

# Situation Assessment of the HIV Response among Young People in Zambia





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**Population Council**





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# ACRONYMS

|          |   |
|----------|---|
| ART      | Antiretroviral Therapy  |
| ARV      | Antiretroviral  |
| CBO      | Community-based Organization  |
| CCM      | Country Coordinating Mechanism  |
| CSO      | Civil Society Organization  |
| DHS      | Demographic and Health Survey   |
| FBO      | Faith-based Organization  |
| FGD      | Focus Group Discussion  |
| HAART    | Highly Active Antiretroviral Therapy                                  |
| HEART    | Helping Each Act Responsibly Together                                 |
| HTC      | HIV Testing and Counselling   |
| ICT      | Information and Communications Technology                             |
| IEC      | Information, Education, and Communications                            |
| JUNTA    | Joint United Nations Team on AIDS                                     |
| KII      | Key Informant Interview   |
| MARP     | Most-at-Risk Population   |
| MOE      | Ministry of Education   |
| MOH      | Ministry of Health  |
| MOT      | Modes of Transmission   |
| MOYSCD   | Ministry of Sports, Youth and Child Development                       |
| NAC      | National AIDS Council   |
| NAP-WGHA | National Action Plan on Women, Girls and HIV/AIDS                     |
| NASF     | National AIDS Strategic Framework                                     |
| NGO      | Non-governmental Organization   |
| OVC      | Orphans and Vulnerable Children                                       |
| PEPFAR   | President's Emergency Plan for AIDS Relief                            |
| PLHIV    | People Living with HIV  |
| PMTCT    | Prevention of Mother-to-Child Transmission                            |
| PR       | Principal Recipient   |
| RAPIDS   | Reaching AIDS Affected People with Integrated Development and Support |
| SRH      | Sexual and Reproductive Health  |
| STI      | Sexually Transmitted Infection  |
| SWOT     | Strengths, Weaknesses, Opportunities, Threats                         |
| UNAIDS   | United Nations Joint Programme for HIV/AIDS                           |
| UNESCO   | United Nations Educational, Scientific and Cultural Organization      |
| UNFPA    | United Nations Population Fund  |
| UNGASS   | United Nations General Assembly Session on AIDS                       |
| UNICEF   | United Nations Children's Fund  |

|       |  |
|-------|--|
| USAID | United States Agency for International Development |
| WLSA  | Women and Law in Southern Africa                   |
| YMCA  | Young Men Christian Association                    |
| ZDHS  | Zambia Demographic and Health Survey               |
| ZSBS  | Zambia Sexual Behavior Survey                      |



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# EXECUTIVE SUMMARY

## Overall Objective

The main objective of this situational assessment is to compile and synthesize existing recent information on HIV and young people together with the current AIDS response for young people in Zambia, including programmes, policies, and key partners, and to document gaps and challenges in the response. In this document young people refers to individuals aged 10 to 24 years.

## Methodology

A literature review examined the existing recent epidemiological data, policy, legal documents, and frameworks, and the status of programmes addressing the HIV epidemic among young people. It also set up the baseline for the “bold results”<sup>1</sup> within the United Nations Joint Programme for HIV/AIDS (UNAIDS) Business Case for the priority area on young people.

Key informant interviews (KIIs) were conducted with officials from the following groups of stakeholders in Zambia: Government Line ministries, United Nations agencies, and civil society including,

One female and one male focus group discussion (FGD) were conducted in Lusaka, the capital city, and one female and one male FGD were conducted in Chongwe, a semi-rural community located 48 kilometers from Lusaka. Two young women and two young men selected by the National AIDS Council (NAC) were recruited and trained by the consultants to conduct the FGDs, record the proceedings and transcribe them into Microsoft Word documents which were then analyzed by the consultants.

## Findings

### *HIV among young people in Zambia*

Young people in Zambia, especially women, are highly vulnerable to HIV because of poor comprehensive knowledge of HIV; gender inequality and poverty, and the related behaviors of transactional and intergenerational sex; early marriage; alcohol use; peer pressure; and negative gatekeeper attitudes towards condom promotion among young people. HIV prevalence remains high among young people especially in urban areas and among low educated young women and young uncircumcised men. However, there was a trend of decreasing HIV prevalence between 1994 and 2006 among young women that is linked with delayed sexual debut and reduction in number of sexual partners. There is no evidence of reduction in HIV prevalence among young men, or improvement in condom use.

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<sup>1</sup> UNAIDS has applied the business case approach to 10 priority areas including young people. The business cases delineate what is currently working and what needs to change in order to make headway in the 10 areas. The business cases are intended to guide future investment and to hold UNAIDS accountable for its role in achieving tangible results. Each priority area business case presents three bold results to be achieved globally by 2011 (UNAIDS 2010). The three bold results in the area of young people are discussed later in this report in Country Baseline (Levels) and Future Targets for Key Comprehensive Services on page 56.

## ***Legal and policy framework***

### **Legal framework for the HIV response among young people**

The HIV response in Zambia is well enshrined in the Zambian constitution and laws and international conventions to which Zambia is a signatory and in general is conducive to a rights-based approach to HIV programming among young people. However, the current laws have gaps in terms of being unspecific to HIV status with regard to prohibiting discrimination. In addition, there are laws that are repressive toward most-at-risk populations (MARPs), such as sex workers, thus making it difficult for them to be reached with public health programmes and services; young people comprise large proportions of such populations.

### **Policy framework**

The relevant policies in Zambia highlight the importance of HIV prevention among young people. However, they do not highlight the specific needs of young people living with HIV nor the needs of the younger young people aged 10–14. Further, although some young people participated in the formulation of these policies, young people at the grassroots level were not sufficiently involved in their formulation and have not been involved in the dissemination of these policies.

## ***Governmental response to HIV among young people***

### **National coordination structures**

The NAC coordinates the AIDS response through self-coordinating groups of: donors, private sector, public sector, and civil society that work closely with the Director General of NAC. Young people are represented in the self-coordinating group of civil society. At the provincial and district levels the coordination structures are the Provincial AIDS Task Force and the District AIDS Task Force, where young people and civil society organizations (CSO) are represented. However, it is not documented how many young people sit on these committees and what effort is taken to ensure that they are representative of young people in Zambia. Challenges in coordination include: insufficient involvement of young people in planning and coordination of youth HIV activities such as information dissemination; a lack of defined target populations or communities for the various actors leading to poor coverage of rural areas; and a limited functionality of some of the national coordination structures such as the Adolescent Health Technical Working Group.

### **National strategies and action plans**

The activities of the HIV response in Zambia are guided by the National AIDS Strategic Framework (NASF) 2011–2015 (NAC 2010a) supported by the National Action Plan on Women, Girls and HIV/AIDS (NAP-WGHA). The NASF has highlighted HIV prevention among young people as a key priority and the NAP-WGHA highlights the importance of protecting the rights of girls and empowering them to protect themselves from HIV. However, the NASF lacks a specific strategy on care and support for young people living with HIV. There is also lack of a clear link between the HIV response and strategies for economic empowerment, especially of women and girls.

