeholders, when donors provide funding to support a particular agenda item this often elevates the importance of the issue. Stakeholders felt that this can have a negative impact by influencing or changing priorities based on funding rather than on evidence. Multiple stakeholders alluded to the example of the USG and its affiliated organizations, including USAID and PEPFAR, as well as USG-funded partners such as ZPCT/FHI, CIDRZ, and EGPAF. According to multiple stakeholders, the USG has a major influence among other stakeholders because they provide substantial funding for ARVs in Zambia.

In general, stakeholders were concerned about donor dependence because of the challenge of sustainability when donors leave Zambia; many thought that there is no clear commitment from the government to continue work when donor commitments end. Furthermore, stakeholders felt that instead of adhering to the terms set forth in a donor framework, donors simply advocate for and pursue their own interests and in the process create a parallel system instead of strengthening the existing system. Documents reviewed reveal that the donor community has urged the Zambian government to come up with strategies that will reduce the country's dependence on foreign aid for HIV and AIDS interventions. It is notable that in Zambia's 2012 proposed budget the incoming government has promised to increase the MOH's budget by 45% (UNDP 2011).

The document review revealed that the health sector is faced with many coordination challenges related to donors that weaken efforts to harmonize aid. The Sector-Wide Approach to Programming (SWAP) policy has been used by the health sector to co-coordinate external resources from its bilateral and multilateral cooperating partners since 1994. Under the SWAP, bilateral and multilateral donors only fund activities in the National Health Sector Plan. This funding is earmarked for high-priority activities.

The SWAP policy has facilitated alignment of most health sector cooperating partners' external assistance toward implementation of MOH's National Strategic Health Plan. Yet a number of cooperating partners do not align their support within the SWAP framework, particularly more recently. Several donors withdrew from the SWAP after the MOH Global Fund fraud

scandal in 2010, when the Zambia Office of the Auditor General reported that it was not possible to account for a significant amount of funding from Global Fund grants. Many cooperating partners require the MOH to develop separate operating plans and budgets for each major public health disease even though the National Health Strategic Plan clearly articulates all public health priorities. As a result, the health sector has five separate plans for major global health partners contributing to the fight against HIV and AIDS, TB, malaria, and child health illnesses. This leads to inefficiencies with the MoH as staff are required to devote time to duplicative administrative tasks developing plans rather than implementing programs (UNDP 2011).

3.3.3.3 Data/evidence

Multiple stakeholders emphasized the role that data and evidence play in determining which issues become a priority for the agenda for elimination of pediatric HIV. They described how alarming statistics, such as the high mortality associated with children living with HIV, can serve as a catalyst to raise the importance of an issue. Findings from operations research can also bring an issue high on the policymaking agenda. Stakeholders noted the role that evidence-based documents play when discussions are initiated in the PMTCT TWG. Research findings were thought to play a fundamental role in what eventually become policies.

3.3.3.4 International guidance from WHO

Stakeholders emphasized the importance of international guidance from WHO in agenda setting. They described that when WHO releases new guidance, meetings are held to figure out how the guidance can be adapted to the Zambia context. Sometimes this poses a challenge because international guidance and policy are not always in touch with what is happening on the ground in country.

3.3.3.5 Lack of involvement of civil society, community, and traditional leaders

Most of the stakeholders were in agreement that policy initiation, formulation, and adoption take place without the adequate engagement of civil society, the community, and traditional leaders. According to stakeholders, this has resulted in many policies not being responsive to the reality on the ground. For example, there are infrastructure challenges, such as limited space at health facilities, that result in health care workers not being able to ensure confidentiality or provide all of the services that they are supposed. Stakeholders described how policies are based on UNICEF bottleneck analysis and do not examine what is happening at the level of the community. While some stakeholders described the NAC as having a key role in policy formulation and providing a platform for engagement of these groups, other stakeholders felt that NAC does not effectively engage these groups.

According to many of the stakeholders, although the community is sometimes consulted by the PMTCT TWG and government ministries during the policymaking process, in most cases this is seen as tokenism and the feedback is not really taken into consideration in decision making. Although one stakeholder described the PMTCT TWG as a forum for civil society to advocate to the technical team, most stakeholders expressed that civil society is not strong and does not have a voice in the PMTCT TWG. Some civil society organizations felt that when they pushed for elimination of pediatric HIV, they were not really heard and the MOH did not see the need for policy until this received more global attention and donors began advocating for this issue.

Some stakeholders involved in the actual policymaking process questioned whether it is relevant to engage the community on certain issues related to PMTCT. They raised the example of ARV regimen choice, which they described as a technical issue that should not require feedback from the community, while issues related to women's access to services and male involvement would warrant community consultation. According to another stakeholder, communities do not have the capacity to understand the changing global guidelines and standards and it would require too much time and resources to try to build their capacity to understand every updated guideline release.

3.4 Facilitators and Barriers to Elimination of Pediatric HIV Identified in Written Documents

The document review revealed that written policies and laws in Zambia are for the most part conducive or neutral in relation to elimination of pediatric HIV. Through examination of policies and laws summarized in this section (3.4 and Appendix 1), it was apparent that there are some aspects of existing policies and laws that could be strengthened to make the policy and legal environment more supportive of elimination efforts. Information from both the document review and the stakeholder interviews pointed to aspects of customary law that could be potential barriers to elimination efforts.

3.4.1 Written policies, laws, strategies, plans, and guidelines that facilitate elimination of pediatric HIV

3.4.1.1 The EMTCT Plan

The EMTCT Plan is the key policy that addresses elimination of pediatric HIV in Zambia. It is the key strategy and operational plan for an integrated and joint EMTCT and ART scale-up plan and provides 1) a comprehensive account of the progress and key challenges to date in relation to elimination of pediatric HIV and 2) a detailed situation and response analysis to support and sustain scale-up efforts. The plan aligns with the Global Plan in addressing all four prongs of a comprehensive approach to elimination of pediatric HIV, as do its clearly defined goal, aim, objectives, and national targets (summarized in Table 3).

