



THE REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

ZAMBIA NATIONAL HIV & AIDS PREVENTION ROADMAP 2025-2030



GETTING ON TRACK TO END
AIDS AS A PUBLIC HEALTH
THREAT BY 2030



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Foreword

The Zambia National HIV Prevention Roadmap 2025–2030 represents a pivotal step in the nation's commitment to ending AIDS, as a public health threat by 2030.

This roadmap serves as a strategic guide for addressing the evolving challenges in HIV prevention, building on past successes while adapting to new realities. Developed through a consultative process with key stakeholders, the roadmap aligns with international frameworks, including the Global AIDS Strategy 2021-2026 and the Zambia's National AIDS Strategic Framework (NASF) 2023-2027.

The roadmap emphasises targeted and evidence-based interventions for key and vulnerable populations, adolescents and young women, recognising their heightened vulnerability. It integrates biomedical, behavioural and structural interventions, ensuring that no one is left behind.

I urge all stakeholders, including government, civil society organisations, development partners and communities, to work collaboratively to implement this roadmap.

Our collective action is vital to achieving Zambia's ambitious HIV prevention goals and creating a future free of AIDS.



Hon Dr Elijah Julaki Muehima MP.
Minister of Health
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This milestone achievement would not have been possible without the dedication of the HIV prevention technical working groups (TWGs), whose members generously shared their expertise, data and insights.

A special acknowledgement goes to the Ministry of Health (MoH), NAC, the World Health Organization (WHO) and other key partners, whose commitment and dedication were instrumental in the successful development of the National HIV Prevention Roadmap 2025-2030.

We sincerely thank all stakeholders for their trust, collaboration and the critical data that shaped the Roadmap priorities.



Dr Kebby Musokotwane

Director General

NATIONAL HIV/AIDS/STI/TB COUNCIL

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Abbreviations and Acronyms

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired immunodeficiency syndrome
ART	Anti-Retroviral Therapy
CDC	Centre for Disease Control and Prevention
CHCTWG	National Condom and HIV Prevention Technical Working Group
COVID	Corona Virus Disease
CSOs	Civil Society Organisations
DACAs	District AIDS Coordination Advisors
DHIS	District Health Information System
DRMS	Domestic Resource Mobilisation Strategy
DSDM	Differentiated Service Delivery Model
FSW	Female Sex Workers
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
KVPs	Key and Vulnerable Populations
MoH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National HIV/AIDS/STI/TB Council
NGOs	Non-Governmental Organisations
NASF	National HIV/AIDS Strategic Framework
OST	Opioid Substitution Therapy
PACA	Provincial AIDS Coordination Advisor
PEP	Post-Exposure Prophylaxis
PEPFAR	United States Government President Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV

PrEP	Pre-exposure Prophylaxis
PSI	Population Service International
PSP	Peer Service Providers
PWID	People who Inject Drugs
SBCC	Social Behavioural Change Communication
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TWG	Technical Working Group
UNAIDS	Jointed United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
U=U	Undetectable = Untransmittable
WHO	World Health Organization
ZAMPHIA	Zambia Population-Based HIV/AIDS Impact Assessment
ZDHS	Zambia Demographic and Health Survey
ZNPHI	Zambia National Public Health Institute

Executive Summary

The Zambia National HIV Prevention Roadmap 2025–2030 outlines the country’s strategic approach to reducing new HIV infections and achieving epidemic control by 2030. This roadmap builds on Zambia’s commitment to the 2021 UN Political Declaration on HIV/AIDS and the Global AIDS Strategy 2021-2026, aligning national goals with international targets. Developed through an inclusive consultative process, the roadmap addresses critical gaps in HIV prevention, focusing on key populations (KPs), adolescents, young women and other vulnerable groups.

The roadmap’s primary goal is to reduce new HIV infections from the current 28,000 to fewer than 15,000 annually by 2030. It sets ambitious targets, including reaching 95 per cent of key and vulnerable populations with combination prevention services, ensuring 95 per cent coverage for PrEP (pre-exposure prophylaxis), achieving 95 per cent male circumcision among eligible men and reducing stigma and discrimination to less than 10 per cent. The roadmap emphasises the integration of HIV prevention services with broader health systems, including sexual and reproductive health, mental health and social services, to create a more holistic approach to prevention.

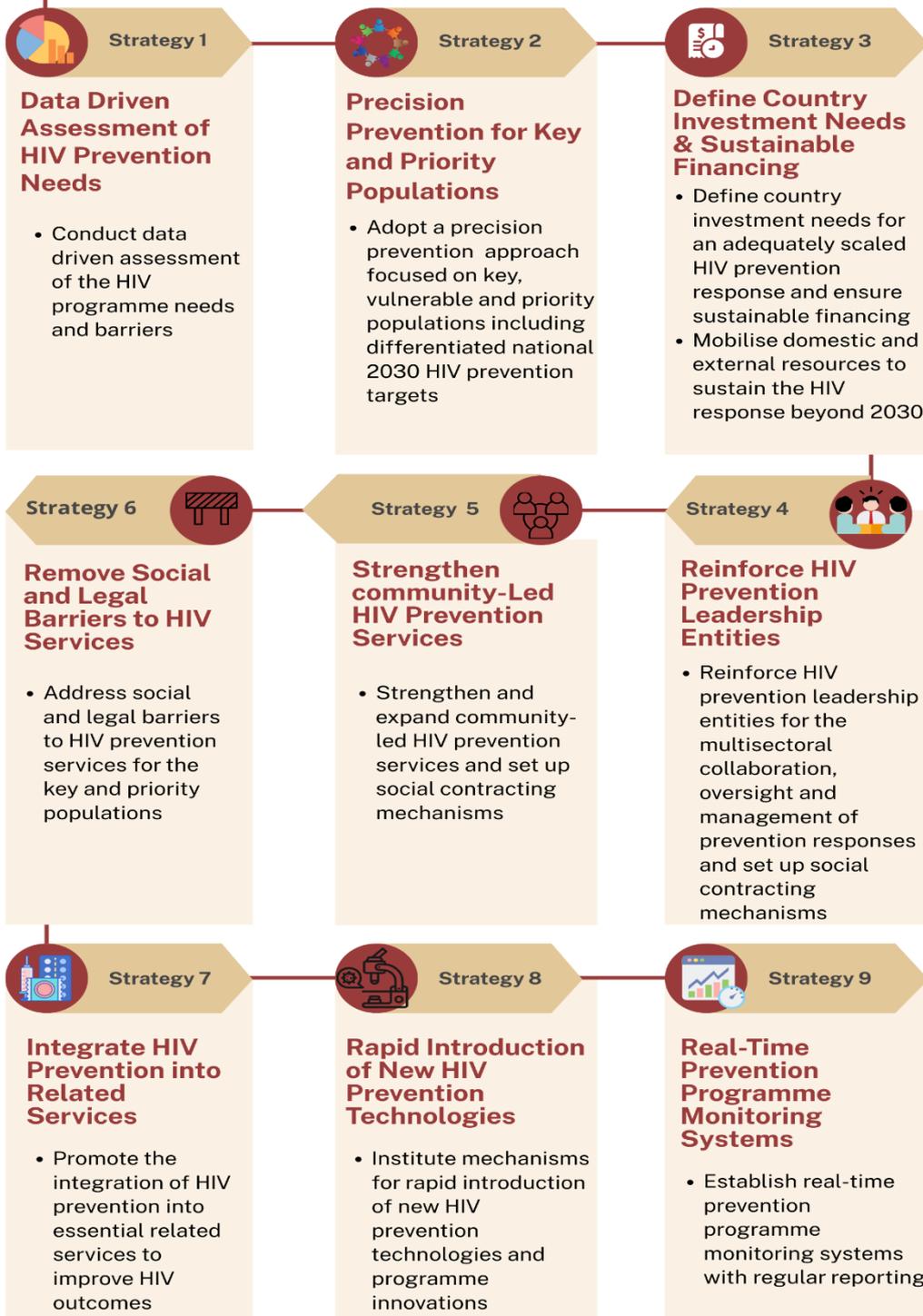
The Zambia National HIV Prevention Roadmap 2025–2030 is a call to action for all stakeholders to work together in ending AIDS as a public health threat by 2030. With clear objectives, robust strategies and a commitment to monitoring and accountability, this roadmap provides a comprehensive framework for addressing Zambia’s HIV epidemic and ensuring that no one is left behind.

By 2030, Zambia aims to significantly reduce new HIV infections and create a healthier and more equitable future for all its citizens.

The Roadmap’s strategic directions also adopt the 10-Point Action Plan outlined in the Global HIV Prevention Coalition’s (GPC) HIV Prevention Roadmap 2025. The Zambian roadmap emphasises strengthening of leadership and political commitment to drive coordinated HIV responses at national and subnational levels. It further promotes the use of data to focus interventions where they are most needed, optimises combination prevention strategies and ensures sustained financing, through domestic resource mobilisation and international support.

The Roadmap, among its strategic directions, also places emphasis on strengthening community-led services through social contracting mechanisms, removing legal and policy barriers and promoting gender equality to address the needs of key and vulnerable population groups. Scaling up new and innovative health technologies, real-time monitoring and fostering multisectoral collaboration are critical components of the roadmap that are focused on enhancing the effectiveness and sustainability of HIV prevention efforts. By aligning these strategic directions with global standards and local needs, the roadmap positions Zambia to make significant progress in reducing HIV infections and achieving epidemic control by 2030.

Strategic Directions for HIV Prevention Roadmap 2025-2030



Ending AIDS as a Public Health Threat by 2030

HIV Targets and Commitments for 2030

- 95% of people at risk of HIV use combination prevention
- 95%-95%-95% HIV testing, treatment & viral suppression among adults and children
- 95% of women access SRH services
- 95% coverage of services for eliminating vertical transmission
- 90% of PLHIV receive preventive treatment for TB
- 90% of PLHIV and people at risk are linked to other integrated health services
- Less than 10% of PLHIV and KPs experience stigma and discrimination
- Less than 10% of PLHIV, women and girls and KPs experience gender based inequalities and GBV
- Access to HIV Prevention health services by key and priority population increased

Strategy 10

Strengthen accountability of all stakeholders

- Strengthen accountability of all stakeholders for progress in HIV prevention

CHAPTER I: Introduction and Background

1.1. Introduction

Zambia continues to face a significant HIV burden, with an adult (15+ years) prevalence of 11 per cent. Women are disproportionately affected, with a prevalence of 13.9 per cent compared to eight per cent among men. The annual HIV incidence among adults aged 15 years and above is 0.31 per cent, translating to about 28,000 new cases per year. Women experience a higher incidence (0.56 per cent) compared to men (0.06 per cent)¹. Despite decades of progress in combating the epidemic, challenges remain in reaching all populations equitably with effective prevention, treatment and care services. The HIV prevention landscape has evolved with new tools, technologies and approaches, emphasising the need for a more focused, population-centred HIV prevention strategy. This strategy is, therefore, essential for Zambia to meet its national and international commitments to ending AIDS as a public health threat by 2030.

1.2. About the HIV Prevention Roadmap

The Zambia HIV Prevention Roadmap 2025-2030 is a key national strategy designed to strengthen and coordinate HIV prevention efforts as the country advances towards ending AIDS as a public health threat by 2030. Building on Zambia's commitments made at the 2021 United Nations High-Level Meeting on HIV/AIDS, the roadmap supports the realisation of Sustainable Development Goal 3- Good Health and Wellbeing by focusing on scaling up high-impact, evidence-based prevention interventions. The roadmap outlines the strategic priorities and programmatic actions necessary to meet the UNAIDS 2025 HIV prevention targets (See Figure 1) and ultimately end HIV as a public health threat by 2030.

Developed through a consultative process led by the National AIDS Council, with support from government ministries, civil society and international partners (See Annex 6), the roadmap reflects a collective commitment and serves as a blueprint for action. It addresses existing gaps, capitalises on opportunities and promotes collaboration to strengthen HIV prevention efforts at both national and sub-national levels. The roadmap is a call to action for all sectors in Zambia to unite in the fight against HIV, ensuring that no one is left behind as the country moves closer to a future free of AIDS.

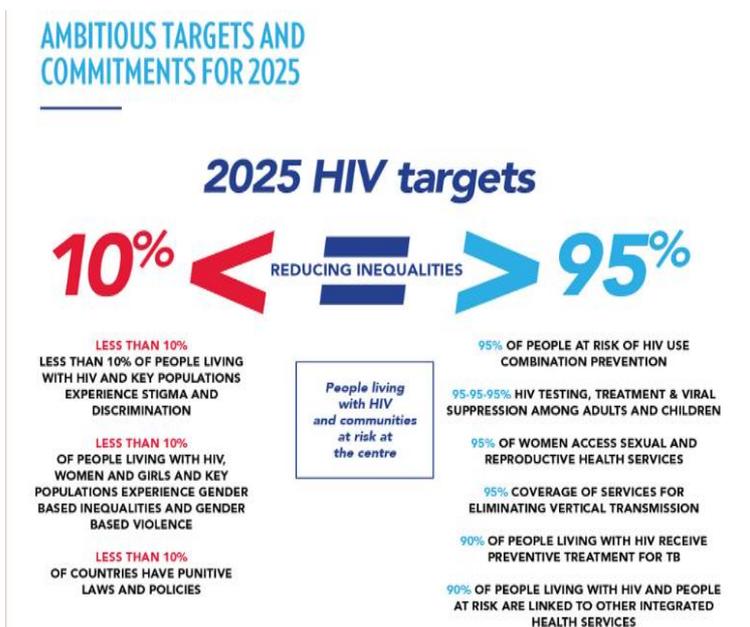


Figure 1: Global HIV 2025 targets (Source: Global AIDS Strategy 2021 – 2026)

¹ The Zambia Population-based HIV/AIDS Impact Assessment 2021 (ZAMPHIA 2021)

1.3. Alignment with international and local frameworks

The Zambia HIV Prevention Roadmap is aligned with key international frameworks, including the 2021 Political Declaration on HIV/AIDS (See Annex 1), the Global AIDS Strategy 2021-2026 and the Global HIV Prevention Coalition’s HIV Prevention Roadmap 2025. These frameworks emphasise a structured approach to HIV prevention through the 10-Point Action Plan (See Figure 2) and the five Pillars of Prevention. The roadmap adapts these global strategies to Zambia’s specific context, ensuring that the 10-Point Action Plan and the five Pillars of Prevention address the country’s unique challenges and opportunities. By tailoring these frameworks to local needs, Zambia aims to meet ambitious HIV prevention targets while aligning with international goals.

These frameworks outline essential actions, including leadership engagement, the expansion of combination prevention, addressing structural barriers and securing sustainable funding.

The Zambian roadmap aligns these global strategies with the country’s national priorities and challenges, ensuring they are relevant to local conditions and can be effectively implemented at both national and subnational levels.

The roadmap is grounded in the NASF 2023-2027, which outlines the overarching goals and priorities for Zambia’s HIV response. It emphasises a people-centred precision prevention approach, targeting the right people, in the right locations, with the right interventions, at the right time and in the right way. This ensures that Zambia’s roadmap not only aligns with international strategies but is also specifically tailored to address the unique needs of its population, maximising impact and effectiveness.