## ***Technical support agencies***

**The vast majority of funding for the AIDS response is from external donors.**

A good proportion of the funding is provided by the Global Fund to Fight AIDS, TB and Malaria to the national government. Technical and financial support for HIV programming in general is provided by donor countries through international and national non-governmental organizations (NGOs) which in turn provide funding to community level community-based organizations (CBOs), faith-based organizations (FBOs) and youth groups that are directly involved in service delivery. The financing and technical support is within the framework of the NASF and other national guidelines which provide policy and technical guidance. UN agencies support the HIV response by working with the government to provide technical support to government ministries as well as other stakeholders including young people (through the Youth Forum and Youth Networks).

## ***Current programmatic response to HIV among young people***

The programmatic response to HIV among young people in Zambia comprises the following, broad programmes which are all within the area of prevention:

1. ***Schools are providing life skills-based HIV education.*** Some NGOs are working with the education sector to support life skills education in the classroom as well as through anti-AIDS clubs. It is generally agreed that schools remain the best channel to reach the vast majority of young people with HIV and sexuality education since the traditional approach of teaching about sex through grandparents is not applicable to many families.
2. ***Youth peer education is a widely used approach.*** Peer education has been used to reach young people in various locations including schools, health centers, communities, and other locations where young people congregate. Youth peer educators can be trained to provide education, counselling, and services and can be vital in referring young people to seek services. Evaluation data is scarce but the one study with outcome data (Svenson, Burke, and Johnson 2008) has shown that peer education increases uptake of youth friendly health services and increases HIV knowledge and condom use among young people.
3. ***Multi-media are a major approach used in Zambia to reach young people.*** Multi-media include TV and radio broadcasting, interactive radio, information and communications technology (ICT) as well as mobile phones. Use of ICT and mobile phones has not been evaluated and yet they have great potential to attract more young people.
4. ***Edu-sports and theatre provided by NGOs and CBOs are targeting young people and the general public.*** They have the advantage of enabling young people to be involved in delivering the activity while simultaneously receiving information. The other advantage is that in communities where there is very little entertainment for young people, sports and dramas find a ready void to fill. However, the number of young people being reached by these services has largely not been documented and the evaluation of their impact is still limited.
5. ***Abstinence-only campaigns are being conducted mainly by FBOs.*** The campaigns target all young people, but with special emphasis on younger youth who have not yet started sex. However, there is a paucity of data evaluating these programmes to determine their effectiveness.
6. ***Youth friendly health services are the mainstay of the health sector response to HIV among young people.*** The NASF 2011–15 calls for the establishment of youth friendly

services in health facilities in the country. Peer educators/counselors are an integral component of these services as they can provide a number of adolescent sexual and reproductive health (SRH) services once they receive the appropriate training and supervision. HIV testing and counselling (HTC) is promoted through youth friendly health services and the vast majority of young people are aware of where to seek HTC. Family support is important for young people to make decisions to seek HTC. Although young people prefer friends and peers, as opposed to family, to accompany them to HTC, young people tend to disclose their HIV status to family rather than sexual partners. Many young women appear to be accessing HTC through prevention of mother-to-child transmission (PMTCT) when they become pregnant.

### ***Gaps identified in current HIV programmes for young people***

- Gaps in content of HIV programmes for young people in Zambia included:
  - Lack of emphasis on vocational skills.
  - Lack of consensus in messaging about condoms use versus abstinence-only, which is confusing to young people.
  - Messages and messengers are not sensitive to the needs of the female audience.
- Specific gaps in content of life skills education:
  - Teachers of HIV and life skills education do not sufficiently cover condoms, sexuality, and love issues.
  - The curriculum for life skills education is deficient on sexuality issues.
  - Parents are not sufficiently empowered to address sexuality issues of their children.
  - Anti-AIDS clubs do not sufficiently address girls' information needs.
  - Current messaging is not sufficiently grounded in research evidence.
- Gaps in strategy and approach of HIV programmes for young people in Zambia:
  - There is insufficient gender segregation in HIV programmes for young people.
  - Current HIV education approaches are indirect and tend to avoid the issues.
  - There is limited involvement of young people in programme design and implementation.
  - There is insufficient effort at targeting of sub-groups of young people.
- Gaps in coverage and access of HIV programmes for young people in Zambia:
  - Insufficient coverage especially in rural areas.
  - Coverage limited by demand due to young people's lack of awareness of services.
  - Coverage limited by supply type service-site related barriers.
  - Health workers' attitudes and knowledge relating to young people's sexuality.
  - Lack of adequate resources.
- Gaps in meeting the needs of HIV-positive young people:
  - Young people living with HIV experience stigma that is different from adults with HIV and yet they are expected to seek care with adults.
  - Young people living with HIV have sexuality issues that are not addressed by current services.

- A major and overarching gap is the lack of systematic monitoring and evaluation of programmes.

### ***Financing of HIV programmes for young people***

There is no ready source of information about specific funding for HIV programmes for young people. The information available is for HIV activities that target young people together with the general population and are mostly in terms of what is budgeted, and may not reflect what is eventually spent on these activities.

### ***Proposed baselines and targets for the UNAIDS Business Case for the priority area on young people***

The study team has proposed the following baselines and targets based on targets in the NASF 2011–2015 and the data in 2007 Zambia Demographic Health Survey (ZDHS). These figures are tentative pending discussion by a high level advocacy meeting on HIV programmes for young people in Zambia for which this report has been prepared.

- Percent of young people aged 15–24 years with comprehensive knowledge of HIV should increase from the baseline of 37 percent for men and 34 percent for women in the 2007 ZDHS to 80 percent for both men and women in 2015.
- Percent of young single people aged 15–24 years who used a condom at last sex among those who had sex in the past 12 months should increase from the baseline of 47 percent among young men and 39 percent among women in the 2007 ZDHS to 94 percent among young men and 78 percent among young women in 2015.
- Percent of young people aged 15–24 who received an HIV test in the last 12 months and knew their results should increase from the baseline of 10 percent among young men and 17 percent among young women in the 2007 ZDHS to 20 percent among young men and 34 percent among young women in 2015.

## **Conclusions and Recommendations**

This report reflects a self-examination and stocktaking exercise of the HIV response among young people in Zambia. The following recommendations are aimed at further strengthening this response by all stakeholders including the Government of the Republic of Zambia, the UN, faith-based organizations, civil society organizations, donors, young people, and youth led organizations towards “Zero New HIV Infections”, “Zero Discrimination” and “Zero AIDS Related Deaths”.

### ***There is need to amend and strengthen current laws, and create new ones, relating to HIV programming among young people.***

Stakeholders including civil society, the health sector, and parliamentarians should advocate for amendments to be made to the current laws to protect people with HIV from being discriminated against and enable sexually active young people (emancipated minors) to access SRH services without requiring parental consent.

The data reviewed by this assessment suggests that Zambia has supportive laws for young people's HIV programmes but there are a number of key gaps. The current legal framework is not strong enough to prevent discrimination based on HIV status. The law on legal minors is a hindrance to young people seeking sexual and SRH services without parental consent. There is insufficient enforcement of laws that can protect women and girls from gender-based violence. Further, while the Juvenile Act provides protection of children from exploitation, sexual abuse, and human trafficking its implementation remains weak because there are no systems within the community to monitor child welfare and protect children from exploitation.