3.4.1.2 Additional written documents that facilitate elimination of pediatric HIV

Zambia has many additional policies that facilitate elimination of pediatric HIV. In most cases, these policies do not explicitly mention "elimination of pediatric HIV," because this is a new concept that was not present when these policies were written. Therefore, many of these documents refer to "PMTCT." The National AIDS Strategic Framework 2011–2015, which provides strategic policy and technical orientation for the implementation of a multi-sectoral and decentralized HIV response in Zambia, prioritizes prevention efforts and includes virtual elimination of pediatric HIV as an impact-level result (NASF 2011). The 2005 National HIV/AIDS/STI/TB Policy, which provides a framework for addressing HIV and other epidemics and sets forth a vision, measures, and institutional and legal frameworks necessary for implementation, includes PMTCT as a critical component of the government's response to HIV. However where PMTCT is mentioned, the document focuses only on prong 3 and excludes prongs 1 and 2, which limits its scope in maximizing efforts toward elimination. Table 4 provides examples of other policies that facilitate efforts toward elimination of pediatric HIV by strengthening the health system.

3.4.1.3 The Constitution

The Constitution of Zambia contains various articles that are relevant in the context of elimination of pediatric HIV. It generally fosters a positive legal environment for elimination of pediatric HIV, but incorporating specific language around HIV could make some of the provisions stronger in protecting the rights of people living with HIV and thus be more conducive to elimination of pediatric HIV. Article 12 of the Constitution guarantees everyone in Zambia the right to life, and this can be interpreted to encompass all things that contribute to survival, including health (Constitution of Zambia). Currently, the Constitution does not specifically guarantee the right of access to

TABLE 3. GOAL, AIM, OBJECTIVES, AND NATIONAL TARGETS OF THE EMTCT PLAN

Goal	To move toward the elimination of new HIV infections among adults, adolescents, children, and their families and keep those already infected alive.
Aim	To reach men, women, adolescents, and exposed children in the provision of comprehensive and quality HIV prevention, treatment and care, and support services in order to reduce the number of new HIV infections among adults, adolescents, and children and reduce HIV/AIDS–related adult, adolescent, and child mortality.
Objectives and National Targets	• Reduce HIV incidence in adults, including that of women of childbearing age (15–49 years), by 50% by 2015. • Reduce the unmet need for family planning (any method) to zero for married women and to 14% for all other women by 2015. • Reduce the risk of mother-to-child transmission of HIV to less than 2% at 6 weeks and less than 5% at 18 months by 2015. • Reduce the number of new HIV infections among children by 90% by 2015.

TABLE 4. EXAMPLES OF POLICIES, LAWS, STRATEGIES, PLANS, AND GUIDELINES THAT FACILITATE EFFORTS TOWARD ELIMINATION OF PEDIATRIC HIV

The National Health Strategic Plan 2011–2015, which provides the strategic framework for ensuring the organization, coordination, and management of the health sector in Zambia, includes various areas such as communicable diseases (including HIV); maternal, neonatal, and child health; and health service delivery issues, such as human resources for health, essential medicines, infrastructure, and leadership and governance, as national health priorities. All of these areas are critical to elimination of pediatric HIV. PMTCT is noted as a key strategy in the plan.
The Sixth National Development Plan (SNDP), a medium-term planning instrument to focus the government of Zambia's policy and programming, includes HIV as a crosscutting health sector issue, and vertical HIV transmission is acknowledged as one of six key drivers of new HIV infections to be targeted by the plan. The SNDP aims to improve the health status for the people of Zambia and provide equitable access to quality health services by addressing many health delivery system weaknesses, such as access to services, human workforce shortages, and access to essential drugs.
The National Gender Plan 2000 and the National Action Plan on Gender-Based Violence 2008–2013 seek to address various gender issues, including the links between gender inequality and violence and women's risk of HIV infection, unplanned pregnancy, and access to HIV services. These policies address some of the key issues in the context of Zambia that affect elimination of pediatric HIV.
The Civil Society Framework 2011 guides civil society organizations (CSOs) toward more collaborative and systematic involvement in country-wide multi-sectoral efforts to address HIV, TB, and malaria. It provides a framework to strengthen partnerships and linkages among CSOs, equip CSOs to have high standards of accountability and effectiveness, create an environment empowering participation of communities, create an enabling legal and policy environment for CSO activities, and build the evidence of the work of CSOs.

health care, which would oblige the government to fulfill basic health care needs, including provision of ARVs and services for elimination. It is anticipated that the new Constitution that the country is working on will include these provisions.

Article 17 of the Constitution guarantees everyone in Zambia the right to privacy (Constitution of Zambia). However, in practice, there is forced or unapproved disclosure of personal information, including HIV status, and compulsory medical testing. This violates the confidentiality of people living with HIV and can be a major issue in the context of women fearing partner, family, or community disclosure in the context of PMTCT. These practices can lead to stigma and discrimination of persons living with HIV. Article 23 of the Constitution guarantees the right to freedom from discrimination, but does not include any specific language on discrimination and health status, which could protect people living with HIV from discrimination based on their HIV status (Constitution of Zambia).

The Constitution of Zambia is currently under revision. Several stakeholders noted that the revision of the Constitution serves as an opportunity to make some HIV-specific suggestions because most national-level legal/policy attention is currently focused on the Constitution.

3.4.2 Written policies, laws, strategies, plans, and guidelines that hinder elimination of pediatric HIV

There are several laws that are potential barriers to elimination of pediatric HIV because these laws reinforce gender inequality, which has been identified as a factor making women more vulnerable to HIV and serving as an obstacle to women's access to services in this context.