1.4. Rationale for HIV Prevention Roadmap

The 2025-2030 HIV Prevention Roadmap presents a comprehensive, evidence-based and people-centred strategy to accelerate progress in reducing new HIV infections, particularly among key and vulnerable populations. It offers a unified strategic framework, integrating clear indicators and ambitious targets aligned with the NASF 2023-2027, the 10-Point Action Plan and the five Pillars of HIV Prevention. By addressing structural inequalities and guiding

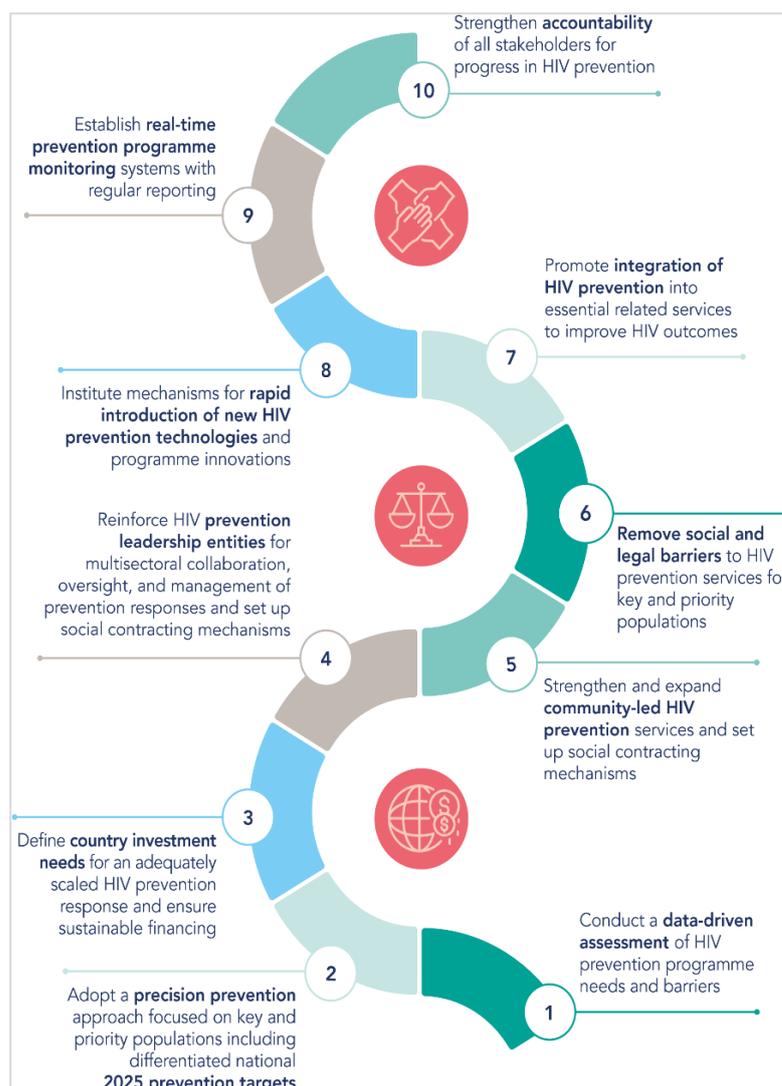


Figure 2: The HIV Prevention 2025 Road Map: 10 Point Action Plan (Source: UNAIDS - HIV Prevention Road Map)

stakeholders across sectors, the roadmap ensures coordinated, context-specific interventions that advance Zambia's efforts to meet both national and global targets, including the goal of ending AIDS as a public health threat by 2030.

1.5. Reflections from implementation of previous roadmap

Lessons from recent years offer key insights into effective HIV prevention, stakeholder engagement and addressing systemic challenges.

Community-Based Interventions: Involving local communities and traditional leaders has been highly effective, boosting HIV awareness and service uptake, particularly in underserved rural areas.

Service Integration: Integrating HIV services with other health programmes, such as maternal and child health, improved accessibility and coverage.

Addressing Stigma: Initiatives to reduce stigma, like the “Open Up” campaign, significantly increased HIV testing and counselling uptake. Reducing stigma remains critical for access to care.

Key and Vulnerable Populations: Tailored strategies for high-risk groups, such as outreach for sex workers, proved effective in increasing condom use and HIV testing.

Sustainable Funding: Financial instability, such as the 2016 Global Fund shortfall, highlighted the importance of securing consistent and sustainable funding for HIV programmes.

Monitoring and Evaluation: Strong data-driven practices have led to improved outcomes, ensuring programmes remain responsive and effective.

Recommendations

- * Strengthen community engagement to improve service uptake, especially in rural and underserved areas.
- * Enhance integration of HIV with broader health and other socio-economic services to improve access and comprehensive care.
- * Continue efforts to combat stigma and discrimination, particularly for key and vulnerable populations.
- * Expand targeted interventions for high-risk groups to address challenges like inconsistent condom use.
- * Advocate for sustainable funding mechanisms to ensure long-term programme stability.
- * Invest in robust monitoring and evaluation to maintain an adaptive and effective HIV response.

1.6. The Process of Developing the HIV Prevention Roadmap

The development of the roadmap followed a structured participatory approach, to ensure it was comprehensive, inclusive and effective in addressing the country's HIV epidemic. The process began with a thorough situation analysis, including desk reviews, stakeholder mapping and consultations with key stakeholders, to assess the current HIV landscape. There is also a monitoring and evaluation framework for tracking progress and ensuring the roadmap's continued relevance and effectiveness (See Figure 3).

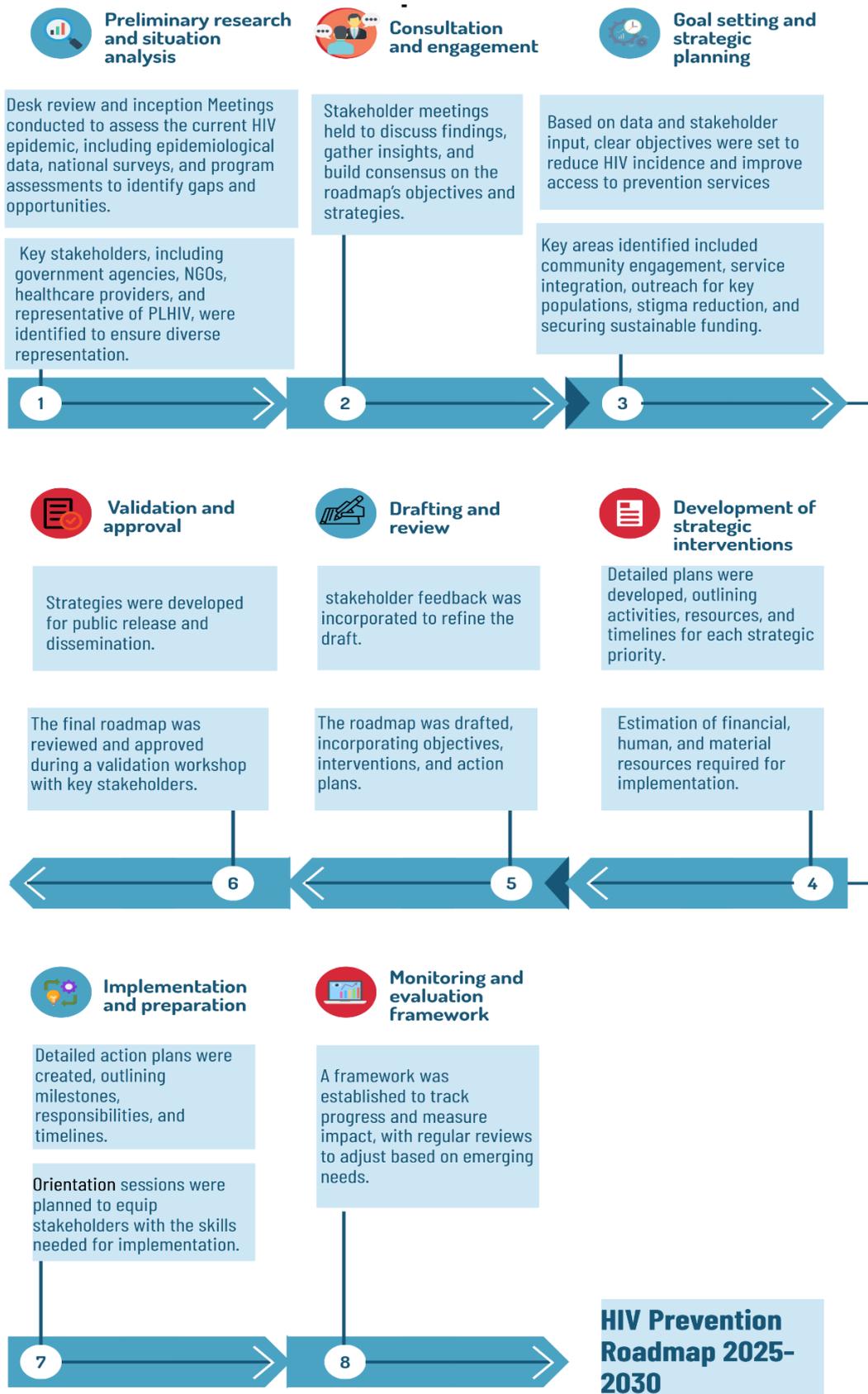


Figure 3: Development process for the HIV prevention roadmap

CHAPTER II: Situation Analysis

According to the ZAMPHIA 2021 report², the annual HIV incidence among adults aged 15 years and above was 0.3 per cent, translating to approximately 28,000 new infections each year. HIV prevalence among adults stood at 11 per cent, equating to about 1,108,000 people living with HIV.

2.1 HIV Burden by Age and Sex

The ZAMPHIA 2021 report further highlights a higher HIV burden among women compared to men. Among adults aged 15-49 years, the annual HIV incidence was 0.3 per cent overall, with women experiencing a significantly higher rate of 0.6 per cent compared to 0.1 per cent among men. For young people aged 15-24 years, the incidence was 0.4 per cent, driven by a higher rate of 0.8 per cent among young women, while no new infections were reported among young men. Similarly, among adults aged 25-34 years, HIV incidence was 0.4 per cent among women, with no new infections observed in men.

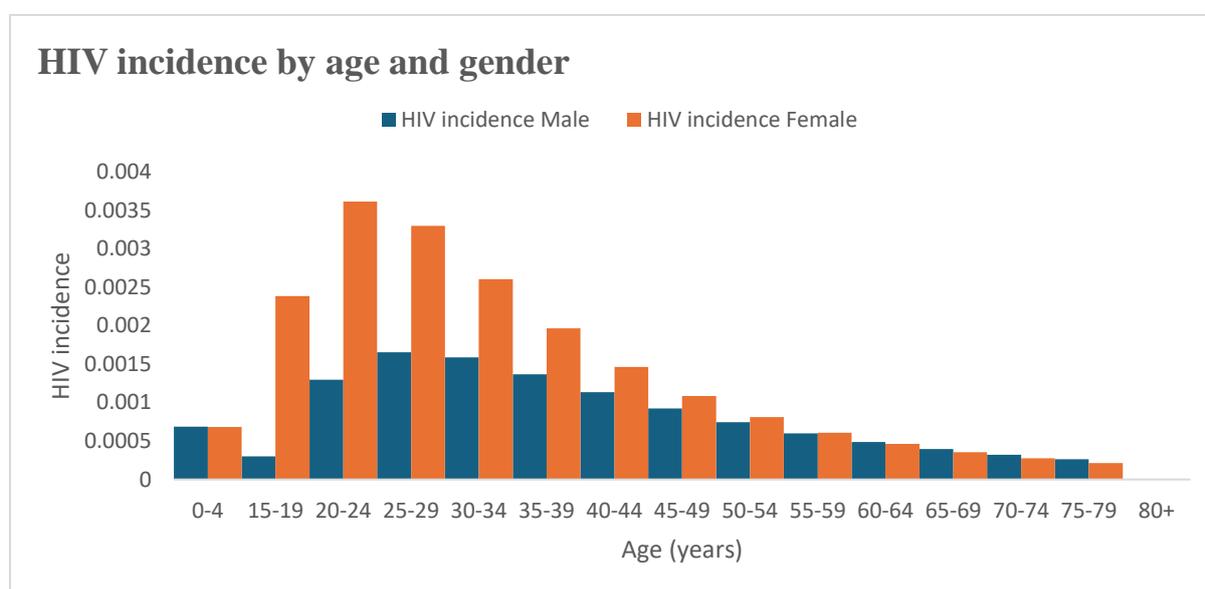


Figure 4: HIV Incidence by Age and Gender

Regarding prevalence, women were also disproportionately affected, with a prevalence of 13.9 per cent compared to eight per cent among men. The prevalence ranged from 1.9 per cent among women aged 15-19 to 30.5 per cent among women aged 45-49, while for men, it ranged from 1.8 per cent in the 20-24 age group to 28.8 per cent among those aged 50-54. Across all five-year age groups, women consistently had a higher prevalence than men, particularly between the ages of 20-39 years.

² Ministry of Health, Zambia. Zambia Population-based HIV Impact Assessment (ZAMPHIA) 2021: Final Report. Lusaka, Ministry of Health, DECEMBER 2023 ACCESS THIS REPORT ONLINE <https://nada.zamstats.gov.zm>

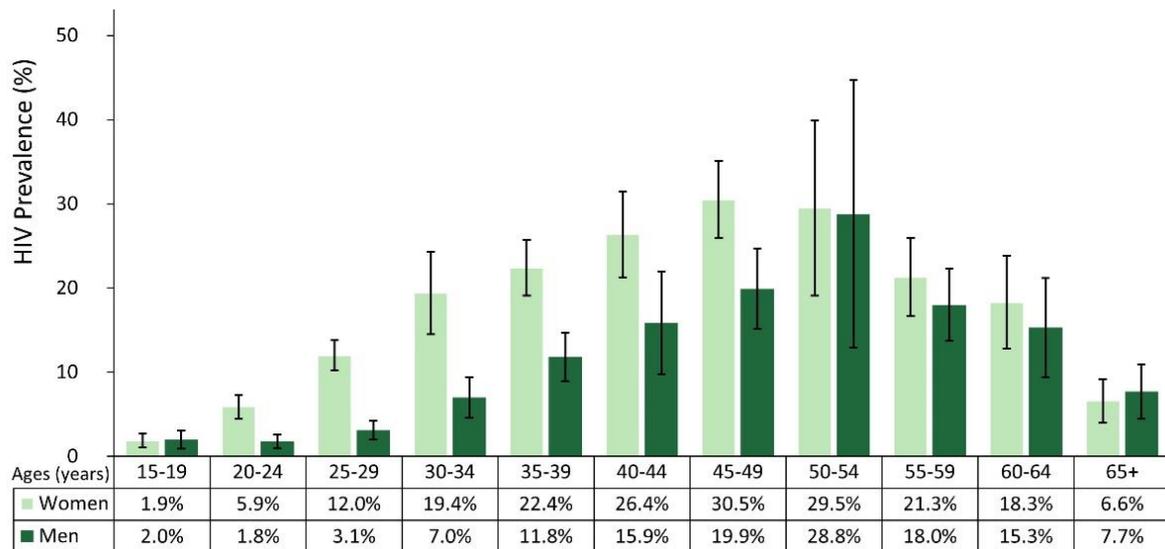


Figure 5: HIV Prevalence by Age and Sex (Source: ZAMPHIA 2021 Report)

Encouragingly, viral load suppression (VLS) rates were high, with 86.2 per cent of adults living with HIV achieving VLS, including 86.6 per cent of adult women and 85.5 per cent of adult men.