- Amend current laws to protect people with HIV from being discriminated against and enable sexually active young people (emancipated minors) to access SRH services without requiring parental consent.
- Enforce legislation to protect women and girls from gender-based violence.
- Strengthen structures and systems to implement existing laws, such as the Juvenile Act, that protect children from exploitation, sexual abuse and trafficking.

### ***Young people should be meaningfully involved in HIV policy and programme design and implementation.***

The assessment has shown that structures have been put in place for the involvement of young people. However, the views of young people interviewed in this assessment were that the structures are either non-functional or they do not enable a fair representation of young people across the spectrum especially the rural dwellers. There was also a strong view that organizations led by young people at the community level were not receiving funding and information resources for the implementation of programmes. The findings also indicate that there is limited involvement of young women in the design and communication of HIV messages targeting young women.

- Ensure meaningful engagement and participation of young people in the AIDS response, including policy and programme design.

### ***Young people friendly health services and life skills HIV education are priority programmes for scaling up.***

Based on the data reviewed in this situation analysis a key priority programmes area is the scale up of young people friendly health services to be functional in all public health facilities, as a minimum. Young people friendly health services are a medium for young people to access crucial SRH services including: HIV testing and counselling, PMTCT, treatment of STIs, antenatal care, family planning and condom supply.

- Revitalize the Ministry of Health (MOH) Adolescent Technical Working Group to enable better coordination of SRH services and integration of HIV in SRH.

Another priority programme requiring scale up is life skills HIV education in and out of school. Life skills HIV education will empower young people to make decisions to protect themselves from HIV, STIs, and teenage pregnancy. It is the methodology of teaching that eventually enables young people to have critical thinking skills that help them connect what they learn to their lives.

- Develop a comprehensive evidence-informed package of sexuality education for young people that includes life skills for young people who are both in and out of school.



- Apply methods of communication of messages to young people, especially women that are evidence-informed.
- Strengthen the life skills HIV education curriculum with more lessons about sexuality issues.
- Identify and address concerns of teachers who are presenting sexuality topics.
- Support parents with information and skills to educate young people about HIV.

***A comprehensive package of programme guidelines for addressing HIV among young people should be developed.***

The National Youth Policy provides the following list of key services necessary for HIV programming among young people: STI care; training peer educators; providing antiretrovirals (ARVs); promoting young people friendly services; promoting life skills education; HIV information campaigns using print and electronic media and drama and sports; and providing HTC. Indeed the programmes revealed by this assessment concur with this list. However, the document review did not reveal any guidelines that further elaborate this list into a comprehensive package of HIV programmes for young people in Zambia together with guidelines for implementers.

- Develop a programme package with guidelines for HIV programming for young people basing on the list of key services provided in the National Youth Policy.

***Monitoring, evaluation, and operations research are required.***

There is a general lack of systematic monitoring, evaluation, and feedback and as such young people programme content and strategies are not evidence-informed and do not have proof of effectiveness or outcome. A key issue is the lack of disaggregation of output data by age and sex in the national output data reported to the UN General Assembly Session on AIDS (UNGASS). Without such data it remains difficult for policy makers to determine what proportion of young people are being reached by key services such as PMTCT, HTC, condoms, family planning and ART. Furthermore, the data are also not disaggregated by rural versus urban or by risk group. Thus policy makers are not able to determine service coverage for young people in rural areas compared to urban areas and young people among MARPs such as sex workers.

- Undertake systematic monitoring and evaluation of HIV programmes for young people in order to refine the programmes and feed into advocacy for more resources to be directed into this area.

The current assessment found few reports of formative research prior to the development of young people HIV education programmes. There is also no ready source of information about specific funding for HIV programmes for young people. Rather, the information available is for HIV activities that target young people together with the general population.

- Conduct operational research and socio-behavioral studies and use results to inform programme design.
- Carry out a costing study to determine the cost of HIV programmes for young people as well as the current spending on these programmes in Zambia.



***Approaches to HIV programming for young people should be revised to meet the different needs of young people.***

Overall, the policies, strategies and programmes on HIV prioritize young people as targets for HIV prevention but do not focus on the special care and support needs of young people living with HIV, young people aged 10 to 14 years and young people out of school, as well as the economic needs of young people.

- Revise policies to highlight the special needs of young women, young people living with HIV, young people aged 10–14, and young people out of school.
- Establish links between socioeconomic empowerment of women and the HIV response.
- Integrate vocational skills in HIV programmes for young people.
- Commission a survey to identify priority prevention areas for programmes targeting young people out of school by identifying venues where young people socialize and meet sexual partners. Where possible apply innovative methods such as the Priorities for Local AIDS Control Efforts (PLACE) methodology.

***The United Nations team should play a leading role in supporting the government and its partners to achieve the targets for the UNAIDS Business Case for young people.***

The Joint United Nations Team on AIDS (JUNTA) in Zambia is strategically placed to work with the government of Zambia through NAC and key ministries to provide technical assistance to strengthen actions that can empower young people to protect themselves from HIV.

Specifically the UN team should work with the government to:

- Strengthen the capacity to provide strategic information by supporting the collection, analysis, and dissemination of data necessary to support HIV and SRH programmes, policies, and advocacy. This report is one of the first steps towards this goal. This report will be discussed at a high level policy meeting during which the proposed UNAIDS business case targets will be reviewed by national stakeholders and considered for adoption as national targets.
- Provide technical guidance to strengthen the delivery of HIV and SRH services to increase young people's access to rights-based information and services.
- Promote a supportive legal and policy environment for the implementation of evidence-informed prevention and care service for HIV among young people.

These actions should be aimed to enable a range of actors to maximize their contributions to an expanded response for achieving the UNAIDS business case targets for young people in Zambia.

# INTRODUCTION

## Problem Statement and Rationale

One in three Zambians is a young person. The 2007 Zambia Demographic and Health Survey (ZDHS) showed that 32 percent of the household population was aged 10–24, with 15 percent aged 10–14, 9 percent aged 15–19, and 8 percent aged 20–24. Zambia, like many sub-Saharan countries, has also been heavily affected by HIV and AIDS. According to the 2007 ZDHS, HIV prevalence among those aged 15–49 is 14 percent, and is higher among women (16 percent) than men (12 percent). HIV prevalence is higher among urban dwellers (20 percent) than rural dwellers (10 percent). It also varies by age: among women rising from 6 percent among those aged 15–19, peaking at 26 percent among those aged 30–34, and decreasing to 12 percent among those aged 45–49. Among men, prevalence rises from 4 percent among those aged 15–19, peaks at 24 percent among those aged 40–44, and decreases to 12 percent among those aged 55–59. These data show the urgency for a strengthened response to HIV in Zambia especially among young people.

Synthesized, strategic information on Zambia's response to HIV and AIDS among young people and existing gaps in the response is necessary to inform the implementation of Zambia's new National AIDS Strategic Framework (NASF 2011–2015), which emphasizes prevention of HIV among young people. For example, a number of organizations are working with and for young people, yet it is not clear how well coordinated they are. Lack of clarity about coordination may affect mobilization and utilization of resources. It may further breed duplication of efforts, which are mainly concentrated in the same areas and only minimally reach rural and underserved young people such as those living on the streets, those who are employed, and those engaged in sex work.