Article 23(4) of the Constitution excludes adoption, marriage, divorce, burial, and devolution of property on death or other matters of personal law from the freedom from discrimination rights granted in Article 23 of the Constitution (Magagula 2011, ZARAN 2011). Some of these exclusions have the potential to marginalize women in a context where they face tremendous gender inequality and discrimination that makes them more vulnerable to HIV and hinders their access to EMTCT services.

Customary law includes various practices that could potentially undermine efforts toward elimination of pediatric HIV. While the legal age for marriage for girls is 18 according to the written legal code, customary law allows marriage at any age parents permit (OECD 2012). This puts girls at greater risk of HIV and unwanted pregnancy. In accordance with customary law, a man is entitled to inherit the wife of his deceased brother and have sexual intercourse with the wife at his prerogative (Central Statists Office et al. 2010). Not only could these practices make women more vulnerable to HIV and unwanted pregnancy, but they could also hinder women's access to services. The Deceased Brother's Widow Marriage Act, a national law, facilitates this customary law by providing that the marriage of a widow to her deceased husband's brother should not be void.

3.4.3 Stakeholders' views on policies and laws that facilitate and hinder elimination of pediatric HIV

When asked to provide feedback on specific policies and laws that either facilitate or hinder efforts toward elimination of pediatric HIV, many stakeholders were not familiar with specific policies and laws that impact elimination of pediatric HIV, including the EMTCT Plan described in 3.4.1. Stakeholders who were familiar with the EMTCT Plan were those who had been involved in its development or review through the PMTCT TWG or other government forum. It is notable that multiple stakeholders from different backgrounds brought up customary laws as potential barriers to elimination efforts. In response to opinions on policies and laws that hinder or facilitate efforts toward elimination, stakeholders in most cases described different implementation practices that they feel either facilitate or hinder elimination efforts. This feedback will also be explored in this section.

3.4.3.1 Stakeholders' views on policies and laws that facilitate elimination of pediatric HIV

In response to opinions on policies and laws that are facilitators to elimination, stakeholders discussed various implementation practices, including provision of free HIV services, provider-initiated HIV testing, early infant diagnosis (EID) testing, task sharing with community workers, policies on ART integration in MCH, and policies on gender.

Stakeholders described that provision of free condoms, family planning services, HIV testing, and ARVs for PMTCT and HIV care and treatment promote access to these services and facilitate efforts toward elimination of pediatric HIV. Respondents also felt that provider-initiated testing facilitates elimination by encouraging women to get tested for HIV, find out their test result on the same day, and, if positive, get ARVS on their first contact so that they don't have to return to the health facility to initiate, which is when many women get lost to follow-up. Stakeholders discussed how the policy on EID testing ensures that children living with HIV are identified early to get them the necessary care and treatment. Some stakeholders feel that EID should be mandatory so that children diagnosed with HIV can be put on ART quickly. Finally, stakeholders discussed how allowing task shifting to lower cadres of health care workers in the community facilitates efforts toward elimination of pediatric HIV. For example, there is a policy awaiting approval that would allow community volunteers to provide Depo-Provera. Stakeholders feel that this would serve to increase community access to family planning services.

Two categories of policies that stakeholders identified as facilitating elimination include policies of ART integration in MCH and gender policies. They felt that ART integration in MCH services creates a more comfortable setting for women in contrast to having women living with HIV attend a designated HIV clinic, which could be stigmatizing. Multiple stakeholders alluded to gender policies and discussed how these policies facilitate elimination of pediatric HIV. The gender policy empowers women to make their own decisions. The Gender-Based Violence Act makes gender-based violence, which hinders women's access to HIV testing and care and treatment services, an offense.

3.4.3.2 Stakeholders' views on policies and laws that hinder elimination of pediatric HIV

In response to opinions on policies and laws that are barriers to elimination, stakeholders discussed customary law and also raised different implementation practices that they feel are barriers to elimination. Stakeholders noted that reluctance to acknowledge the crucial role that nurses play in HIV service delivery and the reluctance to formalize task sharing limits efforts to eliminate pediatric HIV. Policies related to elimination of pediatric HIV are written for doctors, even though the majority of health care providers who implement the policies are nurses. Only nurses trained in ART are allowed to prescribe full ARVs, and the accredited nurse training program trains only about 30 nurses a year. In addition, there are not enough clinicians to roll out ART.

Stakeholders noted that in some cases health facilities often enforce policies that are not included in national guidelines and have unintended consequences. For example, according to stakeholders, there have been cases where some facilities enforce the policy that if a woman does not bring certain supplies for a facility-based delivery, such as a sheet, gloves, and a blanket, she cannot deliver at the facility. Such policies could pose a barrier to women who cannot afford these items, and many women end up going to traditional health care providers for delivery and do not receive the medical interventions necessary to prevent vertical HIV transmission.

To increase male involvement in PMTCT, some health facilities are said to make it a policy that if a man does not accompany his wife to the clinic, the couple must pay a goat to the clinic. Stakeholders noted that there are no labor laws or workplace policies that facilitate men accompanying their partners to PMTCT. Likewise, there is no policy or mandate for employers to give their male employees time off to accompany their wives to antenatal care, and this in turn negatively affects efforts to promote couples counseling and HIV disclosure.

Stakeholders expressed a need to change policy guidelines on breastfeeding in the context of HIV. They described how many facilities follow an old policy that states that women living with HIV should not breastfeed. Yet this policy was changed in 2009 to encourage women living with HIV to breastfeed safely. In addition, stakeholders described various stigma issues in connection with breastfeeding that are not addressed through current policies, resulting in women trying to conceal their feeding habits from other women in the community. According to stakeholders, it is ultimately because of fear of stigma and discrimination that women overlook what they learn about safe infant feeding in the context of HIV in the clinic setting and can transmit the HIV infection to their children through feeding practices.