2.2 HIV Prevalence by Geography

2.2.1 HIV Burden by Province

The 2021 ZAMPHIA report also shows that HIV prevalence varies significantly across Zambia's provinces, ranging from 5.8 per cent in Northern province to 14.4 per cent in Lusaka. Provincial disparities also exist on VLS, with rates ranging from 77.5 per cent in North-Western province to 92.6 per cent in Southern province. These figures highlight the ongoing progress and challenges in Zambia's fight against HIV.

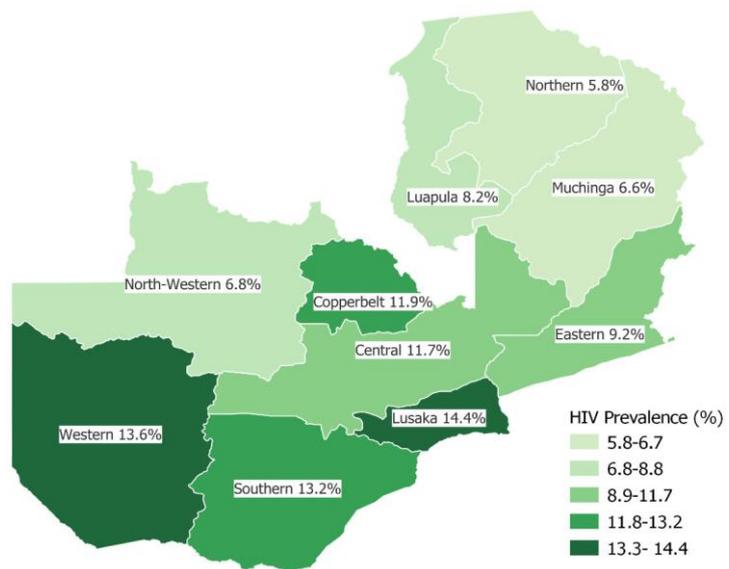


Figure 6: HIV Prevalence by Province (Source: ZAMPHIA 2021 report 2022)

2.2.2 HIV Burden by District

The HIV disease burden in Zambia is highly concentrated in ten districts, which together account for nearly 50 per cent of all new infections. Lusaka leads with 5,016 new HIV cases, followed by Ndola (972) and Kitwe (923), highlighting the significant impact of urban centres with high population densities. Other high-burden districts include Chongwe, Kabwe and Chibombo, all contributing significantly to the national total³. This concentration underscores the need for targeted interventions and resource prioritisation in these areas, where local factors

³ Spectrum Estimates (With Feb 2024 Spectrum File)

such as socioeconomic conditions and healthcare access drive the epidemic. Addressing the specific dynamics in these districts is critical to reducing new infections and achieving broader HIV control goals in Zambia.

Additionally, UNAIDS estimates indicate that about 32 per cent of Zambia's districts contribute 75 per cent of all HIV infections, further indicating a geographic concentration of the epidemic. This highlights the need for targeted interventions in these high-burden areas. Prioritising these districts for enhanced HIV prevention, testing and treatment efforts can help address the disproportionate impact.

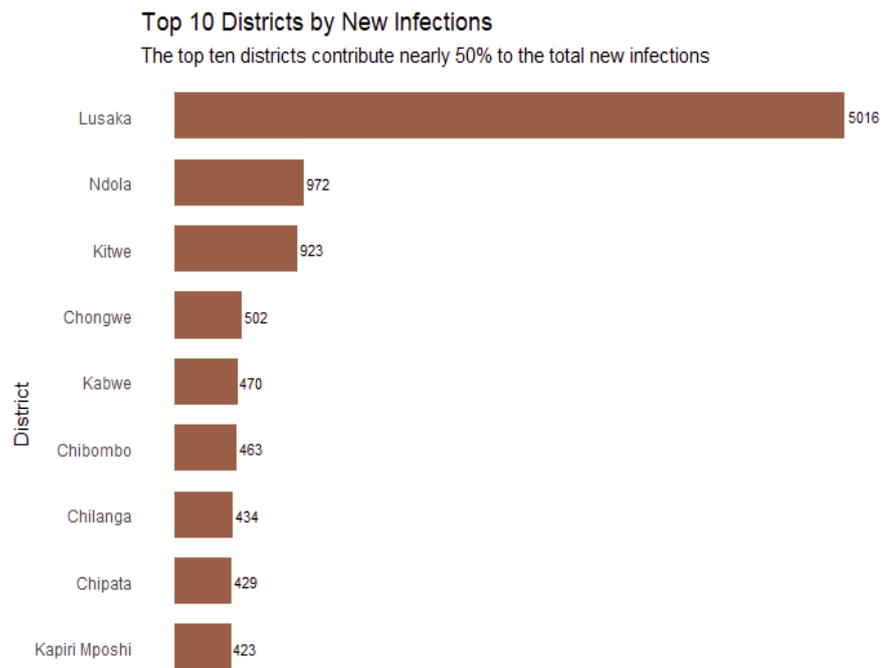


Figure 7: Top 10 Districts by New Infections

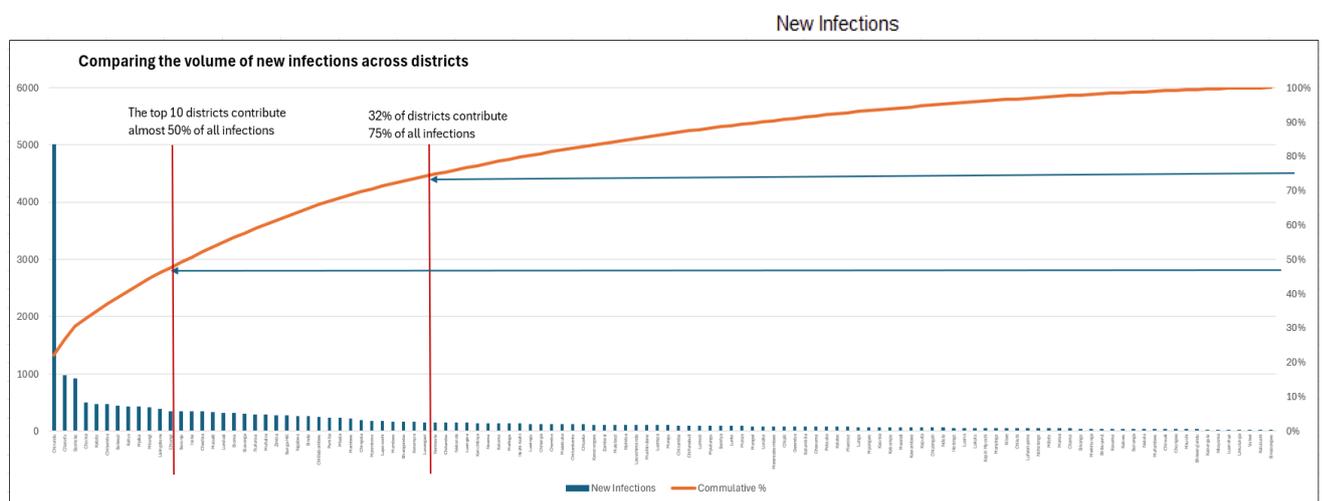


Figure 8: New infections by District (Source: UNAIDS epidemiological estimates 2023)

Additionally, the 2024 Spectrum estimates indicate that thirteen districts collectively account for 50 per cent of the total estimated number of PLHIV in Zambia. Lusaka remains a significant hotspot, representing 20 per cent of the total PLHIV burden, followed closely by Ndola and Kitwe.

2.3 HIV burden by Population

2.3.1 HIV burden among Adolescents and Young People

Adolescent girls and young women (AGYW) face a significantly higher HIV burden compared to adolescent boys and young men (ABYM). AGYW account for 29 per cent of all new HIV infections (despite only representing 10.62% of the total population), with an estimated 6,800 new infections annually, compared to nine per cent for ABYM with 2,000 new infections. The HIV incidence rate is also much higher among AGYW at 3.3 per cent, while ABYM have a rate of 0.9 per cent. AGYW have a five per cent HIV prevalence, compared to 1.4 per cent for ABYM.

ART coverage is relatively high for both groups, with AGYW at 85.4 per cent and ABYM at 82.2 per cent, but still lower compared to the general female population (94.7 per cent) and general male population (90 per cent). This comparison underscores the greater vulnerability of AGYW to HIV compared to their male peers and highlights their higher contribution to the overall HIV burden in the population.

Table 1: HIV Burden by Population

Population	Population in % of total	Population Sizes	Estimated annual new HIV infections	Contribution to all new HIV infections	Estimated HIV incidence rates	Estimated HIV prevalence	ART Coverage
ABYM	10.62%	2,123,000	2,000	9%	0.9	1.4%	82.2%
AGYW	10.75%	2,150,000	6,800	29%	3.3	5%	85.4%
All Males	49.3%	10,182,000	8,200	35%	0.8	4.9%	90%
All Females	50.7%	10,437,000	14,800	64%	1.5	8%	94.7%
Children (0-14)	42%	8,650,000	2,200	9%	0.3	0.6%	71.1%

Sources: (1) Spectrum Estimates (With In-country Feb 2024 Spectrum File) (2) ZAMSTATS, and (3) John Hopkins University IBBS (2022)

2.3.2 HIV Among Key Populations

Key populations (KPs) in Zambia, including people who inject drugs (PWID), sex workers (SWs), men who have sex with men (MSM), transgender individuals and inmates, bear a disproportionately high HIV burden. Despite their small numbers, these groups have significantly higher HIV prevalence and contribute substantially to new infections. Stigma, discrimination and limited access to healthcare exacerbate their vulnerability. Cross-transmission of HIV to the general population is common due to sexual interactions between KPs and the wider community, driven by factors such as stigma, discrimination and criminalisation, which force KPs to engage in both homosexual and heterosexual relationships.

Targeted interventions are urgently needed to reduce HIV transmission and improve health outcomes for these populations.^{4,5,6,7}

People Who Inject Drugs (PWID): Although representing only 0.07 per cent of the population, PWID contribute significantly to new HIV infections. The high HIV prevalence in this group reflects the heightened risks from unsafe injecting practices and limited access to harm reduction services. Tailored interventions, such as needle exchange programmes and opioid substitution therapy, are crucial for reducing HIV transmission in this group.

Sex Workers (SWs): Sex workers contribute nine per cent of new HIV infections despite making up just 0.23 per cent of the population, with an HIV prevalence of 40 per cent. Stigma, discrimination and inconsistent condom use increase their vulnerability.

Men Who Have Sex with Men (MSM): MSM account for three per cent of new HIV infections, with an HIV prevalence of 23 per cent, despite making up only 0.20 per cent of the population. Stigma and limited access to culturally appropriate healthcare exacerbate their risk.

Transgender Individuals: Although comprehensive data for transgender individuals is limited, estimates suggest an HIV prevalence of 23 per cent. Transgender people face significant barriers to healthcare due to stigma, discrimination and violence, all of which heighten their risk of HIV.

Inmates: Inmates are highly vulnerable to HIV, with an estimated prevalence of 14 per cent. Overcrowded conditions, poor access to health services and a lack of preventive measures, such as condom distribution in prisons, increase the risk of transmission.

Table 2: HIV Burden among Key Populations

Population	Population in % of total	Population sizes	Estimated annual new HIV infections	Contribution to all new HIV infections	Estimated HIV incidence rates	Estimated HIV prevalence	ART Coverage
MSM	0.20%	41,364	583	3%	Not Avail	23%	Not Avail
SWs	0.23%	48,420	2,168	9%	Not Avail	40%	Not Avail
PWID	0.07%	13,463	5,099	22%	Not Avail	21%	Not Avail
TGs	Not Avail	8,975	Not Avail	Not Avail	Not Avail	23%	Not Avail
Inmates	Not Avail	22,400	Not Avail	Not Avail	Not Avail	14%	Not Avail

Source: [1] Spectrum Estimates (With In-country Feb 2024 Spectrum File) (2) ZAMSTATS (3) John Hopkins University IBBS (2022) (4) Correctional Services program data)

2.3.3 HIV Among Vulnerable Populations

HIV Among People with Disabilities: People with disabilities in Zambia, who make up 10.9 per cent of the adult population and 4.4 per cent of children, face a heightened risk of HIV due

⁴ Spectrum Estimates (With In-country Feb 2024 Spectrum File)

⁵ ZAMSTATS

⁶ John Hopkins University IBBS (2022)

⁷ Correctional Services program data)

to barriers such as discrimination and limited access to healthcare services⁸. Research done in Chongwe revealed that about 35.7 per cent of HIV/AIDS vulnerable households include a person with a disability and individuals with disabilities are less likely to seek care than their non-disabled counterparts⁹. This underscores the urgent need for inclusive healthcare services that address the unique challenges faced by this demographic. Addressing these barriers through improved healthcare provider training, enhanced accessibility and efforts to reduce stigma and discrimination is essential for reducing the HIV burden among people with disabilities and ensuring equitable health outcomes in Zambia.

Men 25 years and above: The ZAMPHIA 2021 report highlights a significant HIV burden among men aged 25 years and above in Zambia, with prevalence increasing from 3.1 per cent among those aged 25-29 and peaking at 28.8 per cent for those aged 50-54. Viral load suppression (VLS) rates demonstrate strong treatment adherence within this group, ranging from 72.6 per cent among men aged 25-34 to 96.3 per cent for those aged 65 and older. Despite these high VLS rates, gaps remain in HIV diagnosis as the proportion of men aware of their HIV status remains below the UNAIDS 95 per cent target. Improving testing coverage, while maintaining high ART adherence, is essential for reducing the HIV burden in this population.

Refugees and Migrants: Refugees, migrants, migrant workers, fishermen and long-distance truck drivers in Zambia face a significant HIV burden due to their mobility, occupation-related risks and social isolation. These populations often experience limited access to consistent healthcare services, including HIV prevention, testing and treatment, due to factors such as frequent movement, language barriers, cultural differences and financial constraints. Long-distance truck drivers and fishermen are particularly vulnerable, as their work involves long periods away from home and heightened exposure to high-risk behaviours, such as transactional sex, especially in fishing communities and at truck stops. For truck drivers, cross-border movement further increases their exposure to different HIV hotspots. Addressing the HIV burden in these populations requires tailored interventions, such as mobile health services, community-based outreach and partnerships with employers in the transport and fishing industries. These targeted approaches are essential to ensuring culturally appropriate and accessible HIV services for these at-risk groups, helping to reduce their heightened vulnerability to HIV.

HIV Burden among Children and Pregnant and Breastfeeding Women: The HIV burden among children and pregnant and breastfeeding women in Zambia remains a critical issue, largely driven by the risk of mother-to-child transmission (MTCT) during pregnancy, labour, delivery, or breastfeeding. Over 90 per cent of new HIV infections in infants are attributed to MTCT. Without intervention, the transmission risk ranges from 15 per cent to 45 per cent. Zambia's Prevention of Mother-to-Child Transmission (PMTCT) programme is vital in addressing this challenge, aiming to ensure that 95 per cent of pregnant women living with HIV are aware of their status, on antiretroviral therapy (ART) and achieving viral load suppression (VLS). However, gaps remain. Approximately 70 per cent of HIV-exposed infants (HEIs) receive early infant diagnosis (EID) at two months, leaving many untested. An estimated 4,387 new infant HIV infections were projected for financial year 2024 underscoring the need to enhance maternal re-testing and follow-up throughout pregnancy and breastfeeding.