## Purpose

This situation assessment compiles, synthesizes, and analyzes existing strategic information on HIV and young people and identifies gaps in the evidence and in the current HIV response. The report of this assessment will be used for high level advocacy and will inform the operationalization of the NSF. This situation analysis was commissioned by the Joint United Nations Team on AIDS (JUNTA) in Zambia and was carried out by the Population Council under the overall guidance of the Zambia National AIDS Council (NAC). United Nations Joint Programme for HIV/AIDS (UNAIDS), Geneva provided technical and financial support for the assessment.

# OBJECTIVES

## General Objective

The main objective of the situation assessment is to compile and synthesize existing, recent data on HIV and young people together with the current AIDS response for young people in Zambia, including programmes, policies, and key partners, and to document gaps and challenges.

## Specific Objectives

1. Review and synthesize the current data on HIV and young people in Zambia and develop a flagship document for use in advocacy and programming;
2. Document the current HIV response including HIV prevention, treatment, care, and support programmes and services for young people;
3. Extract HIV, sexual and reproductive health (SRH), and life skills education programmatic and service gaps disaggregated by age, gender, and location;
4. Extract information on existing policies and frameworks in Zambia that seek to address HIV among young people and document the policy gaps;
5. Identify and document partners and stakeholders that work with young people including their programme/service areas;
6. Identify the gaps and challenges in the coordination of the AIDS response among young people and organizations that work with them;
7. Identify and synthesize organizations and agencies that are currently providing technical support on HIV and young people and identify gaps;
8. Identify and synthesize human resources that are currently working on HIV and young people with a particular focus on government ministries, UN agencies, and key civil society partners in country;
9. Identify and synthesize information on financial resources for Zambia on HIV and young people; and
10. Compile key services/programmes (e.g., comprehensive knowledge, condoms, HIV testing and counselling) for young people in country baselines.

# METHODOLOGY

## Literature Review

A literature review examined the existing policy and legal documents and frameworks, and the progress made in relation to addressing the HIV epidemic for young people. It also set up the baseline for the bold results within the UNAIDS Business Case (UNAIDS 2010) for the priority area on young people. Documents included:

1. Zambia HIV epidemiological and sexual behavioral reports: the Zambia Demographic Health Survey (2007), Zambia Sexual Behavioral Survey (2009), and the Zambia HIV Prevention Response and Modes of Transmission Analysis (2009).
2. Zambia HIV policy and strategy documents: National AIDS Strategic Framework (NASF) 2011–2015 (NAC 2010a); National HIV/AIDS/STI/TB Policy (2005); NAP-WGHA 2006–2010 (GRZ Cabinet Office Gender Division 2007); National Youth Policy (Ministry of Sport, Youth and Child Development [MOSYCD] 2006).
3. Reviews and progress reports relating to the national HIV strategy: Annual Report of National AIDS Strategic Framework 2006–2010 (NAC 2008); Joint Mid-term Review of National AIDS Strategic Framework 2006–2010 (NAC 2009a); Situation Analysis of Adolescent Health in Zambia (MOH 2009); Response Analysis of the National HIV and AIDS Response 2006–2010 (NAC 2010b); Survey of Health Facilities for the Provision of Key HIV Services by the Ministry of Health (MOH) (2006); Zambia HIV/AIDS Service Provision Assessment Survey 2005 (MOH, CSO, and Macro International Inc. 2006); Zambia National Progress Report to the UNGASS for Jan 2008 to Dec 2009 (MOH and NAC 2010).
4. Un-published documents obtained through UNAIDS Zambia including: six UNFPA reports, two United Nations Educational, Scientific and Cultural Organization (UNESCO) reports, and other reports by individual consultants.
5. Papers and abstracts obtained from the International AIDS Society conference abstracts database, MEDLINE and Google searches using the search phrases: Zambia youth HIV/AIDS, Zambia youth friendly health services; Zambia youth peer educators, and Zambia adolescent SRH programmes. Papers or abstracts were included in the review if they had any of the following information relating to HIV among young people: behavioral data, programme output and outcome data, description of programmes, or a critical review of strengths and weaknesses of policies and programmes. A total of 26 papers and abstracts were included.

See References for a complete list of documents reviewed.

## Inception Meeting

On 17 January 2011 NAC conducted an inception meeting at its office in Lusaka. The purpose of the meeting was to obtain the input of key stakeholders into the methodology and tools for the situation assessment. The meeting was attended by 18 participants from government agencies, UN agencies and youth organizations. The study team, comprising the lead consultant and a study associate, presented their understanding of the terms of reference, a conceptual framework for the assessment as well as the methodology and tools, and received input from the meeting.

## Key Informant Interviews

The study team conducted key informant interviews (KIIs) with officials from the following groups of key stakeholders:

- Line ministries: Ministry of Education (MOE) and NAC
- United Nations agencies: UNAIDS, UNESCO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Health Organization (WHO)
- Civil society including youth organizations: Youth Alive Zambia, Youth Vision Zambia, Community Youth Concern, Zambia Youth Christian Students, Friends of Rawaka

In addition, during the above inception meeting and the subsequent data interpretation meeting the study team held discussions with the following stakeholders and obtained additional relevant valuable information:

- Line ministries: MOSYCD
- Civil society including youth organizations: Zambia Scouts Association; Young Men Christian Association (YMCA)

The stakeholders that participated in the key informant interviews, the inception meeting and the data interpretation meeting were selected and recruited by NAC.

## Focus Group Discussions

Four young people, two men and two women, identified by UNAIDS Zambia and NAC were trained in the conduct of focus group discussions (FGDs), which they held with fellow young people. One female and one male FGD were conducted in Lusaka, the capital city, and one female and one male FGD were conducted in Chongwe, a semi-rural community located 48 kilometers from Lusaka. Each FGD was attended by between 20 and 25 young people. Except for gender, the young people participating in the FGD were not identified by any category such as in or out of school, living with HIV, or being a sex worker. The groups were larger than typical FGDs in order to be conducted as youth forums—structured events to give young people an opportunity to express their ideas, opinions, and needs to decision makers, community, staff, and other young people (Dotterweich 2000).

Since the FGDs sought general information about HIV programmes for young people in Zambia the study team preferred the larger forum in order to keep the conversations at a broader level and avoid discussing individual experiences. Consent to the discussion was given verbally as a group. The participants were convened by youth organizations and as such were members of these organizations. In Lusaka the men were convened by the YMCA and the women were convened by African Directions. In Chongwe the men were convened by Chongwe Youth Group and the women were convened by Chongwe District Women's Association. The age of the participants ranged from 15–30 years. The FGDs were audio taped, transcribed, and typed into Microsoft Word by the young interviewers. Participants received no incentive except a soft drink that was handed out during the discussion.

## Content of Interviews

Both the FGDs and KIIs sought the respondents' views on: policies on HIV for young people, strategies to combat HIV among young people, HIV prevention, AIDS treatment, care, and support services for young people, and SRH services in Zambia. The interview guides were developed based on the objectives of the situation analysis and on issues that emerged during the initial literature review and at the inception meeting.