Multiple stakeholders shared the view that HIV testing of pregnant women should be mandatory rather than allowing pregnant women to opt out of HIV testing, which is the current policy. They felt that this is the only way to ensure that all pregnant women learn their HIV status to enter into PMTCT programming.

While stakeholders discussed gender policies as a facilitator for elimination efforts, they also expressed that issues around gender-based violence and gender-based access to services need to be better addressed through policy. They mentioned a policy where women had to obtain their partner's permission for HIV testing, which was detrimental to elimination efforts. Some health care workers still require this permission.

3.5 Implementation of Policies

Stakeholders raised a number of concerns related to implementation of policies on the ground. These include a lack of responsiveness of policies to the reality on the ground, challenges with dissemination and translation of policies into implementation, challenges with coordination of elimination efforts, and lack of clear responsibility for who oversees and is accountable for policy implementation.

3.5.1 Lack of responsiveness to the reality on the ground

Multiple stakeholders were in agreement that policies are often not responsive to the reality on the ground. They attributed this lack of responsiveness to various reasons, including funding, little consideration of implementation issues when policies are developed, and insufficient adaptation of international policies to the Zambia context.

In terms of funding, certain activities might be a high priority for implementation based on the needs on the ground, but because of insufficient resources the activity is not pursued, while another, perhaps less relevant, but funded, activity is pursued.

Stakeholders pointed out that the status of the health system is often not taken into account when policies are formulated. Policies may be written assuming the best-case scenario of a fully functioning health system, but in reality there are staff shortages, stock-outs, and infrastructure issues that are not always factored into

policies. According to stakeholders, issues such as human resources and infrastructure, and their role in implementation of policies, are rarely considered when policies are developed. A facility could have one nurse who is responsible for PMTCT, but he or she must also tend to other patients. Infrastructure challenges, such as lack of space, prevent nurses from being able to adhere to confidentiality standards in policies.

Many stakeholders described that sometimes policies are prescribed by WHO without proper adaptation to the Zambia context. A lot of policies work well in urban environments but not in rural environments, where there are increased staff shortages and much more strained systems. It is challenging to try to work with a one-size-fits-all policy when there are such diverse environments on the ground. According to stakeholders, it is the lack of community participation in the policy-making process that results in a problem understanding how policies will work out on the ground.

3.5.2 Challenges with translation and dissemination of policies

The majority of stakeholders were in agreement that there are challenges associated with dissemination of policies and translation of policies into implementation. One major issue raised is that national elimination efforts do not include clear, detailed planning on how to achieve elimination and bring policies to fruition on the ground. Non-health-specific policies that may contribute to these challenges, such as the gender policy, do not make it to the ground at all and are not understood by the public.

Sometimes the government comes up with policies and doesn't share them. While organizations and partners might know about policies, health care workers do not know about them or understand the correct details of policies. People who do the actual work are often excluded from the meetings. Only people who attend meetings get the information, and the people who do the actual work get excluded.

It takes a long time for information to reach facilities because of bureaucracy, resulting in late implementation at facilities. In addition, policies are not well understood at facilities because of lack of training, staff capacity to understand technical language, equipment that is inadequate or outdated with respect to current policies, and materials that are not translated into local languages. Although the central government wants policies to be disseminated through off-site trainings and on-the-job trainings at the district level, these trainings often fail to materialize at the district level due to lack of resources. There are often no resources to relay the new information to sites, and there is no supervision because vehicles are not available for staff to go to facilities; this results in a lack of follow-up and supportive supervision at facilities.

3.5.3 Challenges with coordination of elimination efforts

Discussions with stakeholders around coordination of elimination efforts revealed that many feel that there is confusion surrounding leadership and coordination of elimination efforts. This, in turn, weakens implementation because it is not clear who is responsible for implementation. According to multiple stakeholders, it is technical partners and outside organizations driving the elimination agenda, as opposed to leadership from within the MOH.

Multiple stakeholders pointed to NAC as the responsible party for a multi-sector response to elimination. According to stakeholders, NAC is tasked with national and subnational coordination and the overall oversight to ensure that the response is moving in a coordinated manner. One of NAC's chief mandates is to ensure a policy environment that facilitates the work of stakeholders. Yet it is the MOH that supervises the health sector. According to multiple stakeholders, while the MOH is strong technically, it does not have the capacity, or the financial or human resources, to see that policy is translated into implementation on the ground.

Multiple stakeholders described challenges with coordination at the district level, where there is tremendous variation in allocation of resources and standards for services among districts. Although guidance comes from the MOH at the central level, implementation happens at a decentralized level. According to stakeholders, there is need for stronger coordination mechanisms and capacity at the district and provincial levels.

3.5.4 Accountability challenges

Multiple stakeholders raised concerns regarding accountability and expressed the necessity to redefine accountability. Stakeholders described the need to shift to a situation where accountability is measured in terms of concrete outputs and results.

3.5.5 Implementation challenges

The document review and stakeholder interviews revealed numerous challenges on the ground that hinder efforts toward elimination of pediatric HIV, including gender issues, cultural practices, lack of male involvement, exclusion of traditional healers from elimination efforts, lack of community engagement in elimination efforts, access to health facilities, lack of available drugs, lack of human resources, lack of a human-rights-based approach, infrastructure challenges, lack of data collection, and lack of resources for implementation.

3.5.5.1 Gender issues

Stakeholders discussed how gender issues hinder implementation efforts on the ground. Intimate partner violence and fear of this violence, especially in the context of HIV counseling, testing, and disclosure, often prevent women from accessing or continuing to access services. As a result of violence or fear of violence, women are afraid to share information about HIV with their partners. Many stakeholders felt that existing approaches to elimination do not take into account or address these issues adequately. Although gender-based violence is an offense under the Gender-Based Violence Act, there is a lot of work that needs to be done to implement this act.