Pregnant women have high ART coverage, with over 93 per cent of those diagnosed receiving treatment during pregnancy, significantly reducing transmission risks. In 2022, 94 per cent of pregnant women attended their first antenatal care (ANC) visit and 84 per cent of them knew

⁸ Human Rights Watch: "We Are Also Dying of AIDS" Barriers to HIV Services and Treatment for Persons with Disabilities in Zambia. 2014

⁹ Kathryn Fleming: Vulnerability For Households with Persons with Disabilities and HIV/AIDS in Chongwe, Zambia

their HIV status. Of those aware of their status, eight per cent tested positive for HIV and 93 per cent were initiated on ART (HMIS report, 2022). Women in Zambia have a higher HIV incidence rate of 0.56 per cent compared to men, who have a rate of 0.06 per cent. Additionally, data from the 2022 Spectrum Model estimates that 66,364 children under 15 years are living with HIV, representing a prevalence of 0.79 per cent. There are approximately 4,385 new annual HIV infections among children, accounting for 0.05 per cent of the total population. These figures highlight the ongoing need for targeted interventions to reduce the HIV burden among children and pregnant and breastfeeding women, particularly in rural areas.

2.4 HIV/AIDS related mortality

AIDS-related deaths continue to significantly impact the population, with an estimated 17,000 deaths attributed to AIDS across all age groups. Of these, 15,000 deaths occurred among adults aged 15 years and above, with women accounting for 8,700 of these deaths and men for 5,800. Additionally, AIDS claimed the lives of approximately 2,300 children aged 0 to 14 years. The epidemic has also resulted in a substantial number of orphans, with an estimated 390,000 children aged 0 to 17 years having lost one or both parents to AIDS. These figures highlight the ongoing toll of the epidemic on Zambia's population, particularly among women and children¹⁰

2.5 Epidemic Response – HIV Prevention Interventions and Challenges

The national response to HIV in Zambia continues to be robust, with various biomedical, behavioural and structural HIV prevention interventions in place. The epidemic response has led to 88.7 per cent of adults (15+ years) living with HIV being aware of their status, with slightly higher awareness among women (89.9 per cent) compared to men (86.6 per cent). Among those who are aware of their status, 98 per cent are on antiretroviral therapy (ART), showing a strong uptake of treatment (98 per cent for women and 98.1 per cent for men). Furthermore, 96.3 per cent of those on ART have achieved viral load suppression, with 95.7 per cent of women and 97.3 per cent of men reaching this critical milestone, which is key to preventing further transmission and improving health outcomes.

2.5.1 Biomedical interventions

Zambia's biomedical interventions in the fight against HIV and AIDS include HIV testing, condom use, pre-exposure prophylaxis (PrEP) use, voluntary medical male circumcision (VMMC), elimination of mother-to-child transmission (eMTCT), ART and treatment of sexually transmitted infections (STIs).

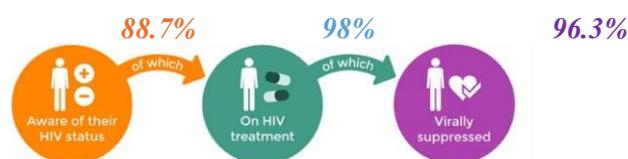


Figure 9: Status on the 95-95-95 (Source: ZAMPHIA)

2.5.1.1 HIV Testing

Zambia's HIV testing strategy includes various approaches aimed at improving HIV case finding. Key methods include provider-initiated testing and counselling in routine healthcare, index testing to trace contacts of HIV-positive individuals and community-based testing through outreach services. HIV self-testing is also available, offering a private option to reduce stigma as well as ensuring convenience for those in the world of work. Additionally, testing is

¹⁰ 2023 UNAIDS Estimates

integrated with other services like immunisation programmes to enhance coverage and rapid diagnostic tests facilitate quick results. Public awareness campaigns encourage individuals to know their status, while training community health workers has expanded testing beyond traditional healthcare settings.

The country has made significant progress in HIV testing, with 88.7 per cent of adult PLHIV aware of their status. The ZAMPHIA 2021 report shows that 79.8 per cent of adults aged 15 years and older have been tested for HIV at least once, with higher testing rates among women (85.5 per cent) compared to men (73.9 per cent). However, testing rates are lower among young men aged 15-24, with only 17.3 per cent of those aged 15-19 and 43.5 per cent of those aged 20-24 tested within the past year. Additionally, 12.6 per cent of HIV-positive individuals aged 15-49 and 27.2 per cent of those aged 15-24 were unaware of their HIV status, highlighting the need for more targeted testing efforts, particularly for young men and adolescents.

Challenges:

- * Low utilisation of HIV testing services among young men aged 15-24.
- * Gaps in testing coverage for underserved populations.
- * Constant stock-outs of HIV testing kits, which limit testing availability.
- * High proportion of HIV-positive individuals unaware of their status, particularly among younger age groups.
- * Age of consent remains 18 years for HIV testing and sexual reproductive health (SRH) services, which is a limiting factor for comprehensive HIV services.

2.5.1.2 Condom programming

Condom distribution remains a vital intervention in Zambia's HIV prevention efforts with approaches including distributions in health facilities, workplaces, recreational and lodging facilities. The 2023 Zambia HIV Prevention Scorecard shows that, in 2023, approximately 17 million condoms were distributed or sold, but this figure only met 16 per cent of the estimated national condom distribution need. This shortfall indicates a substantial gap in ensuring consistent access to condoms, especially for sexually active individuals in high-risk groups. For people aged 15 to 49 years, the number of condoms distributed or sold per couple-year is 54 for men and 35 for women, reflecting a gender disparity in distribution efforts.

Condom use among KPs also remains below optimal levels. Among MSM, 58 per cent reported using a condom during their last anal sex encounter. While this represents some progress, it still falls short of full protection for this vulnerable group. The situation is more concerning among sex workers, with only 25 per cent reporting condom use during their last paid sexual encounter. This low rate of condom use among sex workers highlights the need for increased condom distribution and education efforts targeted at this group.

Comprehensive HIV prevention interventions, which include condom distribution, are not reaching all at-risk individuals. The 2023 Scorecard shows that only five per cent of MSM received at least two HIV prevention interventions in the past three months. This indicates that many high-risk individuals are not receiving the services they need, including access to condoms, to protect themselves from HIV.

Challenges:

- * Only 16 per cent of the estimated condom distribution need is met, leaving a significant shortfall.
- * Gender disparities in condom distribution exist, with men receiving more condoms than women (54 per couple-year for men versus 35 for women).

- * Low condom use among KPs, with only 58 per cent of MSM and 25 per cent of sex workers using condoms during their last sexual encounter.
- * Limited reach of combination HIV prevention interventions, with only five per cent of MSM receiving at least two HIV prevention interventions in the past three months.
- * Structural barriers, such as the criminalisation of sex work, same-sex sexual acts and drug use, contribute to stigma and discrimination, making it difficult for key and vulnerable populations to access condoms and other HIV prevention services.

2.5.1.3 ARV-Based Prevention

ARV-based interventions, which include Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP), are effective biomedical interventions for preventing HIV among people at high risk of infection. In Zambia, approximately 184, 256 people received PrEP in the past 12 months. This represents a significant increase in PrEP uptake, contributing to the reduction of new HIV infections, particularly among key and vulnerable populations and other high-incidence groups.

ART coverage in Zambia is impressively high, with 98 per cent of PLHIV who are aware of their status receiving treatment. This widespread access to ART has been a cornerstone of Zambia's HIV response, helping to reduce community viral loads and prevent the spread of the virus. Among those on ART, 97 per cent have achieved viral suppression, which is crucial for both improving the health outcomes of individuals and reducing the transmission of HIV.

Challenges:

- * Awareness of PrEP and PEP remains low in some high-risk groups, particularly in rural areas.
- * Misunderstandings about PrEP and PEP, as well as stigma associated with HIV prevention services, hinder broader uptake, especially among KPs.
- * There are gaps in the availability of PrEP and PEP services, with some healthcare facilities lacking trained personnel to offer these interventions or adequate supplies of medication.
- * Legal frameworks that criminalise key and vulnerable populations, such as sex workers and MSM, in addition to age of consent/access make it difficult for these populations to access ARV-based prevention services without fear of discrimination or legal consequences.

2.5.1.4 Voluntary Medical Male Circumcision

Voluntary Medical Male Circumcision (VMMC) is a central component of Zambia's HIV prevention efforts, significantly reducing the risk of female-to-male HIV transmission by approximately 60 per cent. Since its launch in 2009, the VMMC programme has grown substantially, with over three million men circumcised to date. The programme's aim is to achieve 95 per cent coverage of men aged 10 to 49 years by 2025, focusing on the 15-29 age group, where HIV prevention is most critical. VMMC is also integrated with other HIV prevention services, such as HIV testing and counselling (HTC) and condom promotion, ensuring a combination, comprehensive and layered approach to HIV prevention.

Key strategies employed by the VMMC programme include targeted outreach to young men, who are at high risk of HIV infection as they become sexually active. Mobile and community-based services have been particularly effective in extending VMMC to rural and underserved areas, ensuring that even hard-to-reach populations have access to circumcision services. These services are often combined with school-based outreach during holidays to maximise uptake.

Furthermore, VMMC is embedded within broader HIV prevention efforts, providing men with access to condoms, sexual health education and HIV testing alongside circumcision, ensuring they receive comprehensive support. The programme has seen notable successes. By end of 2025, the programme aims to circumcise 2.86 million males, a significant contribution to Zambia's goal of HIV epidemic control. Acceptance of VMMC has grown, with the proportion of circumcised men increasing from 22 per cent in 2014 to 32 per cent in 2018.

Challenges:

- * Cultural and religious resistance continues to limit VMMC acceptance in some communities.
- * Geographic barriers hinder access to services in remote and rural areas.
- * Long-term sustainability is a concern as the programme shifts from donor dependence to routine funding.
- * Ensuring integrated, high-quality data for decision-making and programme improvement remains a challenge.

2.5.1.5 Prevention of Mother-to-Child Transmission of HIV

Zambia Prevention of Mother-to-Child Transmission (PMTCT) of HIV, Syphilis and Hepatitis B (triple elimination) is a key strategy in Zambia's efforts to reduce transmission from mothers to their infants during pregnancy, childbirth and breastfeeding. The programme includes HIV and syphilis testing during antenatal care (ANC), providing ART to HIV-positive pregnant women and ensuring HIV care for infants. It has significantly contributed to reducing paediatric HIV infections and improving maternal health outcomes.

Nearly 98.5 per cent of women who delivered in the past three years attended at least one ANC visit and 83.8 per cent of women who delivered in the previous 12 months knew their HIV status. ART uptake is also high, with 94 per cent of HIV-positive women who delivered in the last 12 months reporting ART use. Additionally, as of 2023, 90 per cent of pregnant women living with HIV received ART for PMTCT, leading to a notable decrease in the rate of new infections among infants. The estimated final vertical transmission rate, including during breastfeeding, stands at 6.58 per cent, demonstrating the effectiveness of Zambia's PMTCT programmes. However, mother-to-child transmission of HIV persists with approximately 3,000 HIV exposed infants testing HIV positive annually attributed to incident maternal HIV infections in the maternity and postnatal period, failure to initiate ART and dropping off ART for pregnant and breastfeeding women testing HIV positive.

Challenges:

- * Stigma and discrimination continue to prevent some women from accessing PMTCT services, particularly in rural areas.
- * Late antenatal care attendance delays the initiation of HIV testing and ART, increasing the risk of HIV transmission to the infant.
- * Some women drop out of the care continuum after delivery, leading to gaps in ART adherence and follow-up care.
- * Geographic disparities exist, with certain provinces lagging in PMTCT services coverage and uptake.
- * Insufficient partner/male engagement in maternal and child health services.

2.5.1.6 Treatment of Sexually Transmitted Infections (STIs)

While Zambia's HIV prevention strategy has focused primarily on addressing the HIV epidemic, the treatment of other sexually transmitted infections (STIs) is an integral component of the country's broader biomedical interventions. STIs, such as syphilis, gonorrhoea and chlamydia, contribute to the risk of HIV transmission and exacerbate the progression of the disease among people living with HIV. To this end, integrating STI treatment into HIV care services is essential for managing co-infections and reducing the overall burden of HIV.

According to the 2021 ZAMPHIA, STIs remain a significant public health concern, particularly among the sexually active population aged 15 to 49 years. The data indicates a steady rise in STI cases, increasing from 204,756 cases in 2017 to 347,923 in 2022, reflecting a growing need for strengthened healthcare services to address these infections. The most commonly reported STI syndromes include lower abdominal pain, genital ulcer syndrome, vaginal discharge syndrome (VDS) and urethral discharge syndrome (UDS). Services to control and treat STIs in Zambia are incorporated within the broader sexual and reproductive health (SRH) services, targeting not only people living with HIV but also key populations such as adolescents, pregnant women and other vulnerable groups. The government has prioritised the integration of STI treatment into ANC services, as three per cent of pregnant women were reported to have active syphilis infections, which, if untreated, could lead to severe birth outcomes such as stillbirths, neonatal deaths and congenital disabilities.

Challenges

- * Inadequate community awareness campaigns, which result in delayed treatment-seeking behaviour.
- * Inadequate partner notification and referral systems, compounded by a lack of cross-border patient information sharing.
- * Frequent stock outs of diagnostic and treatment commodities.
- * Limited condom promotion and distribution mechanisms, particularly targeting adolescents and young people, pregnant women and key populations.
- * Syndromic reporting of STIs rather than specific diagnostic tests, which limits the accuracy of reported data.
- * Poor data collection and management within the health information systems, hindering effective tracking of STI trends.

2.5.2 Behavioural Factors

Knowledge about HIV prevention among young people aged 15 to 24 years is relatively moderate in the country, with around 41.7 per cent demonstrating a comprehensive understanding of how to prevent HIV transmission. Gender disparities exist, with 42.6 per cent of young women and 40.6 per cent of young men having adequate knowledge about HIV prevention. These statistics highlight the need for continued and enhanced educational campaigns to improve awareness and understanding of HIV prevention methods among the youth, which is crucial for reducing the incidence of new infections (UNAIDS, 2023).

The age of sexual debut in Zambia varies, but it typically occurs during adolescence. Data suggest that many individuals engage in sexual activity for the first time in their teenage years, with significant implications for HIV transmission risk. Early sexual debut is associated with a higher likelihood of multiple sexual partners and unprotected sex, both of which increase the risk of acquiring HIV and other sexually transmitted infections. It is essential to address early sexual debut through Life Skills and Health Education (LSHE) that emphasises the importance of safer sex practices and delays the initiation of sexual activity (UNAIDS, 2023).

The average number of sexual partners varies by sex and age group in Zambia. Men generally report having a higher number of sexual partners than women. This difference in sexual behaviour is a key factor in the transmission dynamics of HIV, as individuals with multiple sexual partners are at a greater risk of contracting and spreading the virus. Promoting monogamous relationships, consistent condom use and regular HIV testing are critical strategies to mitigate the risk associated with having multiple sexual partners (Zambia. Ministry of Health et al., 2022).