## Data Analysis

The young interviewers listened to the tapes and transcribed and typed the FGDs into Word documents. The data were then managed using the qualitative data management software, NovoSpark, which categorized the data according to major codes developed earlier for the study. The investigators then read the data under each main code to extract emerging themes. The data are presented in the various sections of this report to support findings from the literature review. Direct quotes are inserted, where appropriate, to illustrate a point of view.

## Data Interpretation Meeting

The preliminary results of the literature review, the FGDs and KIIs were summarized in a power point presentation to a meeting of stakeholders in Lusaka, Zambia on 3 February 2011. The meeting was attended by 12 participants from government agencies, UN agencies and young people organizations. The inputs from this meeting guided the study team in terms of areas requiring emphasis and in-depth analysis as well as on the overall flow of the report.

## Limitations

Because of resource limitations, it was not possible to obtain a nationally representative sample of young people to participate in the FGDs. However, the literature included a good number of studies conducted in various parts of the country that obtained the views of a wide variety of young people. The young people in those studies included: rural, urban, primary school, secondary school, teenage mothers, 10–14 year olds, members of anti-AIDS clubs, young people who had undergone HIV testing, young people attending health services, youth leaders, and HIV-positive young people. The study team would have preferred reports that had a good description of the services and/or programmes, a report of outputs, and a report of outcomes. However, the literature showed a paucity of programmes that met these criteria due to a general lack of monitoring and evaluation data on HIV programmes for young people in Zambia. Hence, the examples given offer limited data on effectiveness.

It should also be noted that, apart from the National Youth Policy which listed key services for young people, the literature review did not identify a guideline that articulates a comprehensive package of HIV services for young people in Zambia. Another limitation is the lack of information regarding financing of HIV programmes by target audience. Hence, this study was unable to generate information regarding current or projected spending specifically on HIV programmes for young people in Zambia.

## Working Definition of Young People

The Zambia National Youth Policy defines youth as a male or female aged 18–35 but acknowledges that organizations define youth differently including the United Nations which defines youth as aged 15–24 (MYSC 2006). The Zambia Ministry of Health report on adolescent reproductive health services defines adolescents as persons aged 10–19 (MOH 2009). In the two main national surveys of SRH, the 2007 ZDHS and the 2009 Zambia Sexual Behavioral Survey (ZSBS) the indicators specific to young people are calculated for the age group 15–24 years. The UNAIDS business case for young people uses the age group 15–24 years for its bold results indicators (UNAIDS 2010). In order to be inclusive of young people beginning their adolescence and in order for the information to be comparable internationally, this situation analysis focuses on the age group 10–24 years. Further, although there are several terms such as adolescents, youth and young people, that could be used when referring to these age groups, for consistency this situation analysis uses the term young people.



# RESULTS

## Current Situation of HIV among Young People

This section focuses on HIV among young people in Zambia including HIV prevalence, factors that make young people vulnerable to HIV, and the sexual behaviors of young people.

### *HIV prevalence among young people in Zambia*

#### **HIV prevalence trends over time**

There is a general trend of reduction in HIV prevalence among young women but not among young men. Data from the 2007 ZDHS show that in the general population of 15–19 year olds, the prevalence of HIV decreased among women from 7 percent in 2001 to 6 percent in 2007, but increased among men from 2 percent to 4 percent. Among those aged 20–24 there was a decrease among women from 16 percent to 12 percent but an increase among men from 4 percent to 5 percent. In addition, prevalence has significantly decreased among young pregnant women aged 15–19 from 14 percent in 1994 to 9 percent in 2006–07 (NAC 2009c).

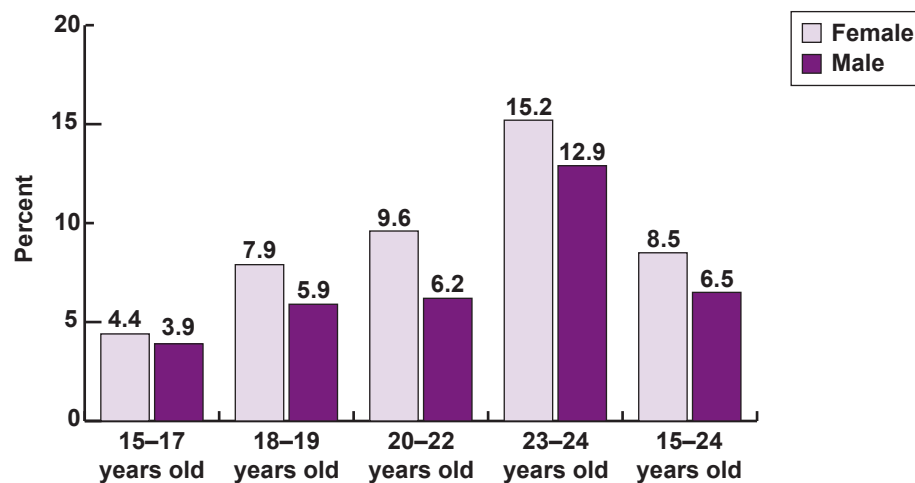
#### **HIV prevalence by age, sex, and residence**

HIV prevalence among young people in Zambia is higher among young women than young men, urban than rural young people, and older (20–24 years) than younger young people (15–19 years). The 2007 ZDHS shows that among those aged 15–19, the prevalence of HIV is slightly higher among women (6 percent) than men (4 percent). Figure 1 shows that while HIV prevalence is higher among young women compared to young men in all age groups, the female-to-male ratio is lowest in the age group 15–17 years (1.1:1), highest in the age group 20–22 years (1.5:1) and tapers off in the age group 23–24 years (1.2:1). This trend confirms that while both sexes start off at almost the same level of risk, women become more vulnerable to HIV at an earlier age than the men, due to earlier sexual debut and intergenerational sex<sup>2</sup>, but the men begin to catch up and the difference by gender becomes minimal as they grow older.

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<sup>2</sup> The MOT study (NAC 2009c) defines intergenerational sex a sexual relationship where there is a 10 year gap of age between the partners.