The document review supported these findings. Gender-based violence has been identified as one of the primary barriers to women accessing HIV counseling and testing and obtaining information on their HIV status if tested in an antenatal clinic in Zambia (MOH 2010). Women's reluctance to disclose their HIV status for fear of violence prevents them from continuing to access PMTCT services (NAC UNGASS 2010).

In addition, Zambia has high levels of sexual violence, which can put women at increased risk of HIV. Survey results show that 15% of all women aged 15–49 (15% in urban and 14% in rural areas) have ever been sexually abused by being forced to have sex against their will (Zambia Sexual Behavior Study 2009). The vast majority of perpetrators of violence are partners who live with women (67.5%) and boyfriends (25%) (MOH 2010).

3.5.5.2 Cultural practices

Stakeholders discussed harmful cultural norms and how these practices, such as sexual cleansing, widow inheritance, and polygamy, put women at greater risk of HIV. While many traditional healers encourage these practices, many have developed practices to reduce the risk facilitated by customary laws. Some traditional practices, such as "sexual cleansing" of widows, a ritual that involves the brother or close relative of a dead man having sex with his brother's or close relative's surviving widow, may facilitate the spread of HIV. Data support the prevalence of sexual cleansing; among women who have ever been widowed, one-third of widows in both urban and rural areas underwent a sexual cleansing ritual (Zambia Sexual Behavior Study 2009).

In addition, the National AIDS Strategic Framework 2011–2015 discusses various cultural factors related to gender inequalities that drive the HIV epidemic in women. Gender norms in Zambia promote male

dominance and female subservience that limit women's ability to negotiate safer sex. Women are taught not to refuse to have sex with their husbands regardless of whether their husbands are having extramarital affairs. Socialization processes include traditional and cultural rituals where women are taught to accept that men can have multiple sexual partners and can be violent in marriage (MOH 2010). There is also social pressure for women to demonstrate their fertility, contributing to low use of condoms.

3.5.5.3 Low male involvement

Low male involvement in PMTCT is a challenge in Zambia. The health system seems to be geared toward women, and men tend to only go to hospitals when they are seriously ill. Yet men are the chief decision makers when it comes to health and reproductive decisions. Stakeholders discussed how there are no laws in the workplace to give men time off to attend antenatal visits with partners, and this is one factor that perpetuates low male involvement.

3.5.5.4 Traditional healers not enlisted in elimination efforts

According to many stakeholders, a large percentage of the population (with estimates ranging from 60%–80%) receives care from traditional healers, including women during pregnancy, delivery, and the postnatal period. In one study conducted in Zambia, 88% of respondents utilized traditional healers (2005). Yet stakeholders felt that traditional healers are not engaged in elimination efforts. There is no policy or referral system between traditional healers and modern medicine. Multiple stakeholders discussed the view that traditional healers have been virtually excluded from civil society and government efforts. Furthermore, there is little research and training for traditional healers with respect to H IV. One stakeholder described that only 3,000 out of 25,000 registered traditional healers have been trained in HIV, which is only a fraction of the number of traditional healers who practice. Stakeholders felt that some of the practices in which traditional healers engage are detrimental to the spread of HIV and there is a need for traditional healers to be educated on the modes of HIV transmission.

3.5.5.5 Insufficient community engagement in elimination efforts

Although community involvement is seen as crucial to elimination efforts, a majority of stakeholders stated that there are not enough efforts to disseminate information to the community and engage the community in elimination efforts. As a result, there is insufficient ownership of elimination efforts by communities when there is a need to build community-based support groups and structures to deal with the most challenging issues, such as adherence. Community sensitization is overlooked. Yet community perceptions are critical to elimination efforts and if not addressed can hinder a program. There is no professional body that oversees community volunteers, so it is not clear who is responsible for their organization, mobilization, and regulation. Despite the important work that community health workers do, such as contributing to the numbers of people tested for HIV, there are no incentives for community health workers.

3.5.5.6 Access to services in rural areas

Stakeholders discussed challenges with access to facilities and adequate services in rural areas as barriers to implementing programs to achieve elimination of pediatric HIV. Marginalized populations tend to live in peripheral areas of the country, where services are scarce and of poor quality. In these areas it is especially difficult for women to access health services, especially ART. The distance to clinics prevents pregnant women from attending antenatal care and therefore accessing PMTCT services (NAC UNGASS 2010). When women are able to access health facilities, they often encounter long waits, shortages of skilled personnel, and insufficient lab equipment (such as CD4-count machines and polymerase chain reaction (PCR testing) that make the process of accessing basic PMTCT and especially ART a challenge (NAC UNGASS Biennial Report 2010). There are high rates of loss to follow-up of mother-baby pairs. Fewer sites offer access to ART (456) as compared to PMTCT (1,200) (MOH 2012). Stakeholders reported that it is difficult to refer women to ART sites because sites are far away, especially in rural areas. Services need to be brought closer to the communities so that women can access services.

3.5.5.7 Availability of essential drugs

Stakeholders described challenges with drugs and supplies as a barrier to elimination. They described either too many drugs that expire on the shelf or too few drugs available. The availability of essential drugs at health facilities in Zambia is erratic (MOH 2010). A review of the availability of essential drugs from 2006–2008 revealed that the percentage of months that drugs were in stock in health centers was 69% and in hospitals 77% (Note: In Zambia this is measured by monitoring the proportion of months during a given time period that tracer drugs were in stock) (HMIS

2008). Health centers in some rural areas had drugs in stock only 53% (HMIS 2008). The reasons for Zambia's current drug supply status include inadequate pharmaceutical managerial capacities at various levels, pilfering, poor prescription habits of health care staff, and varying disease patterns. In addition, the current Drugs Logistics Management System is regarded as weak in providing consumption data from facilities and districts that outsource to inform drug procurements and distribution patterns (HMIS 2008).