Zambia has implemented a range of behavioural interventions to address low HIV prevention knowledge, early sexual debut and multiple sexual partners among youth. Life Skills and Health Education (LSHE) programmes in schools and communities use interactive methods to improve awareness of HIV prevention, safer sex practices and the importance of delaying sexual activity. Peer-led interventions provide counselling, testing and health education to adolescents in youth-friendly spaces, while mass media campaigns promote condom use, monogamy and HIV testing through radio, TV and social media. Community dialogues engage parents, teachers and leaders to reinforce prevention messages and address gender norms. Additionally, adolescent-friendly health services offer confidential, youth-tailored HIV testing, counselling and sexual and reproductive health services.

Zambia employs a range of behavioural HIV prevention interventions aimed at reducing transmission rates and improving health outcomes, particularly among young people aged 15 to 24 years. These strategies focus on addressing key factors, such as low HIV prevention knowledge, early sexual debut and multiple sexual partners, all of which drive the epidemic. The interventions aim to increase awareness, promote safer sexual practices and reduce the incidence of new HIV infections.

- 1. Peer-Led Interventions:** Peer-led interventions engage adolescents through peer educators who provide counselling, testing and promote safe sexual practices in youth-friendly spaces. This method has been effective in reducing risky behaviours, as young people are more likely to discuss sexual health with their peers. However, these interventions face challenges in rural areas where peer-led programmes are less prevalent and inconsistent training of peer educators sometimes results in variability in the quality of information provided.
- 2. Social and Behavioural Change Communication (SBCC):** SBCC aims to shift social norms and attitudes towards HIV prevention through targeted messaging, community engagement and mass media. It has been crucial in raising awareness about HIV prevention, reducing stigma around testing and promoting condom use. The challenge with SBCC is maintaining sustained behaviour change, especially without continuous engagement and ensuring effective outreach in remote or underserved communities due to limited resources.
- 3. Life Skills and Health Education (LSHE):** LSHE is integrated into school curricula to equip young people with the knowledge necessary to make informed decisions about their sexual health, delay sexual debut and engage in safer sexual practices. LSHE faces challenges of funding constraints for implementation in all schools.
- 4. HIV Self-Testing (HIVST):** HIV self-testing kits have gained popularity in Zambia, particularly among individuals who are hesitant to use traditional healthcare services. Self-testing allows for private access to knowing one's status, which increases the likelihood of individuals seeking care. However, limited availability of self-testing kits in rural and hard-to-reach areas remains a challenge, as does the lack of immediate follow-up care after a positive result, which can delay treatment.
- 5. Community Outreach Programmes:** Community outreach programmes focus on reaching high-risk populations by offering HIV testing, counselling and education through mobile clinics and community events. These programmes facilitate increased

access to HIV prevention services in underserved areas. Nonetheless, geographical barriers and inconsistent supply of resources, such as condoms and test kits in mobile units, pose significant challenges to the effectiveness of these outreach efforts.

6. **Mass Media Campaigns:** Mass media campaigns, utilising radio, television and social media, are essential in spreading messages about HIV prevention, promoting regular testing and normalising conversations about sexual health. While these campaigns have been successful in urban areas, their reach in rural regions is limited due to scarce access to media platforms. Additionally, relying heavily on mass media without sufficient community engagement weakens the impact of these campaigns.
7. **Targeted Interventions for Key and vulnerable Populations:** Specific programmes target key and vulnerable populations, such as sex workers, MSM and AGYW, addressing their unique risks and barriers to accessing healthcare services. Despite the success of these programmes, stigma and discrimination continue to be major barriers, particularly for MSM and sex workers, preventing them from fully accessing services. Furthermore, limited resources hinder the expansion of these targeted interventions across the country.

2.5.3 Structural Factors

Structural barriers in Zambia, such as stigma, discrimination, legal constraints and gender inequality, significantly impede access to HIV prevention, care and treatment services, especially for KPs such as SWs, MSM, TGs, PWIDs and inmates. These populations face legal repercussions due to the criminalisation of their sexual orientation and behaviours, leading to social ostracism and limiting their willingness to seek health services. Additionally, pervasive societal stigma, compounded by harmful cultural norms, exacerbates the marginalisation of these groups, creating further challenges in accessing healthcare, including HIV services.

Zambia has made efforts to address these structural barriers through various interventions. Discussions have been initiated around legal and policy reforms aimed at creating a more inclusive environment for KPs to access health services without fear of discrimination or arrest. Anti-stigma campaigns are in place to challenge harmful societal norms and key population-led community organisations advocate for the rights of these groups, providing peer-led health services. LSHE has been expanded to reach out-of-school youth and other high-risk groups, enhancing HIV knowledge and preventive behaviours. Additionally, gender-transformative approaches aim to address gender inequality and promote women's empowerment, while cash transfer programmes and other social protection measures are helping to reduce the financial barriers to healthcare access for vulnerable populations.

Progress has been made in creating more supportive environments for KPs. Anti-stigma campaigns have reduced some of the barriers faced by KPs in accessing HIV services and peer-led initiatives have empowered these groups by increasing access to safe spaces and confidential services. Efforts have also been made to strengthen social protection programmes like Social Cash Transfers, which now better target vulnerable populations, ensuring more comprehensive support. Moreover, gender-transformative approaches have helped shift harmful cultural norms, promoting male involvement in HIV prevention and increasing support for women's and girls' participation in healthcare decisions. Legal reform discussions have begun, signalling a growing recognition of the need to address laws that hinder KPs' access to HIV services.

Challenges

- * The criminalisation of same-sex relations, sex work and drug use creates fear and deters KPs from seeking healthcare services.

- * Stigma and discrimination in healthcare settings persist, discouraging KPs, including PWIDs and MSM, from accessing HIV-related services.
- * Heavy reliance on external funding (PEPFAR, Global Fund) limits the sustainability and expansion of services, with significant gaps in condom distribution (16% coverage) and PrEP access (89% coverage).
- * Social protection programmes, such as Social Cash Transfers, suffer from inadequate funding and poor targeting, leaving many vulnerable groups without necessary support.
- * Legal barriers, such as the requirement for parental consent for adolescents under 16 years to access health services, hinder young people from receiving timely care, limiting their knowledge of HIV prevention.

CHAPTER III: National HIV Prevention Roadmap 2025-2030

3.1 Context

The Global HIV Prevention Coalition recommends an HIV prevention approach that emphasises focussing on five key prevention pillars. Pillars 1 to 3 focus on delivering people-centred combination prevention packages for KPs, AGYW and adolescent boys and men in high-incidence areas. Pillar 4 emphasises the promotion and availability of condoms, while Pillar 5 highlights antiretroviral-based prevention, stressing the importance of integrating HIV prevention with treatment.

Zambia has adapted this approach in its **National HIV Prevention Roadmap 2025-2030**, creating a precision-focused, people-centred framework. Zambia's five HIV prevention pillars reflect a commitment to tailored combination prevention packages for various high-risk groups, addressing their unique needs.

- * **Pillar 1: AGYW** – This pillar targets AGYW with a comprehensive prevention package including social behaviour change (SBC) messages, condom distribution, HIV testing services (HTS), PrEP, PEP, STI prevention and treatment, cervical cancer screening, economic strengthening and referrals for ongoing care.
- * **Pillar 2: ABYM** – This pillar focuses on adolescent boys and young men with a similar combination package, including SBC messaging, condom distribution, HTS, PrEP, PEP, STI screening and management, VMMC and economic empowerment programmes, alongside curricula like "Couching Boys into Men" to promote healthier behaviours.
- * **Pillar 3: Key Populations (KPs)** – This pillar promotes delivery of a tailored prevention package for KPs, including SBC, condom and lubricant distribution, HTS and VMMC. It also covers mental health support, STI screening and management, ART, PrEP, PEP and hepatitis B and C screening. Support for gender-based violence (GBV) and intimate partner violence, cervical cancer screening and harm reduction measures are integrated. Additionally, the package includes economic strengthening initiatives and referrals to the continuum of care, to ensure comprehensive ongoing support for KPs.
- * **Pillar 4: Pregnant and Breastfeeding Women** – This pillar focuses on women in the reproductive phase, offering services such as condom distribution, HTS, mental health support, STI screening, hepatitis B and C screening, ART, PrEP, PEP, GBV support, cervical cancer screening, breastfeeding, counselling, Early Infant Diagnosis (EID), family planning and ongoing care.
- * **Pillar 5: Migrant, Mobile and Other Vulnerable Populations** – This pillar addresses the unique needs of migrant and mobile populations, as well as other vulnerable groups such as people with disabilities. The prevention package includes SBC messaging, condom and lubricant distribution, HTS, VMMC and mental health support. Additionally, it provides ART, cervical cancer screening and support for GBV and intimate partner violence. The roadmap ensures that these populations have access to comprehensive, tailored HIV prevention services to overcome the barriers posed by mobility, disability and other vulnerabilities.
- * **Cross-Cutting Interventions** include gender integration, sexual and reproductive health rights, access to economic empowerment, multisectoral and differentiated service approaches and the promotion of a conducive policy environment. Sustained

investment in HIV prevention is also emphasised to ensure the long-term success of the roadmap.

- * **Access Pathways** will be made available through community-based and community-led outreach, facility-based services, virtual platforms and private sector engagement, ensuring that all key populations and vulnerable groups can access essential HIV prevention services.
- * This roadmap reflects Zambia's commitment to delivering precise, targeted and integrated prevention services that meet the specific needs of various populations, ensuring no one is left behind in the response to HIV.

3.2 Guiding Values

The Zambia National HIV Prevention Roadmap is grounded in values aligned with WHO and UNAIDS standards, emphasising human rights, social justice and equitable access to HIV and AIDS services. It upholds universal health coverage, providing integrated prevention, treatment, care and support for all and values inclusive stakeholder engagement, involving community members, key populations, public and private sectors and international partners, in decision-making. The roadmap is guided by people-centric service delivery, evidence-based planning and collaborative partnerships, ensuring tailored, effective and accountable responses to the HIV epidemic. The roadmap is built on several fundamental principles tailored to the country's specific context:

1. **Commitment to Human Rights and Justice:** The Roadmap emphasises human rights, social justice and equal access to HIV and AIDS services, ensuring that all individuals, regardless of socio-economic status or background, receive fair and equitable health services.
2. **Universal Health Coverage and Accessibility:** The Roadmap aims to achieve universal health coverage by providing high-quality, integrated HIV prevention, treatment, care and support services, ensuring no one is excluded and that all gaps in care are addressed.
3. **Active Stakeholder Engagement and Inclusiveness:** The Roadmap prioritises the engagement of diverse stakeholders, including community representatives, key populations and vulnerable groups, ensuring their voices are central to decision-making. It also embraces an inclusive approach that recognises the varying prevention needs at different life stages.
4. **People-Centric and Community-Led Service Delivery:** The Roadmap anchors services designed with a focus on the needs and preferences of those affected by HIV, with an emphasis on community leadership in service delivery and monitoring, particularly among key populations, to improve service acceptance and retention.
5. **Gender Responsiveness:** The Roadmap adopts a gender-responsive approach, catering to the distinct needs of women, girls, men and boys in accessing HIV and sexual and reproductive health services.
6. **Evidence-Based Planning and Investment:** The Roadmap promotes planning and investment decisions guided by the latest data and research, ensuring that interventions are targeted, effective and based on evidence.
7. **Multisectoral, Collaborative and Accountable Partnerships:** The Roadmap fosters collaboration and shared responsibility among various sectors and stakeholders, establishing mechanisms for accountability and ensuring coordinated efforts toward common goals.
8. **Ending Inequalities and Inequities:** The Roadmap addresses health inequalities through rights-based programming, focusing on key populations who face persecution,

stigma and disproportionate HIV risks and seeks to address legal and socio-economic barriers to accessing services.

- 9. Value for Money:** The Roadmap emphasises maximising and sustaining equitable, high-quality health outcomes in a constrained economic environment by optimising costs and ensuring efficient resource allocation and programme implementation.
- 10. Sustainability:** The Roadmap is built on sustainability principles, promoting reliance on domestic resources, strengthening partnerships with external funders and fostering community ownership and leadership commitment, to ensure long-term programme success.

3.3 Goal, Purpose, Objectives and Expected Results

3.3.1 Goal

To attain HIV epidemic control and reduce the number of new HIV infections from the current 28, 000 to less than 15, 000 by 2027.

3.3.2 Overall Objective

To outline strategies aimed at enhancing the equitable expansion and delivery of HIV prevention services through a complementary combination of behavioural, biomedical and structural interventions with a particular focus on those most at-risk, such as adolescents, priority, key and marginalised populations through a coordinated, multisectoral approach to accelerate the implementation of existing and new HIV prevention interventions.

3.3.3 Specific Objectives

The specific objectives of the HIV Prevention Roadmap include:

1. To provide direction for geographical and population prioritisation of HIV prevention efforts to maximise the reduction of new infections.
2. To provide direction for the scaling up and implementation of tailored combination HIV prevention interventions, incorporating biomedical, behavioural and structural interventions through community-led and integrated approach.
3. To provide direction for monitoring and evaluating the effectiveness and progress of HIV prevention initiatives.
4. To accurately define resource requirements for HIV prevention and enhance strategies for resource mobilisation and efficient allocation.
5. To strengthen HIV prevention leadership entities to enhance multisectoral collaboration, oversight and management of prevention responses.

3.3.4 Expected results

The expected results include:

1. Reach 95 per cent of key and priority populations with combination HIV prevention by 2027.
2. Ensure that 30 per cent of HIV testing, 30 per cent of social enablers and 30 per cent of HIV prevention services at community level are delivered and monitored by KVP-led organisations.
3. Reach 95 per cent of KPs and adolescents with comprehensive knowledge on HIV and AIDS by 2027.
4. Reach 95 per cent of condom use among KPs and adolescents, who engage in risky sexual behaviour, by 2027.
5. Ensure 95 per cent of eligible people receive PrEP at least once during the last 12 months.
6. Achieve 95 per cent Male Circumcision among eligible males by 2027.
7. Increase the percentage of PWID benefiting from needle and syringe exchange programmes from zero to 30 per cent by 2027.

8. Increase the percentage of eligible PWID receiving opioid substitution therapy from zero to 30 per cent by 2027.
9. Increase the percentage of people aged m,,15-49 years with STIs treated from 20 per cent to 50 per cent by 2027.
10. Increase the percentage of SWs with STIs treated from 28 per cent to 60 per cent by 2027.
11. Increase HIV prevention funding to 50 per cent.

CHAPTER IV: Strategic Direction

Strategy 1: Conduct an Evidence-Driven Assessment of HIV Prevention Programme Needs and Barriers

The Zambia HIV prevention programme is advanced with a myriad prior evaluation, programme data sources and strategic documents addressing different components of HIV prevention. This strategy will synthesise HIV prevention data from the different existing sources into a consolidated baseline assessment report. It will highlight specific needs and barriers in the HIV prevention programme and ensure alignment with both national priorities and global HIV prevention targets. The document will be reviewed periodically to assess the progress in each HIV prevention domain. Through this strategy, the programme will optimise HIV prevention interventions and address any gaps in service delivery, ultimately contributing to Zambia's goal of reducing new infections.