**Figure 1 HIV prevalence by sex and age groups (2007 ZDHS)**

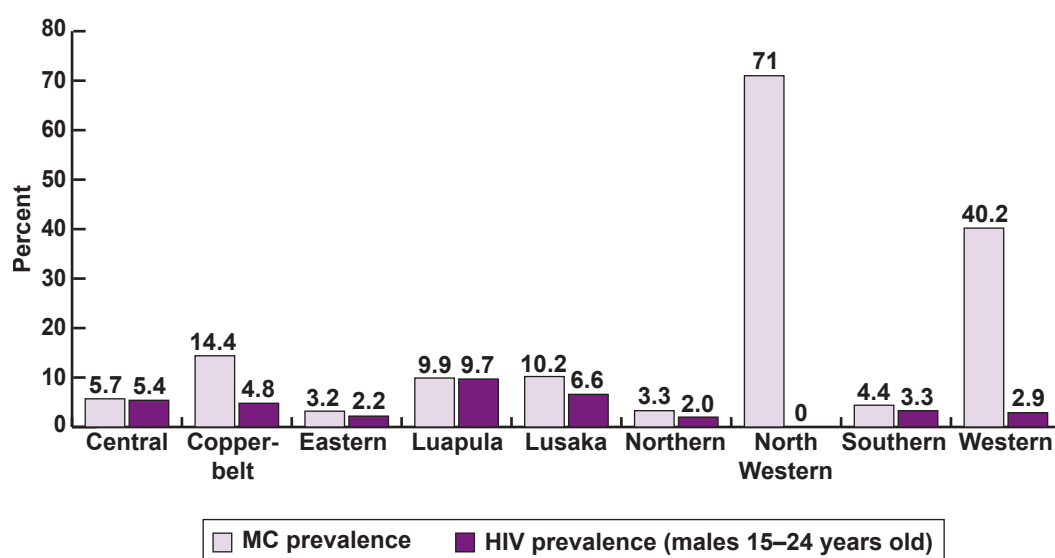


HIV prevalence among urban women is 5.5 percent compared to rural 5.9 percent; among urban men it is 4.3 percent compared to 3.0 percent among rural men. In the 20–24 years age group, prevalence is higher among urban than rural women (19 percent vs. 7 percent) and men (8 percent vs. 3 percent). Overall, HIV prevalence among young people aged 15–24 differed by province of residence from a high of 10 percent in Central, followed by 9 percent in Lusaka, to 2 percent in North Western. These differences are likely a result of level of urbanization but also due to the fact that some provinces have a higher level of male circumcision and hence the men are more protected from HIV.

### **HIV prevalence and male circumcision**

The 2007 ZDHS shows that young men aged 15–19 who were circumcised had zero HIV prevalence compared to their uncircumcised counterparts who had a prevalence of 4 percent. In the age group 20–24 years the difference by male circumcision was not so pronounced: 4 percent among circumcised men compared to 5 percent among the uncircumcised. Figure 2 shows that in Zambia circumcision rates vary by province. The highest rates are in North Western where 71 percent of the men are circumcised and the HIV prevalence among young men (15–24 years) was zero. This province has the lowest population (706,462) which is 5 percent of the Zambian population and hence the low HIV prevalence may have negligible effect on the overall population of Zambia. The lowest circumcision rates are in Central, Eastern, Northern and Southern (< 6 percent) and the HIV prevalence among young men (aged 15–24) was 5 percent in Central, 2 percent in Eastern, 2 percent in Northern and 3 percent in Southern. This data confirms existing findings that male circumcision is protective for young men.

**Figure 2 HIV prevalence by level of male circumcision (2007 ZDHS)**



### **HIV prevalence and sexual exposure**

The 2007 ZDHS shows that young women (aged 15–24) who are divorced or widowed have the highest HIV prevalence (19 percent). Women who have ever had sex and those currently married have a high HIV prevalence (11 percent and 10 percent, respectively) compared to those never married (7 percent). Thus it is clear that exposure to sex especially through marriage is a risk factor for young women. Among men aged 15–24 the highest HIV prevalence was among those married (10 percent) and the lowest was among those not married (3 percent) and ever had sex (3 percent). The number of young men widowed or divorced was too small to generate a HIV prevalence rate. Thus for young men it appears that HIV is most commonly transmitted in marriage. Among those young people who had never had sex, HIV prevalence is 4 percent among women and 3 percent among men, suggesting perinatal infection.

The modes of transmission study (NAC 2009c) estimated that for 2008 the largest contribution to total HIV incidence in Zambia came from individuals whose partners have casual heterosexual sex (37 percent of total incidence), followed by individuals reporting casual heterosexual sex (34 percent), those reporting low risk heterosexual sex i.e. mutual monogamy (21 percent), and clients of female sex workers (4 percent). One percent of new infections are estimated to occur among men who have sex with men through unprotected anal sex. However, this model did not review the risk groups by age and as such it is not possible to determine the contribution of young people to the projected HIV incidence in Zambia.

### ***Sexual behavior of young people in Zambia***

In general there has been a trend towards decreased sexual activity among young people in Zambia. Data from the ZSBS 2009 shows that between 2000 and 2009 among young people aged 15–24 the median age at first sex increased from 16.5 to 17.5 years among women and from 17.5 to 19.5 years among men. In the same age group the percent reporting sex in the past 12 months decreased from 60 percent to 53 percent among women, and from 47 percent to 35 percent among men. For those who are sexually active there has been a decrease in the number of sexual partners. The percent of young people (aged 15–24) who had sex with more than one

partner in the last 12 months, among those who were sexually active in the past year, decreased for men from 26 percent to 15 percent and for women from 4 percent to 2 percent.

However, the ZSBS 2009 survey showed that there has been no improvement in sex with non-marital and non-cohabiting sexual partners and in condom use for high risk sex. The percent of respondents aged 15–24, who were sexually active in the past 12 months and who had sex with non-marital, non-cohabiting partners rose for men from 67 percent to 72 percent and for women from 26 percent to 28 percent between 2000 and 2009. Among respondents aged 15–24 who were sexually active in the past 12 months the proportion who used a condom at last sex with a non-marital, non-cohabiting partner decreased between 2000 and 2009 from 38 percent to 33 percent among women and from 40 percent to 39 percent among men (ZSBS 2009).

### ***HIV prevalence and sexual behavior of young people in Zambia in relation to wealth and education status***

In Table 1 the 2007 ZDHS data shows that among women aged 15–24, those in the fourth wealth quintile had better comprehensive knowledge about HIV (36 percent) compared to those in the second quintile (26 percent) and a higher proportion reported condom use at last higher risk sex contact (40 percent in fourth quintile vs. 21 percent in second quintile). However, those in the wealthier quintile had a higher HIV prevalence (11 percent in fourth quintile vs. 4 percent in second quintile). The same trend was observed regarding the level of education. Those with secondary education had better comprehensive knowledge about HIV (46 percent) compared to those with primary education (24 percent) and a higher proportion reported condom use at last higher risk sex contact (45 percent with secondary education vs. 29 percent with primary education). However, those with secondary education had a higher HIV prevalence (9 percent with secondary education vs. 8 percent with primary education).

**Table 1 Sexual behavior and HIV prevalence of young women in relation to wealth and education level (2007 ZDHS)**

|   | Women (aged 15–24)     |                        |                     |                   |
|---|------------------------|------------------------|---------------------|-------------------|
|   | Fourth wealth quintile | Second wealth quintile | Secondary education | Primary education |
|   | %                      | %                      | %                   | %                 |
| Percent with comprehensive HIV knowledge    | 35.6                   | 25.6                   | 45.9                | 23.7              |
| Percent used condom at last higher risk sex | 40.1                   | 21.0                   | 44.5                | 29.1              |
| HIV prevalence                              | 11.4                   | 4.3                    | 8.9                 | 8.1               |

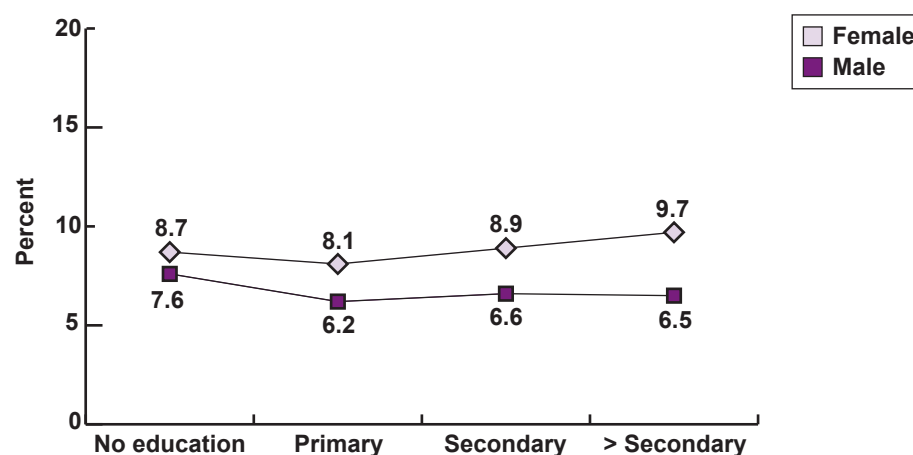
The same trends were observed among young men aged 15–24 (Table 2).