3.5.5.8 Human resources

The EMTCT Plan acknowledges that adequate, qualified, well-remunerated human resources are one of the building blocks of a strong health system and critical to achieving elimination of pediatric HIV (MOH 2012).

Zambia faces a critical shortage of health workers caused by a number of factors, the most prominent of which include unattractive conditions of service, poor working conditions, weak human resource management systems, and insufficient education and training systems (MOH 2010, UNDP 2011). Stakeholders described human resource shortages as a challenge to implementation of activities for elimination of pediatric HIV. Staff shortages and unequal workload among staff, in which some staff are disproportionately overloaded, have a detrimental impact on access to and quality of care and patient demand. They result in insufficient health care workers to scale up essential services, such as HIV services and maternal and child health services, and contribute to overall inefficiency in health care delivery.

Evidence of challenges with human resources also emerged from the document review. In December 2009 the MOH measured staffing levels in Zambia at 39%, leaving a 61% gap (MOH 2010). These levels are insufficient to meet the demands of the population, leading to high staff workloads, especially in rural areas (the average patient ratio in 2008 was 18.6 patients per staff member and 36.4 patients per staff member in rural areas) (UNDP 2011). Many health facilities in Zambia are understaffed, especially in rural areas (UNDP 2011). Zambia's staff-to-patient ratio in 2009 was 0.93 per 1,000 compared to the WHO

recommendation of 2.5 per 1,000 (MOH 2010). As of December 2009, Zambia was short by 19,606 health care workers (UNDP 2011).

Multiple stakeholders discussed limitations regarding task sharing that hinder the roll-out of services for elimination of pediatric HIV. Provision of ART is allocated to the role of doctors, who are few in number and not available at all facilities. Task sharing to allow nurses to prescribe ART is a matter of ongoing debate. Advocates have pushed for nurses who are trained in PMTCT to be able to prescribe ART, but the Nurses Council argues that nurses cannot prescribe. Currently, only nurses who have been trained through a specific program, which trains only 30 nurses a year, are technically allowed to prescribe ART.

3.5.5.9 Limited human-rights-based approach

Several stakeholders described the perception that despite articulation of a human-rights-based approach as an overarching principle in relevant policies, this approach has not been adequately incorporated into implementation of elimination efforts in Zambia. This in turn has limited implementation. Stakeholders described that there is a focus on medical interventions with respect to elimination of pediatric HIV efforts as opposed to both medical and social interventions.

Stakeholders brought up several examples illustrating how they felt human rights were overlooked. At many health care facilities HIV testing for pregnant women is made mandatory by health care workers, despite the fact that this is not consistent with policy. Some clinics paint the part of the clinic providing HIV services pink and use pink folders for clients living with HIV, which subverts confidentiality and stigmatizes these clients. Other examples include informing patients in the presence of others that they are living with HIV and using red ink on a child health card for clients living with HIV.

3.5.5.10 Data collection

Stakeholders noted challenges with data collection related to indicators for elimination of pediatric HIV in the country. Monitoring of progress toward elimination is based on quarterly reports and updates from the PMTCT program manager. Quarterly reports include a performance assessment of the province conducted by the national level, and then the province conducts an assessment of the district and the district conducts an assessment of individual sites. Quantitative and qualitative data are assessed. Some stakeholders felt that the evaluation process is superficial and does not truly measure performance. The follow-up and documentation of HIV is minimal, especially if mothers present outside the ART clinic. The mechanisms to monitor implementation focus on how many services are dispensed. There needs to be defined catchment areas and examination of uptake of services in those catchment areas. Once policies are released, there is little feedback from the ground. Monitoring and evaluation of behaviors are not consistent. There are tremendous weaknesses in tracking infant ARV prophylaxis, with many infants lost to follow-up.

3.5.5.11 Resources for implementation

Stakeholders discussed resource limitations that hinder implementation. According to stakeholders, resources for elimination are targeted toward the technical teams and not the community where implementation takes place. These findings are supported in the document review. A review of the MOH domestic budget indicates that the administrative level of the MOH receives the greatest proportion of the budget (from 20% of the budget in 2004 to 48% of the budget in 2009), in comparison to structures on the ground responsible for service delivery (allocations to other levels such as tertiary and general hospitals have been constant between 8%–10%, and district health services increased from 19% in 2004 to 24% in 2007) (UNDP 2011). In addition, it must be noted that documents report that there is little confidence among donors in the financial management and accountability mechanisms of the MOH, a problem exacerbated by the 2009 scandal where more than 10 billion Zambia kwacha was allegedly misappropriated by the MOH staff, leading to some key cooperating partners withholding funding (UNDP 2011). For the next five years, in addition to regular audits, value for money audits will be conducted at regular intervals in randomly selected institutions. NASF will promote evidence-based funding for implementing partners.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

Zambia has in place many structures to pursue elimination of pediatric HIV, including the Cabinet Committee of Ministers on Health and HIV and AIDS, NAC, the PMTCT Technical Working Group, the Directorate of Public Health and Research (DPHR), the Directorate of Clinical Care and Diagnostic Services (DCCS), and the newly established Ministry of Community Development, Mother and Child Health. However, these structures are not optimally coordinated to achieve elimination of pediatric HIV.

Decision making around elimination policies is highly influenced by the PMTCT Technical Working Group, donors (in the context of limited resources, data, and evidence), and international guidance from WHO, and while these are critical to the response, local stakeholders, including civil society, the community, traditional healers, and religious leaders, are, for the most part, not included in policy formulation and adoption.

Zambia has a strong foundation of written policies and laws to pursue elimination of pediatric HIV. The EMTCT Plan is the key policy focused on elimination of pediatric HIV, and it is closely aligned to the "Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive." Major HIV policies in Zambia, such as the National AIDS Strategic Framework 2011–2015 and the 2005 National HIV/AIDS/STI/TB Policy, prioritize prevention of mother-to-child transmission of HIV. However, certain aspects of customary law could potentially undermine efforts toward elimination of pediatric HIV.