Table 3: Priority actions, milestones and timelines for strategy 1

Milestone	Priority Actions	Implemented by
HIV Prevention landscape assessment baseline and periodic reports	<ul style="list-style-type: none"> Synthesise available HIV prevention information and documents into a consolidated HIV prevention landscape assessment baseline report 	
	<ul style="list-style-type: none"> Annual reviews of the HIV landscape assessment reports to evaluate the progress made in specific HIV prevention domains 	2025, Q2
	<ul style="list-style-type: none"> Gather evidence for the health sector, especially of issues affecting adolescents and young people's access to HIV prevention services to be used as a basis for policy change advocacy. 	

Strategy 2: Adopt a Precision Prevention Approach Focused on Key, Vulnerable and Priority Populations Including Differentiated National 2025 Prevention Targets

This strategy focuses on detailed population-specific data to target HIV prevention interventions where they are needed most. By prioritising geographies and populations with the highest HIV burden, it aims to address service gaps and inequities by ensuring that resources are aligned for maximum impact and support the goal of epidemic control.

Table 4: Milestones, priority actions and timelines for strategy 2

Milestones	Priority actions	Implemented by
Differentiated (precision) HIV prevention framework	Development of SOPs	Q1 2025
Annual HIV Prevention Bulletin	Programmatic analysis to identify key drivers of HIV epidemic by geography and population	Q4 2025
Targeted HIV prevention packages	Develop and implement standardised minimum age and risk-appropriate service packages for HIV combination prevention	Q3 2025

for key, vulnerable and priority
populations.

Strategy 3: Determine Country Investment Needs for Adequately Scaled HIV Prevention Responses and Ensure Sustainable Financing

This strategy aims to ensure that national HIV prevention efforts are adequately financed and aligned with both national priorities and global targets. By developing national financing benchmarks and optimising resource allocation, it seeks to achieve a sustainable, evidence-based HIV response. The strategy emphasises the importance of multi-sectoral investment, equity, efficiency and public financing of community-led prevention services.

Table 5: Priority actions, milestones and timelines for strategy 3

Milestones	Priority actions	Implemented by
HIV Prevention financing strategy	<ul style="list-style-type: none"> Undertake an HIV prevention resource needs assessment through a comprehensive desk review and targeted stakeholder interviews to address identified gaps. Prioritise funding for evidence-based interventions and ensure efficient, equitable resource allocation. Establish national and subnational HIV financing targets aligned with national and subnational priorities. Prioritise high-impact interventions and reallocate resources from low-impact programmes. Mobilise resources and allocate dedicated budgets towards integrated HIV prevention services. 	Q3, 2025
Multisectoral investments supporting wholistic HIV prevention efforts.	<ul style="list-style-type: none"> Multisectoral stakeholder engagement to support prevention efforts across various areas, including education, social protection and legal reform. Boost private sector involvement in HIV prevention. Enhance public-private collaboration to pool resources for HIV services. 	Q1, 2025
Sustainable financing for high-impact, evidence-based HIV prevention interventions.	<ul style="list-style-type: none"> Implementation of the HIV sustainability roadmap. Promote domestic financing through initiatives such as match-funding (matching funds). Integrate HIV into public health insurance to ensure financial sustainability. Boost private sector involvement in HIV prevention. Advocate for progressive increases in government health budgets through 2026, prioritising HIV funding. 	Q4, 2025
Stronger public financing mechanisms for community-led HIV prevention services.	<ul style="list-style-type: none"> Explore public-private partnerships and diverse funding sources for community-led HIV services. Maximise the use of existing domestic resources 	Q1, 2025 Q4, 2024
Develop a social contracting policy	<ul style="list-style-type: none"> Outline enterprise mechanisms for contracting civil society organisations. 	Q2, 2025

Strategy 4: Reinforce HIV Prevention Leadership Entities for Multisectoral Collaboration, Oversight and Management of Prevention Responses

This strategy aims to strengthen national and subnational leadership entities responsible for the coordination, oversight and management of HIV prevention programmes. It focuses on maximising synergies between various stakeholders, including government, civil society and community-led organisations, to ensure a unified and effective response to HIV prevention. The approach emphasises multisectoral collaboration and assigns adequate authority and resources to ensure accountability and progress toward national HIV prevention goals.

Table 6: Milestones priority actions and timelines for strategy 4

Milestones	Priority actions	Implemented by
Leadership and coordination mechanisms at national and subnational levels	<ul style="list-style-type: none"> Strengthen multisectoral coordination and ensure effective programme oversight 	Q1, 2025
Public Private Partnership engagement strategy	<ul style="list-style-type: none"> Establish a unified, evidence-based agenda with clearly defined roles for government, communities and partners. Foster cross-sector collaboration and enhance accountability to maximise synergies in HIV prevention programmes. 	Q2, 2025

Strategy 5: Strengthen and Expand Community-Led HIV Prevention Services and Set Up Social Contracting Mechanisms

This strategy focuses on empowering community-led organisations to take a leading role in HIV prevention, service delivery and advocacy. By fostering community leadership and expanding the involvement of civil society, the strategy seeks to establish sustainable HIV prevention efforts driven by the needs and priorities of the communities themselves. The establishment of social contracting mechanisms will ensure that community-led initiatives receive public and private funding to enhance their capacity to deliver effective HIV prevention services.

Table 7: Milestones, priority actions and timelines for strategy 5

Milestones	Priority Actions	Implemented by
Community-led HIV service package developed	<ul style="list-style-type: none"> • Develop and validate community-led package. • Strengthen community led monitoring data utilisation, reporting and use in communities 	Q2,2025
Social contracting mechanisms developed	<ul style="list-style-type: none"> • Establish and institute social contracting mechanisms to empower and involve communities in leading HIV responses, ensuring inclusivity and effectiveness. • Create clear guidelines for funding allocation, performance monitoring and accountability to ensure transparency and efficiency in the use of resources. 	Q2, 2025

Strategy 6: Remove Social and Legal Barriers to HIV Prevention Services for Key and Priority Populations

This strategy seeks to remove the social and legal barriers that hinder access to HIV prevention services for key and priority populations. By fostering enabling legal and policy environments, the strategy aligns with the Global AIDS Strategy (2021–2026) and aims to enhance access to justice, promote gender equality and eliminate stigma and discrimination. It focuses on addressing structural and legal barriers that hinder access to essential HIV services.

Table 8: Milestones, priority actions and timelines for strategy 6

Milestones	Priority Actions	Implemented by
<p>Access to HIV Prevention health services by key and priority population increased</p>	<ul style="list-style-type: none"> • Conduct legal environmental assessment that should assess laws that hinder access to HIV services. • Develop a position paper on legal changes that are needed to improve access to HIV Prevention services. • Develop policy briefs to communicate to policy makers. • Advocate for reduction of age of access to HIV prevention services. 	<p>Q4, 2030</p>
<p>Stigma reduction roadmap</p>	<ul style="list-style-type: none"> • Develop a Civil Society Organisation strategy for stigma reduction. 	<p>Q1, 2025</p>

Strategy 7: Promote the Integration of HIV Prevention into Essential Related Services to Improve HIV Outcomes

This strategy focuses on integrating HIV prevention services into broader health services to improve accessibility, convenience and overall health outcomes. Thus, HIV services in Zambia must cease to be a vertical programme but be integrated in primary health services (PHC), in-patient services, maternal and child health services, community health services, SRH, mental health, GBV prevention, drug dependence treatment, tuberculosis control, noncommunicable diseases and legal and social support. Combination HIV prevention services including HIV testing, linkage to other prevention services, PrEP, SBCC, condom distribution or VMMC could be included in the service packages in the above health service areas. By doing so, HIV prevention services will be provided in a holistic approach that caters to the complex needs of at-risk populations, especially those underserved by formal health systems, such as inmates, migrants, PWDS and other vulnerable populations.

Table 9: Milestones, priority actions and timelines for strategy 7

Milestones	Priority actions	Implemented by
Leadership and governance for HIV prevention integration into health services	<ul style="list-style-type: none"> Stakeholder engagements. Develop guidelines for HIV prevention integration into other services. 	Q1 2026
Integrated logistics and supply chain	<ul style="list-style-type: none"> Alter primary health commodity packages to include HIV prevention services commodities including PrEP. Include HIV prevention service in the universal health care NHIMA packages. 	Q3 2027
Service provision of integrated HIV prevention services into essential health services to improve overall health outcomes.	<ul style="list-style-type: none"> Develop integrated HIV prevention data systems. Training on Integrated HIV prevention services. Monitoring of integrated HIV prevention services. 	Q4, 2027

Strategy 8: Set Up Mechanisms for the Rapid Introduction of New HIV Prevention Technologies and Programme Innovations

The HIV prevention landscape is continually evolving with new technological advancements. This strategy focuses on establishing systems and frameworks for the rapid adoption of new HIV prevention technologies and innovations, as part of comprehensive combination prevention packages. These include the introduction of advanced options such as antiretroviral drug-releasing vaginal rings, long-acting PrEP regimens, vaccines (when available) and other emerging technologies that have proven to be effective. Zambia will establish a standard framework that will ensure rapid adoptions, registrations, financing, procurement and deployment of new HIV preventions technologies.

Table 10: Milestones, priority actions and timelines for strategy 8

Milestone	Priority Actions	Implemented by
Prompt identification and adoption of available new HIV prevention technologies that should be scaled up.	<ul style="list-style-type: none"> Annual stakeholder consultations on technology use among the high-risk populations by the HIV prevention TWG and annual HIV prevention technologies report must be produced. 	Q 4. Every year
Policy and guidelines updates and review to enable rapid introduction of new HIV prevention technologies.	<ul style="list-style-type: none"> New HIV prevention technologies should be prioritised for waiver and fast tracked for product registration and clearance through an internal memorandum produced by the Permanent Secretary at Ministry of Health. Lobby for tax incentives for HIV prevention products for easy introduction of products. Lobby for ring-fenced budget line for HIV prevention commodities from Ministry of Finance. 	Q2, 2026
Setup innovative product introductions and dissemination processes.	<ul style="list-style-type: none"> Develop a standing protocol, implementation scale up procedure and SOPs for rapid introduction of new HIV prevention technologies. Establish sentinel centres of excellence sites for rapid introduction of HIV prevention technologies. 	Q1, 2026

Strategy 9: Establish Real-Time Prevention Programme Monitoring Systems with Regular Reporting

Strategy 9 focuses on developing and implementing robust real-time HIV prevention programme monitoring systems. The aim is to ensure that the progress of HIV prevention efforts can be tracked at national and subnational levels, facilitating data-driven decision-

making and enabling timely course corrections when necessary. This system will integrate regular reporting, data analysis and feedback mechanisms to improve programme efficiency, align with national prevention targets and contribute to global goals. This framework will assess the continuum of HIV prevention services, from uptake to retention and evaluate whether programmes meet national goals and global targets. It will track outputs and outcomes at both national and subnational levels, ensuring alignment with Zambia's specific needs. Additionally, it will incorporate a performance measurement system for real-time monitoring and feedback.

Table 11: Milestones, priority actions and timelines for strategy 9

Milestones	Priority Actions	Implemented by
Improved data quality of the NACMIS	<ul style="list-style-type: none"> • Appoint and assign HIV prevention data entry clerks in local authorities • Build capacity of data entry clerks • Improve documentation in NACMIS 	Q4, 2026
Improved data analysis and use to enhance decision-making.	<ul style="list-style-type: none"> • Bi-annual HIV prevention bulletins established • Establish a real-time tracking system for a comprehensive HIV prevention dashboard 	Q4, 2026
Inter-operability of the HIV data prevention system with other existing prevention information systems.	<ul style="list-style-type: none"> • Indicator mapping on HIV prevention across available systems • Software integration for various data systems 	Q3, 2027
community-led monitoring approach available.	<ul style="list-style-type: none"> • Establish a community-led monitoring system on HIV prevention services 	Q4, 2026

Strategy 10: Strengthen Accountability of All Stakeholders for Progress in HIV Prevention

Strategy 10 focuses on ensuring that all stakeholders, including government entities, community-led organisations and civil society, are held accountable for their roles in achieving progress in HIV prevention. This involves strengthening data systems to monitor implementation of the national HIV Prevention Roadmap, identifying gaps and making course corrections. The strategy emphasises the importance of transparency, leadership and sustainability to drive success in HIV prevention efforts, with a particular focus on community engagement and collaboration through elaboration of an HIV prevention accountability framework (Annex 2).

Table 12: Milestones, priority actions and timelines for strategy 10

Milestone	Priority Actions	Implemented by
Accountability framework developed and validated	<ul style="list-style-type: none"> Engage stakeholders in the development of the accountability framework. 	Q3, 2025
Accountability framework funded	<ul style="list-style-type: none"> Resource mobilisation for the development and implementation of accountability framework conducted. 	Q4, 2025
Increased community-led organisations implementing the accountability framework	<ul style="list-style-type: none"> Engage and support (technical, financial, other systems) the community-led organisations to implement the accountability framework process. 	Q1, 2026

CHAPTER V: Monitoring and Evaluation Framework

To effectively monitor and evaluate the HIV prevention strategies outlined in Zambia's 10-Point Action Plan, a comprehensive monitoring and evaluation framework is essential. This framework will enable continuous assessment of progress, effectiveness and impact, ensuring that HIV prevention efforts are data-driven, responsive and aligned with national and global goals. The framework will focus on multiple components to provide a holistic approach to monitoring and evaluation. A monitoring and evaluation framework will be developed, clearly outlining indicators at all levels (especially at output, outcome and impact levels) and for all strategies. Data points (meta data) will be formulated against each indicator and will be the basis to develop data collection tools for measuring progress of implementation. The framework will specify who will be responsible for collecting different pieces of data at different levels as well as the means of verification or data sources and the frequency of data collection. It is recommended that a single electronic web-based national monitoring and evaluation system be established. NAC and MoH will work together to use existing data systems to collect, analyse and report on progress made for all identified indicators.

In addition to routine monitoring, periodic evaluations will be conducted to ascertain effectiveness of interventions and impact. These will include mid-term and final evaluations and impact assessment. The Mid-term evaluation will be conducted to assess the effectiveness of HIV prevention strategies, identify any emerging challenges and recommend necessary adjustments. This will ensure that strategies remain relevant and effective over time. A comprehensive final evaluation will be conducted at the end of the action plan period to measure overall outcomes and impacts, assess the cost-effectiveness of different interventions and draw lessons learned for future planning and policy direction. Impact assessments will use rigorous methods such as randomised control trials (RCTs) or quasi-experimental designs to evaluate the impact of key interventions on reducing HIV transmission rates and improving health outcomes.

In addition, other methodologies for prevention outcome monitoring will be implored which include the biobehavioural surveys and polling booth surveys targeting key populations and adolescents and young people.

As a precondition for an effective monitoring and evaluation system, there will be need for capacity building for key staff at all levels. There will be provision of ongoing training and capacity-building programmes for monitoring and evaluation personnel, including government staff, health workers and community organisations, to enhance skills in data collection, collation, management, analysis and reporting. This will require mobilisation and allocation of adequate resources. Thus, NAC will ensure and coordinate resources and expertise (financial, human, technical) to support robust monitoring and evaluation activities. This includes investment in digital tools, data management systems and training programmes.