**Table 2 Sexual behavior and HIV prevalence of young men in relation to wealth and education level (2007 ZDHS)**

|   | Men (aged 15–24)       |                        |                     |                   |
|---|------------------------|------------------------|---------------------|-------------------|
|   | Fourth wealth quintile | Second wealth quintile | Secondary education | Primary education |
|   | %                      | %                      | %                   | %                 |
| Percent with comprehensive HIV knowledge    | 91.6                   | 81.1                   | 92.9                | 81.5              |
| Percent used condom at last higher risk sex | 49.9                   | 35.2                   | 54.1                | 37.8              |
| HIV prevalence                              | 9.7                    | 3.9                    | 6.6                 | 6.2               |

The same data is shown graphically in Figure 3 below.

**Figure 3 HIV prevalence by highest level of education attained (2007 ZDHS)**



This data suggests a much more complex HIV risk context for young people in the Zambia setting. The 2007 ZDHS shows the same trend for adults (data not shown). Speculations, to explain this observation, can be put forward but they will require further study to validate. For example, it is possible that the increased knowledge and higher condom use are not achieved before sexual exposure. It could be that the wealthier and more educated Zambians are more vulnerable to HIV exposure due to high HIV prevalence in the urban areas, or that because they are in urban settings they tend to acquire higher levels of knowledge about HIV as well as higher levels of condom use than their less wealthy and less educated counterparts (Stephenson 2009) but they will already have been HIV infected. It is also possible that the social life around schooling tends to increase the vulnerability of girls to HIV through the desire for material goods, due to peer influence, and the resultant intergenerational sex (Dube and Sachingongu 2007).

### ***Young people and their vulnerability to HIV***

This section discusses factors that enhance HIV vulnerability among young people in Zambia. In addition to poor knowledge of HIV and negative attitudes towards HIV prevention, underlying

risk factors include poverty and inequitable gender norms, which perpetuate multiple sexual partners and intergenerational sex, especially without condom use, and gender-based violence. Cultural factors, such as desire for children, also render young women particularly vulnerable to HIV (Jackson 2007; Dube and Sachingongu 2007; Mukuka and Slonim-Nevo 2006).

### **Limited comprehensive knowledge about HIV among young people**

The UN General Assembly Session on AIDS (UNGASS) knowledge indicator defines comprehensive knowledge about HIV as: correctly identifying ways of preventing the sexual transmission of HIV (condom use and having one HIV-negative, faithful partner); and rejecting major misconceptions about HIV transmission (that HIV can be transmitted by mosquitoes or by supernatural means) (MOH and NAC 2010). The 2007 ZDHS showed that young people aged 15–24 had limited knowledge about HIV: only 35 percent (34 percent of women and 37 percent of men) could demonstrate comprehensive knowledge. The percentage was lower among women aged 15–19 (32 percent) compared to women aged 20–24 years (36 percent). A similar trend was seen among men: 35 percent among those aged 15–19 compared to 40 percent among those aged 20–24. Thus about 65 percent of young people in Zambia do not demonstrate comprehensive knowledge about HIV. The NASF 2011 to 2015 indicates that knowledge of HIV is actually declining: from 48 percent in 2005 (51 percent for men and 45 percent for women) to 35 percent in 2007 (37 percent for men and 34 percent for women).

One key factor that may influence the level of knowledge is socioeconomic status. Indeed the 2007 ZDHS confirms this in that while 42 percent of urban young women aged 15–24 had comprehensive HIV knowledge only 27 percent of their rural counterparts had this knowledge. Similarly, among urban young men aged 15–24 years 46 percent had this knowledge compared to only 29 percent of rural young men. A secondary analysis of Demographic Health Survey (DHS) data from Burkina Faso, Ghana, and Zambia with a focus on young people revealed that the community of residence influences HIV related knowledge of young people differently depending on age, gender, and country. For example young women in communities with better socioeconomic opportunities tended to have better HIV knowledge (Stephenson 2009).

### **Attitudes toward HIV prevention among young people**

Adults—including parents, teachers, health care providers, religious leaders, and other community leaders—are key gatekeepers who determine what kind of SRH information and services young people receive. Thus their attitudes regarding HIV prevention approaches can influence the HIV response among young people. The 2007 ZDHS found that 56 percent of female and 68 percent of male Zambians aged 18–49 supported the idea of young people (aged 12–14 years) being taught about condoms for HIV prevention. This perception differed by age, sex and level of education of the respondent. Female respondents aged 40–49 were less likely to support young people being taught about condoms (52 percent) compared to men of the same age (64 percent). Younger female respondents (aged 18–24) were more likely to support young people being taught about condoms (59 percent) than older women aged 40–49 (52 percent). Women with no education were less likely to support young people being taught about condoms (50 percent) compared to men with no education (59 percent). The 2007 ZDHS also showed that about 90 percent of respondents aged 18–49, both male and female, were of the view that all young people should abstain from sex until they are married. Thus the general attitude in among community members is that young people should abstain from sex and only half of the community members support the idea of condom promotion among young people. It is even more notable that the proportion of adults supporting condom education among young people has declined. Women aged 18–49 supporting condom education declined from 56 percent in 2007 to 51 percent in 2009 and men from 68 percent to 56 percent.

## **Alcohol use and HIV sexual behavior**

Alcohol use is likely to lead to high risk sexual behavior (Kalichman et al. 2007). Indeed the Zambia HIV/AIDS Communication Strategy considers alcohol use by young people to be a key issue, and one of its objectives is to reduce the percentage of young people who have sex under the influence of alcohol (Dube and Sachingongu 2006). Data from the ZSBS 2009 shows that among sexually active young people aged 15–24, 9 percent of men and 8 percent of women reported being drunk during a sexual act. Borg et al. (2010) conducted a survey among 1,500 young people in Zambia and found that 22 percent of young people reported having sex while drunk, with men 9 percent more likely than women to report this behavior.

## **Poverty**

While young people aged 15–24 constitute only 25 percent of the global working population, they represent about 44 percent of the unemployed (PEPFAR 2009). The 2007 ZDHS showed that women aged 20–24 were more likely to report being unemployed in the past year (49 percent) compared to those aged 25–29 (41 percent). Similarly, a higher percent of men aged 20–24 (24 percent) reported being unemployed in the past year compared to those aged 25–29 (5 percent).