On the ground, optimal health care delivery is challenged by both the fractured health care delivery system and social issues. The health care delivery system is characterized by lack of resources, a shortage of health care workers, and lack of availability of essential drugs and supplies. Social issues, such as gender inequality and gender-based violence, cultural practices, and low male involvement, put communities at higher risk of HIV and hinder families' access and adherence to services related to elimination of pediatric HIV. Challenges persist in ensuring that policies are responsive to this reality on the ground. Furthermore, policies are not always effectively disseminated and translated to the level of implementation due to the absence of clear planning to bring policies to fruition. Policies are not well understood on the ground.

As Zambia transitions to implementation of Option B+, it will be even more critical to bolster efforts to strengthen the health care system and mitigate the impact of social issues, all of which compromise coverage, access, and retention in care.

Six key policy- and systems-related issues that have potential to challenge efforts toward elimination of pediatric HIV emerged from this analysis:

- Different conceptions and lack of knowledge and understanding of virtual elimination of pediatric HIV among key decision makers and implementers have weakened collective support for efforts to eliminate pediatric HIV.
- Weak coordination and oversight for national efforts toward elimination of pediatric HIV and no clear plans to bring policies to fruition on the ground undermine the effectiveness of policies toward elimination of pediatric HIV.
- The lack of cohesive representation and involvement of local stakeholders, including civil society, the community, traditional healers, and religious leaders, in the policy formulation process and implementation roll-out strategies limit the responsiveness of policies to the reality on the ground and the feasibility of implementation of policies.
- The lack of policies in place to address some of the main barriers prevents the involvement of men in efforts to eliminate pediatric HIV.
- The lack of policies to mitigate the potential negative impact of customary laws hinders elimination of pediatric HIV efforts.
- Insufficient human resources limit the health system's capacity to meet the needs of the elimination of pediatric HIV agenda, especially in the context of the forthcoming shift to Option B+.

Despite these issues, and in light of the strong existing policy structure, a tremendous opportunity exists to achieve elimination of pediatric HIV in Zambia.

4.2 Recommendations

This section outlines key actionable recommendations toward elimination of pediatric HIV in Zambia by 2015, as informed by the foregoing analysis. While these recommendations are targeted toward the elimination of pediatric HIV, many can be expected

to have positive impacts on the broader HIV response and health system. To effect actions on the recommendations listed below, collaboration may be needed to review and update existing laws and policies.

1. Enlist the government of Zambia to communicate a consistent and comprehensive message on elimination of pediatric HIV.
    a. Emphasize that the scope of elimination of pediatric HIV goes beyond prong 3 (delivery of PMTCT services) and includes preventing HIV among women of childbearing age; reducing unmet family planning needs; and providing ongoing HIV care, support, and treatment.
    b. Launch a national campaign targeting elimination of pediatric HIV. "Champions of Elimination" could be identified as part of this effort.
    c. Package elimination of pediatric HIV messages for different audiences. Messaging should be tailored so that elimination of pediatric HIV clearly resonates with different stakeholders.
    d. Harness existing platforms and synergize with existing health initiatives to promote understanding of how elimination can contribute to the goals of these health initiatives.
2. Ensure the inclusion of local stakeholders, including civil society, the community, people living with HIV and AIDS (PLWHA), traditional healers, and religious leaders, in the policymaking process and roll-out implementation strategies to make policies more responsive to the reality on the ground.
    a. Include a representative from these stakeholder groups in the policy formulation process (within the PMTCT TWG and at the district level).
    b. Clarify the role for the Ministry of Community Development, Mother and Child Health
    c. (MCDMCH) to mobilize these groups and provide a mechanism for organized representation of these stakeholders.
3. Strengthen the coordination of stakeholders.
    a. Strengthen the HIV and AIDS coordination mandate of the NAC to cover elimination of pediatric HIV.
    b. Consider merging the PMTCT and ART TWG to enhance coordination of efforts, especially in light of the forthcoming shift to Option B+.
    c. Enlist an independent body to annually review the progress toward elimination goals.
4. Enhance the country's human resources for health capacity for elimination of pediatric HIV, especially in light of the forthcoming shift to option B+.
    a. Implement initiatives to recruit, retain, and retrain health care workers to meet human resources needs.
    b. Revise policies around task sharing for provision of ART to include nurses as prescribers of ART.
    c. Amend the national training program to train all nurses to prescribe ART.
    d. Identify and describe roles of other health care workers in elimination of pediatric HIV efforts.
5. Restructure and improve the functioning of the body (NAC) that provides coordination and oversight for the national efforts toward elimination of pediatric HIV.
    a. Provide more effective leadership and coordination, specifically for the elimination of pediatric HIV.
    b. Increase the ability to exert influence within the MOH and other national-level stakeholders.
    c. Include better representation from civil society and the community to ensure the responsiveness of elimination efforts to the reality on the ground.
6. Bring stakeholders together and conduct advocacy with lawmakers to influence the following aspects of policy relevant to the elimination agenda.
    a. Strengthen implementation of existing policies to address gender inequality, including gender-based violence, in the context of elimination of pediatric HIV.
    b. Establish a policy/law to mitigate the potential negative impact of customary laws on elimination efforts.
        i. Bring key stakeholders together for a workshop to better understand the potential negative impacts of specific customary laws on elimination efforts.
        ii. Develop a policy brief that will highlight the impact of specific customary laws on elimination of pediatric HIV.
        iii. Conduct advocacy with lawmakers to enact legislation to address the harmful impact of aspects of customary law on elimination efforts.