The monitoring and evaluation system will generate regular monitoring reports (quarterly and annually) to provide updates on the progress of each HIV prevention strategy. Reports will include data on KPIs, analysis of trends, identification of challenges and recommendations for improvement. Regular stakeholder meetings will be held with relevant stakeholders, including government, NGOs, community-based organisations and donors, to assess progress, discuss challenges and make strategic adjustments.

The monitoring and evaluation system will use an adaptive management and continuous improvement approach. It will implement feedback mechanisms to ensure that data and insights from monitoring activities are shared with all stakeholders. This feedback will guide adjustments to strategies and interventions to address emerging challenges and enhance

effectiveness. In addition, there will be learning and knowledge sharing through regular knowledge-sharing sessions, workshops and dissemination events to share lessons learned, best practices and innovative approaches.

Chapter VI: Costing of the Roadmap

The financing structure for the HIV Prevention Roadmap (PRM) 2025-2030 is designed to align seamlessly with the National AIDS Strategic Framework (NASF), rather than functioning as an isolated budget. The alignment ensures that each strategic intervention under the PRM is supported by corresponding NASF budget lines, integrating resource allocations across both frameworks to maximise efficiency and impact in achieving HIV prevention goals. The following interpretation of the NASF budget highlights the allocation across strategic interventions, underscoring a multi-year commitment to resource stability and strategic coherence.

NASF Budget Interpretation:

1. **HIV Prevention Landscape Assessments:** Allocated under **HMIS & Research**, with progressive increases from \$19.82 million in 2025 to \$22.01 million by 2027, supporting ongoing monitoring and baseline reporting essential for assessing the HIV prevention landscape.
2. **Precision Prevention for Key Populations:** The funding across multiple prevention categories (e.g. eMTCT, PrEP, blood safety, AGYW/ABYM) underlines a targeted approach to HIV prevention, with budgets scaling up annually, notably with **\$55.04 million in eMTCT and PrEP** and **\$53.84 million for Key Populations by 2027**. This ensures prioritised, differentiated intervention delivery to key groups.
3. **Investment Needs and Sustainable Financing: Finance and Sustainability** is allocated modestly (e.g. \$2.48 million in 2025, reaching \$2.75 million in 2027) to ensure sustainable financial planning for HIV prevention responses.
4. **Leadership and Multisectoral Collaboration:** Strategic investment under **Governance, Policy and Coordination** (e.g., \$64.42 million in 2025) underscores a commitment to robust oversight and cross-sector coordination to enhance HIV prevention leadership.
5. **Community-Led HIV Services and Social Contracting:** Funding under **Community Systems Strengthening** grows from \$9.91 million in 2025 to \$11.01 million in 2027, supporting the expansion of community-driven HIV prevention services.
6. **Social and Legal Barrier Removal for Key Populations:** With allocations aligned under Key Population Prevention, this strategy benefits from a growing budget, with a steady increase to \$53.84 million by 2027, aiming to mitigate obstacles to service access.
7. **Integration of HIV Prevention into Essential Services:** Under **Critical Enablers**, this allocation reaches \$140.32 million by 2027, promoting a broad-based integration of HIV prevention across essential health and social services, maximising reach and impact.
8. **Introduction of New Technologies and Innovations:** Funding under **Laboratory Systems and Equipment** (e.g. \$14.87 million in 2025, growing to \$16.51 million) is intended for advancing the rapid adoption of novel HIV prevention tools.
9. **Real-Time Prevention Monitoring:** Funded under **HMIS and Research**, with an increase from \$19.82 million to \$22.01 million, facilitating continuous data-driven improvements in prevention programming.
10. **Stakeholder Accountability in HIV Prevention:** Emphasised under **Governance, Policy and Coordination**, this strategic intervention highlights accountability mechanisms for all stakeholders, ensuring a shared commitment to achieving

prevention goals.

Table 13: Financing of the HIV Prevention Roadmap 2025-2030

PRM Strategic Inventions	NASF Budget Line	NASF Budget Amounts		
		2025	2026	2027
HIV Prevention landscape assessment baseline and periodic reports	HMIS & Research	19.82	20.62	22.01
Strategy 2: Adopt a Precision Prevention Approach Focussed on Key, Vulnerable and Priority Populations Including Differentiated National 2025 Prevention Targets	Prevention: (eMTCT, PrEP, Blood Safety)	41.68	48.25	55.04
	Prevention: (Condoms, STIs, SBC & VMMC adult)	22.37	25.49	30.46
	Prevention: (AGYW/ABYM)	12.91	16.03	18.00
	VMMC for ABYM	0.12	0.11	0.09
	Prevention: Key Populations	43.34	48.71	53.84
Strategy 3: Determine Country Investment Needs for Adequately Scaled HIV Prevention Responses and Ensure Sustainable Financing	Finance and Sustainability	2.48	2.58	2.75
Strategy 4: Reinforce HIV Prevention Leadership Entities for Multisectoral Collaboration, Oversight and Management of Prevention Responses	CE: Prog. Governance, Policy & Coordination	64.42	67.01	71.54
Strategy 5: Strengthen and Expand Community-Led HIV Prevention Services and Set Up Social Contracting Mechanisms	CE: Community Systems Strengthening (CSS)	9.91	10.31	11.01
Strategy 6: Remove Social and Legal Barriers to HIV Prevention Services for Key and Priority Populations	Prevention: Key Populations	43.34	48.71	53.84
Strategy 7: Promote the Integration of HIV Prevention into Essential Related Services to Improve HIV Outcomes	Critical Enablers (excl. Governance & Procurement)	126.36	131.43	140.32
Strategy 8: Set Up Mechanisms for the Rapid Introduction of New HIV	CE: Laboratory Systems and Equipment	14.87	15.46	16.51

PRM Strategic Inventions	NASF Budget Line	NASF Budget Amounts		
		2025	2026	2027
Prevention Technologies and Programme Innovations				
Strategy 9: Establish Real-Time Prevention Programme Monitoring Systems with Regular Reporting	HMIS & Research	19.82	20.62	22.01
4.10. Strategy 10: Strengthen Accountability of All Stakeholders for Progress in HIV Prevention	CE: Prog. Governance, Policy & Coordination	12.6	13.1	14.0

Annexes

Annex 1: Commitments of the 2021 Political Declaration on HIV and AIDS

1. **Ending inequalities:** Take urgent and transformative action to end the social, economic, racial and gender inequalities that perpetuate the HIV pandemic.
2. **Equitable outcomes and granular targets:** Achieve HIV combination prevention, testing and treatment targets across relevant demographics, populations and geographical settings.
3. **Prioritised combination HIV prevention:** Prioritise comprehensive packages of HIV prevention services and ensure they are available and used by 95 per cent of people at risk of HIV infection.
4. **Key populations:** Act on the recognition that key populations—including gay men and other men who have sex with men, people who inject drugs, sex workers, transgender people and people in prisons and other closed settings—are at high risk of HIV infection.
5. **New HIV cascade:** Reach the new 95–95–95 testing, treatment and viral suppression targets across all demographics, populations and geographical settings.
6. **Undetectable = Untransmittable (U = U):** Recognise that viral suppression through antiretroviral therapy is a powerful component of combination HIV prevention (since people living with HIV who have undetectable viral loads cannot transmit the infection to others).
7. **Elimination of new HIV infections in children:** Ensure that 95 per cent of pregnant and breastfeeding women have access to combination HIV prevention, antenatal testing and retesting; 95 per cent of women living with HIV achieve and sustain viral suppression before delivery and during breastfeeding; and 95 per cent of HIV-exposed children are tested within two months of birth and, if HIV positive, receive optimised treatment.
8. **Fully fund the HIV response:** Invest US\$ 29 billion annually in low- and middle-income countries, including at least US\$ 3.1 billion for societal enablers.
9. **10–10–10 targets for societal enablers:** Reduce to less than 10 per cent the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence. Ensure that less than 10 per cent of countries have restrictive legal and policy environments that lead to the denial or limitation of access to HIV services. Ensure that less than 10 per cent of people living with, at risk of and affected by HIV experience stigma and discrimination.
10. **Sexual and reproductive health:** Ensure that 95 per cent of women and girls of reproductive age have their HIV and sexual and reproductive health care service needs met.
11. **Access to affordable medicines, diagnostics, vaccines and health technologies:** Ensure the global accessibility, availability and affordability of safe, effective and

quality assured medicines and other health technologies for preventing, diagnosing and treating HIV infection and its coinfections and comorbidities.

12. **Service integration:** Invest in health and social protection systems to provide 90 per cent of people living with, at risk of and affected by HIV with people-centred and context specific integrated services.
13. **Community leadership, service delivery and monitoring:** Increase the proportion of community-led HIV services to achieve 30– 60–80 targets⁷ and ensure relevant networks and organisations are sustainably financed, participate in decision-making and can generate data through community monitoring and research.
14. **GIPA:** Uphold the Greater Involvement of People Living with or Affected by HIV principle.:

Annex 2: Accountability framework

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
		Scale up of combination HIV prevention						
Scale Up of combination HIV Prevention interventions	Scale up intensive behavioural change communication targeting adolescents and KPs.	X	X		X	X	X	MoH & NAC
	Integrate HIV education in school curricular and extracurricular activities especially colleges and universities – accredited HIV/SRH/Life skills course	X	X		X	X	X	MoE, Curriculum Development Centre (CDC), NAC, MoH, Ministry of Youth Sport & Arts (MOYSA) & Partners
	Train the media and programme people and scale up the use of mainstream, social media and digital application for HIV behavioural change communication targeting youth and KP	X	X		X	X	X	MoH, NAC, CSOs & Media Institute of Southern Africa (MISA)-Zambia
	Scale up Bio-medical HIV prevention interventions (Condom, PrEP, PEP, U=U, VMMC, STIs treatment, IP and blood screening)	X	X		X	X	X	MoH
	Develop national guidelines on harm reduction and opioid substitution therapy, train providers and programme people, engage experienced partners to implement needle syringe social marketing and re-innovate health facilities mental health programmes to introduce opioid substitution therapy, treatment of overdose and PWID rehabilitation	X	X		X	X		MoH, NAC, DEC, GF, UNODC, KP Consortium.

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
	Disseminate U=U communication strategy, standard messages and materials.	X	X	X	X	X		MoH, NAC, PEPFAR, UNAIDS, WHO.
	Conduct promotion and creative communication through mainstream, print and social media on PrEP, U=U and HIV prevention.	X	X	X	X	X		MoH, NAC, Media and ZAMHEALTH, USAID.
	Strengthen the STIs programme with training of providers, better availability of treatment kits and partner notification.	X	X	X	X	X	X	MoH, CSOs
Expand HIV service delivery models and integration	Expand KP health facilities to all the 10 provinces.	X	X	X	X	X	X	MoH, NAC, GF, PEPFAR & CSOs
	Make the general HIV services friendly to KPs, adolescents and PLHIV.	X	X	X	X	X	X	MoH, PEPFAR, USAID
	Establish standard peer service providers service in all the 10 provinces.	X	X	X	X	X	X	MoH, NAC, WHO, PEFAR & CSOs
	Integrate HIV behavioural and biomedical services in health programmes of workplaces, correctional services and schools and universities.	X	X	X	X	X	X	MoH, MoE, CSOs
	Mainstream HIV prevention in the strategic sectors core functions and mandates (assign staff, budget, implement and monitor HIV prevention).	X	X	X	X	X	X	MoH, NAC,
	Conduct KP size estimates.	X	X	X	X	X	X	NAC, MoH and KP Consortium

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
Mapping and identification of KPs.	Train providers and programme staff on KP size estimates.	X	X	X	X	X	X	NAC, MoH, PEPFAR and KP Consortium
	Document and expand best practices and lessons on mapping, identification and targeting of KPs.	X	X	X	X	X	X	NAC, MoH, PEPFAR and KP Consortium
		Addressing the social and legal barriers						
Fighting stigma and discrimination	Conduct policy advocacy and issue a solid legal framework to mitigate stigma and discrimination.	X	X	X	X	X	X	NZP+, TALC, NAC and MoH
	Conduct community education and advocacy through religious and community leaders, electronic media (radio-TV) and social media and print media to reduce /fight stigma and discrimination.	X	X	X	X	X	X	BBC Media, NAC, SAT Zambia, MoH.
Addressing legal and policy barriers	Revise the HIV/AIDS policy of 2005, disseminate the revised policy and orient programme staff.	X	X	X	X	X	X	MoH, NAC, UNAIDS & Cabinet.
	Conduct policy advocacy to address the legal and policy barriers to HIV prevention services to KPs.	X	X	X	X	X	X	MoH, MoJ, NAC, UNODC and CSOs
	Support familiarisation and implementation of revised legal and policy frameworks.	X	X	X	X	X	X	MoH, MoJ, NAC, & CSOs

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
Strengthen HIV response in Emergency and Humanitarian context	Establish national and provincial committees for HIV response in Emergency and Humanitarian Context.	X	X	X	X	X	X	MoH, NAC, DMMU
	Develop a national guideline for HIV Response in Emergency and Humanitarian Context.	X	X	X	X	X	X	MoH, NAC, UNFPA, DMMU.
	Mobilise and implement HIV Response in Emergency and Humanitarian Context	X	X	X	X	X	X	MoH, NAC, UNFPA, DMMU
		Community-led services delivery and monitoring						
Organising communities	Support KPs to be organised in informal support groups and formal associations (finance, material, office and technical support).	X	X	X	X	X		MoH, partners and CSOs
	Train PLHIV and KPP support groups and associations on leadership, organisational management and HIV prevention.	X	X	X	X	X	X	MoH, partners and CSOs
Community led service delivery	Fund HIV prevention services delivered by PLHIV and KPs led organisations through social contracting arrangements.	X	X	X	X	X	X	MoH, NAC, PEPFAR, NZP+ & KP Consortium
	Audit and monitor proportion of community-led HIV testing, HIV prevention and social enabler services.	X	X	X	X	X	X	MoH, NAC, PEPFAR, NZP+ & KP Consortium

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
Community-led monitoring	Establish national and regional task force for community-led monitoring.	X	X	X	X	X	X	MoH, NAC, PEPFAR, NZP+ & KP Consortium
	Develop national guidelines and tools for community-led monitoring.	X	X	X	X	X	X	MoH, NAC, PEPFAR, NZP+ & KP Consortium
	Implement community-led monitoring of community and facility-based HIV service performance and quality.	X	X	X	X	X	X	MoH, NAC, PEPFAR, NZP+ & KP Consortium
		HIV Prevention commodity and Adoption of innovation and technology						
Ensure there is HIV Commodity including condom	Establish technical working groups for condom and HIV commodity at subnational level.	X						MoH & NAC
	Train programme staff on the national condom strategy.	X	X					MoH, NAC, CSOs, AHF, CHAZ, GF
	Ensure that there is continued quality supply of condom and HIV commodity at all levels.	X	X		X		X	MoH, CSOs, ZAMMSA, Local Authorities, NAC.
Ensure timely adoption of technology and innovation	The national technical working group for condom and HIV commodity continuously monitor, evaluate and adopt new technologies and innovations on HIV prevention.	X	X		X		X	MoH, NAC, UNFPA, UNAIDS, WHO, ZAMMSA, CSOs
	Scale up the use of social media and digital applications for HIV prevention training, education and communication.	X	X		X			MoH, Media, NAC, UNICEF & ZICTA.

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
		Leadership and accountability						
	Ensure that there is adequate number and skill mix of staff at the MoH, NAC, ZAMMSA & CSOs.	X	X		X		X	MoH & strategic sectors
	Develop, print and distribute national policy, strategy, service delivery guidelines and SoPs.	X	X	X	X	X	X	MoH, NAC, PEPFAR, GF
	Train programme staff and service providers on the national HIV policy, NASF 2023-2027, HIV Prevention Roadmap 2025-2030.	X	X	X	X	X	X	MoH, NAC, CSOs
		Real time monitoring						
	Train and orient provincial health offices and health posts on their role on collection and reporting of data on community and sectors HIV response together with PACAs and DACAs.	X	X	X	X	X	X	MoH, NAC, Ministry of Local Government and Rural Development, CSOS
	Conduct quarterly provincial review meetings.	X	X	X	X	X	X	MoH, NAC, CSO, UNAIDS, WHO, UNFPA
	Conduct IBBS for KPs.		X	X	X		X	NAC, MoH, KP Consortium
	Conduct annual national and sub-national HIV prevalence and incidence estimates.	X	X	X	X	X	X	NAC, MoH
	Conduct case-based HIV surveillance.	X	X	X	X	X	X	MoH, NAC, CSOs

Action Area	Intervention	2025	2026	2027	2028	2029	2030	Responsible stakeholder
	Conduct ART drug resistance surveillance.	X	X	X	X	X	X	MoH, WHO, NAC
	Conduct STIs surveillance.	X	X	X	X	X	X	MoH
	Manage and produce annual laboratory Management Information system reports.	X	X	X	X	X	X	ZAMMSA
	Manage and produce annual Logistics management information system reports.	X	X	X	X	X	X	ZAMMSA
		Sustainable HIV financing						
Ensure that HIV prevention is fully funded	Assign adequate staff with appropriate skill mix at MoH, NAC, CDC for domestic resource mobilisation.	X	X	X	X	X	X	MoH
	Build capacity of staff at MoH, NAC and CSOs on grant making.	X	X	X	X	X	X	MoH, NAC, CSOs, GF and Partners
	Make effective grant for GF, UN and other donors, utilise and report on funds	X	X	X	X	X	X	MoH, NAC, CHAZ, CSOs, PEPFAR

Annex 3: HIV Prevention Results Framework

Level	Indicator*	Disaggregation	Baseline (2022)	Source	2026	2027	2028	2029	2030
Impact	Per cent and Number of new HIV infections.	All age and sex	28,000	ZAMPHIA	25,000	20,000	19,000	18,000	15,000
		Children (0-14)	4,500	Spectrum	4,000	3,500	2,500	2,000	1,500
	Percentage of people living with HIV (Prevalence)	General Population	11%	ZAMPHIA	10.9%	10.8%	10%	10%	10%
		MSM	21%	John Hopkins	20%	19%	18%	17%	16.8%
		FSW	40%	John Hopkins	39%	38%	37%	35%	34.8%
		PWID	15%	John Hopkins	14.5%	14%	13%	12%	11.9%
		Transgender	22%	John Hopkins	21%	20%	19%	18%	17.8%
		Inmates	20.9%	Prison Assessment report	20%	19%	18%	18%	17.9%
	Number of AIDS-related deaths	All Ages	20,000	Spectrum	19,000	18,000	17,000	16,000	15,000
Outcome	Percentage of people living with HIV and on ART who are virologically suppressed	Adults 15-49	96.44%	MoH	97%	98%	98.1%	98%	97%
		Children 0-14	64%	MoH	70%	75%	85%	90%	91%

Level	Indicator*	Disaggregation	Baseline (2022)	Source	2026	2027	2028	2029	2030
Outcome	Percentage of women and men aged 15-49 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Adults (15 – 49): Male	57.7%	ZDHS, 2018	50%	45%	40%	39%	38%
		Adults (15 – 49): Female	52.1%	ZDHS, 2018	51%	50%	49%	48%	47%
		Young People (15 – 24): Male	48%	ZDHS, 2018	47%	46%	45%	44%	43%
		Young People (15 – 24): Female	51.3%	ZDHS, 2018	50%	49%	48%	47%	46%
Outcome	Percentage of 15-24 who have sex before age 15	Males	13%	ZDHS, 2018	12%	11%	10%	10%	9%
		Females	15.9%	ZDHS, 2018	15%	14%	13%	12%	11%
Coverage	Per cent of HIV HWCs trained on KP sensitivity	All	-	-	15%	35%	55%	75%	95%
Coverage	% 15 – 24 reached with HIV prevention programmes during the last 12 months (e.g. school and out of school Peer or life skills education)	All	305,395	Global Fund	632,215	734,424	921,761	930,221	931,742
Coverage	Number of adolescents and	All	305,395	Global Fund	2,763,519	3,352,387	3,941,284	3,952,212	3,960,113

Level	Indicator*	Disaggregation	Baseline (2022)	Source	2026	2027	2028	2029	2030
	youth reached with school and out of school prevention programmes (Millions)								
Coverage	# of males aged 15-49 circumcised	#of young men 15 – 29	45,321	MoH	46,913	38,8301	37,361	36,732	35,227
		%Adult men 15-49 medically circumcised	32%	MoH	57%	68%	75%	80%	85%
	Number of medically circumcised Men 10+ years	10+ Years	83,207	MoH	85,604	73,392	70,312	66,142	60,732
Outcome	% of people who used condoms during their last high-risk sex act the last 12 months.	Adults (15-49): Females	55.5%	ZDHS, 2018	60%	70.5%	85%	90%	95%
		Adults (15-49): Male	46.6%	ZDHS, 2018	50%	65%	75%	80%	85%
Coverage	Number of male and female condoms distributed annually	Male Condoms	98,542,452	ZAMMSA	148,326,869	170,931,997	193,537,125	216,537,321	238,533,740
		Female Condoms	574,513	ZAMMSA	751,039	811,423	843,495	951,452	1,413,203
Coverage	Number of eligible people who initiated oral PrEP during	All	152,940	PEPFAR	350,531	571,112	730,210	861,774	990,837

Level	Indicator*	Disaggregation	Baseline (2022)	Source	2026	2027	2028	2029	2030
	the reporting period								
Coverage	% of HIV Programme (NSP) Budget funded from domestic sources	ALL	10%	NASA	14%	15.6%	16%	18%	20%

*A more comprehensive results framework will be developed separately and will cover information for 2025 as well as a comprehensive set of indicators including number of personnel trained in KP sensitivity, number of staff trained in data entry for HIV prevention and number of HIV testing for the various populations.

Annex 4: VMMC coverage among males aged 15-49 years

Province	2023	2024	2025	2026	2027
Central	49552	49540	49578	57015	65567
Copperbelt	90054	90413	90808	104429	120094
Eastern	75342	76255	77207	88788	102106
Luapula	44753	44446	44204	50835	58460
Lusaka	113253	113744	114263	131402	151113
Muchinga	34702	35307	35929	41318	47516
Northwestern	14369	14538	14729	16938	19479
Northern	33035	33232	33484	38507	44283
Southern	77492	77774	78085	89798	103267
Western	38609	39278	39997	45997	52896

Source: MoH VMMC Program Targets 2023

Annex 5: Estimated Condoms requirements for full pipeline 2023

Products	GFATM	Govt	GAP	UNFPA	USAID	Grand Total
Female Condom (Nitrile) Lubricated 17 cm 1 Each			\$ 345,030			\$ 345,030
Male Condom (Latex) Lubricated No Logo 53 mm 1 Each	\$ 1,577,744	\$ 1,000,008	\$ 2,508,598	\$ 1,000,000	\$ 1,380,174	\$ 7,466,523
Grand Total	\$ 1,577,744	\$ 1,000,008	\$ 2,853,628	\$ 1,000,000	\$ 1,380,174	\$ 7,811,554

CONDOMS						
Planning Unit	Client Need 2023	Stock required to end at the desired inventory level	Total Need	Expected Closing stock (Dec 2022)	Full pipeline Quantity 2023	Total Cost (USD)
Female Condom (Nitrile) Lubricated 17 cm 1 Each	372,443	186,222	558,665	74,487	484,178	\$ 345,030
Male Condom (Latex) Lubricated No Logo 53 mm 1 Each	148,326,869	74,163,435	222,490,304	32,374,733	190,115,571	\$ 7,466,523
Amount required for full pipeline 2023						\$ 7,811,554

Zambia	Size of population in 2020	Size of Population in 2025	Baseline Coverage (% condom use at last sex)	Target Coverage in 2025	Annual No. of Sex Acts Requiring Protection	Wastage	BASELINE: Total Condoms Used (based on Consumption Data)	Total Condoms Required in 2021	Total Condoms Required in 2022	Total Condoms Required in 2023	Total Condoms Required in 2024	Total Condoms Required in 2025	% of Total Condoms Required in 2025	
								2020	2021	2022	2023	2024		2025
								2020	2021	2022	2023	2024		2025
Key Populations														
PLHIV Couples	318,205	370,864	40.0%	75%	100	20.0%	15,273,840	18,894,630	22,515,421	26,136,211	29,757,001	33,377,792	18%	
Sex workers	126,000	144,942	56.0%	90%	450	20.0%	38,102,400	44,570,242	51,038,084	57,505,926	63,973,768	70,441,610	39%	
Men Having Sex with Men (MSM)	6,500	7,477	55.0%	75%	100	20.0%	429,000	477,789	526,577	575,366	624,154	672,943	0%	
People who have Sex with Non-Regular Partners [PAIRS]														
Young People (15-24) with NR Partners	675,959	777,576	41.2%	75%	50	20.0%	16,707,161	20,363,912	24,020,663	27,677,415	31,334,166	34,990,917	19%	
Men&Women (25-34) with NR Partners (pairs)	347,157	399,345	48.9%	75%	50	20.0%	10,177,295	11,735,942	13,294,589	14,853,236	16,411,883	17,970,530	10%	
Men&Women (35-49) with NR Partners	201,242	231,495	43.2%	75%	50	20.0%	5,218,477	6,258,234	7,297,991	8,337,748	9,377,505	10,417,262	6%	
Men&Women (50-64) with NR Partners	57,276	65,886	32.4%	75%	50	20.0%	1,112,326	1,482,837	1,853,349	2,223,860	2,594,372	2,964,884	2%	
Couples Using Condoms for Family Planning														
Couples Using Condoms for FP	1,058,557	1,217,690	3.0%	3.0%	100	20.0%	3,810,805	3,925,381	4,039,957	4,154,532	4,269,108	4,383,684	2%	
Couples With Unmet Need for FP Condoms	485,172	558,108	0.0%	3.0%	100	20.0%	0	401,838	803,675	1,205,513	1,607,351	2,009,188	1%	
Other Key Populations and Populations at High Risk														
People who Inject Drugs (PWID)	26,800	30,829	40.0%	75%	100	20.0%	1,286,400	1,584,039	1,881,678	2,179,318	2,476,957	2,774,596	2%	
Transgender (TG)	4,000	4,601	45.0%	75%	100	20.0%	216,000	255,624	295,248	334,871	374,495	414,119	0%	
Prisoners	20,800	23,927	0.0%	75%	100	20.0%	0	430,684	861,367	1,292,051	1,722,734	2,153,418	1%	
Other [Please Specify]:	0	0	0.0%	75%	100	20.0%	0	0	0	0	0	0	0%	
Overall Total: Country Target							92,333,704	110,381,152	128,428,600	146,476,047	164,523,495	182,570,943		
Annual Increase in Condom Requirement (%)							100%	120%	139%	159%	178%	198%		
Avg nbr of condoms needed per adult men 15-64y per year							20.3	23.6	26.8	29.7	32.6	35.3		

Comparison of Different Scenarios	BASELINE					
	2020	2021	2022	2023	2024	2025
Country Targets	92,333,704	110,381,152	128,428,600	146,476,047	164,523,495	182,570,943
60% Condom Use Target	96,613,781	108,594,263	120,574,744	132,555,226	144,535,708	156,516,189
90% Condom Use Target	96,613,781	120,149,188	143,684,595	167,220,002	190,755,409	214,290,815
100% Condom Use / Total Need (No Wastage)	80,511,484	103,116,612	125,721,741	148,326,869	170,931,997	193,537,125

Funding Gap Analysis for condoms Source: CNET, V5 Zambia

Annex 6: List of stakeholders consulted.

#	Name	Organisation
1	Violet Mongeza	NAC
2	Charlotte Mvula	LCC
3	Wankumbu Simukonda	CRZ
4	Phiri Jason	AHF
5	Masitano Chilembo	CHAI
6	Chimika Phiri	MOH
7	Gezepi Chakulunta	MHAIS
8	Charity Banda	MIETAFRICA
9	Mercy K Moyo	CWR
10	Henry Sakala	LATU
11	Lucas Msimuko	MKHF
12	Mweete Nglazi	NAC/UNAIDS
13	Mable Mweemba Musheke	MOH
14	Annie Tembo	MHAIS
16	Mclean Kabwe	TLI
17	Maurice Musheke	CIDRZ
19	James Zulu	CIDRZ
20	Joseph Simbaya	Consultant
21	Peter Ndemena	NAC
22	Laston Chitembo	WHO
23	Florence Hamahwa	UNAIDS
24	Liness Mwambanabantu	MHAIS
25	Oswald Chisenga	PYA
26	Estella Mbewe	NZP+
27	Katongo Mumbi Silwizya	NAC
28	Eunice Masi	NAC
29	Maxwell Kasonde	MOH
30	Ackim Kanyika	MOE
31	Andrew Chanda	NAC
32	Rita Chilambu Kalamatila	NAC
33	Jean Simalonda	NAC
34	Lubasi Sundano	MOH
35	Bupe Musonda	MOH

#	Name	Organisation
36	Godwill Silupya	NAC
37	Florence Mulenga	FHI 360
38	Melayi Mhango Mwale	ZAMMSA
39	Natasha Ivy	TBZ
40	Kunyima Banda	TALC
41	Yvonne Shimete	PREO
42	Paul Daka	UNFPA
43	Jane Theu	EHF
44	Munyaradzi Kadimba	PYA
45	Paul Moonga	UNZA
46	joseph Yowera	IOM
47	Remmy Mukonka	UNESCO
48	John Mwale	UNAIDS
49	Robert Banda	UNICEF
50	Trevor Mwamba	CHAI
51	Mercy Luwi Kasoka	UNFPA
52	Caroline Olwande	UNAIDS
53	Suiwilanji Sivile	MOH
54	Joy Masheke	UNFPA
55	Alick Samona	CIDRZ
56	Monica Chibesakunda	CIDRZ
57	Mwilu Leonard Mumbi	UNESCO
58	Wycliffe Matende	UNHCR
59	Constance Halooba	PPAZ
60	Idah Mulala	TALC
61	Fortune Chibamba	NAC
62	Chileshe Chilatu	NAC
63	Yakobe Phiri	AHF
64	Tina Chisenga	MOH
65	Arthur M Moonga	Consultant

Annex 7: Reviewed Documents

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