APPENDIX 1: DOCUMENTS REVIEWED

HIV Policies and Guidelines

The Joint EMTCT and ART National Strategy & Operational Plan 2011–2015: Eliminating Mother-to-Child Transmission of HIV and Scaling Up HIV Care, Treatment and Support for Children, Adolescents and Adults

National AIDS Strategic Framework 2011–2015

2010 National Protocol Guidelines – Integrated Prevention of Mother-to-Child Transmission of HIV

2005 National HIV/AIDS/STI/TB Policy

Health Sector Policies

National Health Strategic Plan 2011–2015

Sixth National Development Plan 2011–2015

National Health Care Standards for Zambia

Zambia MOH Planning Document No. 2011/1

1995 Health Services Act National

Human Resources and Health Strategic Plan 2006–2010

National Health Care Standards for Zambia 2011

Non-Health Sector Policies

National Action Plan on Gender-Based Violence 2008–2013

Civil Society Framework for Responding to HIV, TB, Malaria in Zambia 2011

National Gender Plan 2000

Legislature

Constitution of Zambia / Article 12: Right to Life (Antidiscrimination and Protective Law)

Constitution of Zambia / Article 15: Freedom from Inhumane Treatment

Constitution of Zambia / Article 17: Right to Privacy

Constitution of Zambia / Article 20: Freedom of Expression

Constitution of Zambia / Article 23: Freedom from Discrimination

Constitution Bill 2010 / General Comments and Directive Principles

The Penal Code: Sections 155–158: Unnatural Offenses

The Penal Code: Section 183: Negligent Act Likely to Spread Infection

Public Health Act: Section 9: Notification of Infectious Diseases

Public Health Act: Section 62: Publication of Advertisements of Cures

Pharmaceutical Act / Section 3: Application

Deceased Brother's Widow's Marriage Act / Section 3: Marriage with a Deceased Brother's Widow Not to Be Void as a Civil Contract

Juveniles Act / Section 47

National HIV/AIDS/STI/TB Council Act / Section 4(2) / Functions of the Council

National HIV/AIDS/STI/TB Council Act / Section 5 / Council Membership

National HIV/AIDS/STI/TB Council Act / Section 13(2)(h) / Functions of Secretariat

Partnership Framework between Government of Zambia, Ministry of Finance and National Planning and MOH and the USG

Reports

Zambia UNGASS 2012 Country Report: Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access

United National Development Program, Zambia Human Development Report 2011

The Global Fund Country Audit of Global Fund Grants to Zambia, October 2010

Suffering in Silence, The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia 2002

Zambia Sexual Behavior Survey 2010

The Budget Process in Zambia, Economics Association Zambia 2012

Zambia Demographic and Health Survey 2007

Globalex Law Research Report Zambia 2011

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ELIZABETH GLASER
PEDIATRIC AIDS
FOUNDATION

WASHINGTON, D.C.
1140 Connecticut Avenue, N.W. (Suite 200)
Washington, D.C. 20036
Phone: 202-296-9165
Fax: 202-296-9185
info@pedaids.org

LOS ANGELES, CA
16130 Ventura Blvd., #250
Encino, CA 91436
Phone: 310-314-1459
Fax: 310-314-1469
info@pedaids.org

GENEVA
WCC Center
150, Route de Ferney
1 Route des Morillons
PO Box 2100
Bureaux Rhône 168 et 169
CH-1211 Geneva 2, Switzerland
Phone: +41 22 791 6088/457

CAMEROON
Cameroon Baptist Convention Health Board
P.O. Box 1 Bamenda
North West Province
Cameroon

CÔTE D'IVOIRE
2 Plateaux les Vallons, Rue J 50
08 BP 2678 Abidjan 08
Côte d'Ivoire
Phone: 225-22-41-45-05
Fax: 225-22-41-45-46

DEMOCRATIC REPUBLIC OF CONGO
Avenue Colonel Mondjiba n°63
Kinshasa Gombe
Concession COTEX - Bâtiment n°10 B1
République Démocratique du Congo
Phone: +243 82 382 42 48

INDIA
EGPAF India Consortium Office
c/o SAATHII-Hyderabad
H # 1-4-880/2/36/1
New Bakaram, Gandhi Nagar
Hyderabad-500 080
India
Phone: 040-27654688

KENYA
Ariel House
Westlands Avenue
Off David Osieli Road
P.O. Box 13612 – 00800
Nairobi, Kenya
Phone: +254 20 44.54.081/2/3
Fax: +254 20 44.54.084

LESOTHO
Sechaba House, 1st Floor
4 Bowker Road
P.O. Box 0166
Maseru West 105
Lesotho
Phone: +(266) 22311662
Fax: +(266) 22312729

MALAWI
NEDBANK House, City Center (physical)
P.O Box 2543 (postal)
Lilongwe, Malawi
Phone: +265-1772-052
Fax: +265-1772-050

MOZAMBIQUE
Av. Kwame Nkrumah, n°417
C.P. 1392 (Post Office Box)
Maputo, Mozambique
Phone: +258-21488904
Fax: +258-21488909

RWANDA
5342 KN60 Street
Chadel Building
Kigali, Rwanda
Phone: +250 (0)252570583
Fax: +250 (0)252570584

SWAZILAND
MTN Office Park
Karl Grant Street
Mbabane
Phone: +268-2404-8081
Fax: +268-2409-0026

TANZANIA
P.O. Box 1628
Plot # 8 & 10, off Haile Selassie Road
Oysterbay
Dar es Salaam
Tanzania
Phone: +255-22-260-1692

UGANDA
EGPAF/Kampala:
Plot 18A, Kyadondo Road
P.O. Box 21127
Kampala, Uganda
Phone: +256 312264380

STAR-SW office (Mbarara):
Plot 13, McAllister Road
P.O. Box 881
Mbarara, Uganda
Phone: +256 485420160

ZAMBIA
P.O. Box 39111
Reliance House
Thabo Mbeki Road
Lusaka, Zambia
Phone: 260 211 256 481

ZIMBABWE
107 King George Road
Harare, Zimbabwe
Phone: +263-(0)4-302144