Poverty can prompt young girls to engage in intergenerational sexual relationships. Intergenerational sex is often interlinked with transactional sex<sup>3</sup> especially in urban and informal settlements. Female FGD participants for this situation assessment reported that girls are explicit about having sexual relations with men who are employed and could give them material goods in return. The girls also stated that they did not see anything wrong with having an affair with a teacher as long as he is single. Reasons for relationships with teachers include monetary gain, high grades, sharing information about examinations, popularity, and love (Women and Law in Southern Africa [WLSA] 2006).

The majority of sex workers are younger than age 25, and many were forced into sex work due to poor conditions in their homes. In Zambia, among sexually active young people aged 15–19, 23 percent of men and 8 percent of women reported transactional sex (ZSBS 2009). FGD and KII participants agreed that teenage pregnancy destroys girls' careers and causes financial responsibilities to look after the baby. In this situation many teenage mothers either go into transactional sex or early marriage with the father of the child, which has wide ranging consequences including a curtailment of freedom and the denial of opportunity to grow to their full potential (UNICEF 2001). FGD participants reported that young people who are idle or unemployed are vulnerable to alcohol, drugs, and HIV, and cannot pay for HIV prevention services, for example, sexually transmitted infection (STI) care or condoms. Zambia young people participating in a meeting to review UNGASS progress in 2005 suggested that provision of employment reduces young people's engagement in high risk activities such as alcohol use which may predispose them to high risk sex (Banerjee and Grote 2005).

## **Gender inequality**

Apart from poverty, which disproportionately affects young girls and women, there are other aspects of gender inequality that contribute to the vulnerability of young people to HIV. Intergenerational sex puts the young woman at increased risk of HIV because the older man is usually more sexually experienced and exposed to multiple sex partners. In Zambia, 9 percent of women reported sex with a partner who was 10 years older (ZSBS 2009).

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<sup>3</sup>The modes of transmission study (NAC 2009c) defines transactional sex as the exchange of favors or money for sex.



Cultural norms and practices also tend to increase female vulnerability. The National HIV/AIDS Policy (MOH 2005) highlights the following cultural practices that put young people, especially girls, at increased vulnerability to HIV: the preference of dry sex<sup>4</sup>, the culture of using sex to cleanse widows after the death of their husbands, increased sexual activity surrounding initiation rites (initiating young people into adulthood), and taboos about discussion of sexual matters between children and parents. Cultural norms further put pressure on women, especially young women, who are recently married to have children thus making it difficult for a young woman to suggest condom use with her sexual partner/husband.

Forced sex is another common source of vulnerability stemming from inequitable gender norms. The ZSBS 2009 indicates that forced sex is more common among young than older women. Among women aged 15–19, 10 percent reported being forced to have sex in the past year compared to 5 percent among those aged 20–24, and 4 percent among those aged 25–49. Dahlbäck (2006) examined the experiences of girls who had had an incomplete abortion in Zambia and reported that 39 percent had been forced to have their first sexual intercourse.

Male gender norms also increase girls' vulnerability to HIV. Dahlbäck (2006) used semi-structured interviews to gain a gender perspective of young men. The study revealed that premarital sex was common among boys and was considered a necessity to achieve male autonomy and status. The same culture tends to make it mandatory to women to accept sex with their husbands regardless of whether she suspects or knows that he is having other sex partners and is putting her at increased risk of HIV (NAC 2009c). The 2009 ZSBS showed that only 66 percent of respondents aged 15–24 agree that a woman is justified to refuse sex with her husband if she suspects him to have other sexual partners. This view did not differ by sex, meaning that one-third of young people, both women and men, believed that a woman should not refuse sex with her husband.

Young people participating in FGDs in this assessment confirmed that social and cultural norms condone multiple sexual partners for men and sexual coercion of women. They further elaborated that gender inequality hinders some young women from seeking HIV preventive services such as HIV testing and counselling (HTC) or condoms because they feel shy to ask for condoms or cannot pay for services. Indeed the ZSBS 2009 indicated that the percentage of young people aged 15–24 who reported that they could get condoms on their own was 59 percent for men compared to 49 percent for women. The same survey showed that 55 percent of men and 53 percent of women aged 15–24 considered it acceptable that an unmarried woman can purchase condoms; thus, at least 45 percent did not consider it acceptable.

FGD participants also noted that young men often lack education or training about communication in sexual relations, while young women are taught during traditional initiation ceremonies how to please their future husbands. Rasin (2003) confirms that while almost all tribes in Zambia do have initiation rites for girls, only one tribe has this ceremony for boys. The initiation ceremony may involve girls being put in a house where they are taught a number of issues including hygiene, respect for elders, housekeeping, how to dance for a man in bed, how to pull the labia minora, and to stay away from the opposite sex (WLSA 2006). This sets the stage for poor couples' communication since the man is untrained in communication and the woman is only trained to please the husband.

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<sup>4</sup> The modes of transmission study (NAC 2009c) refers to dry sex as a cultural practice in some tribes where women use herbs to dry the vagina before sexual intercourse. Unfortunately, this practice has been reported to cause vaginal sores and this could increase the risk of HIV acquisition.

In summary, young people in Zambia, especially women, are highly vulnerable to HIV because of poor comprehensive knowledge of HIV and negative community attitudes toward condom use by young people; alcohol use; poverty and gender inequality, and the related behaviors of transactional and inter-generational sex; and early marriage. HIV prevalence remains high among young people especially urban, low educated women and uncircumcised men. However, there is evidence that HIV prevalence is decreasing among young women, which is linked with improved sexual behavior especially delayed sexual debut and reduction in number of sexual partners. There is no evidence of reduction in HIV prevalence among young men, or improvement in condom use. Hence there are both success stories and gaps in the current response to HIV among young people in Zambia. The data has demonstrated that there is a complex form of vulnerability that requires further understanding—higher education and wealth levels are associated with better sexual behavior but not with lower HIV prevalence, especially among women.

## Policy Environment as it Relates to Young People

This section discusses the existing legal and policy frameworks in Zambia relating to HIV among young people with the aim to document the policy and legal gaps that ought to be addressed in order to enhance the response to HIV among young people.

### *Legal frameworks*

The overall National Youth Policy is implemented under the legal framework issued on Gazette Notice No. 547 of 2004 which mandates the MOYSCD to implement the policy.

The AIDS response is well enshrined in the laws of Zambia in that the relevant structures necessary for the AIDS response are covered by Acts of Parliament. In particular, the NAC was established by act of parliament and stipulates civil society organization representation at NAC to include a young people representative and that the National Youth Development Council should participate in NAC (NAC 2009b).

*Perhaps the only legal framework we can refer to is the national AIDS act of parliament.*

Key informant

Further, the constitution and laws of Zambia are protective of people from some types of vulnerability to HIV. For example the law protects the rights of individuals and prohibits discrimination based on social status. In Act 23 of the constitution<sup>5</sup> in clause (3), it defines “discriminatory” as “affording different treatment to different persons attributable, wholly or mainly due to their respective descriptions by race, tribe, sex, place of origin, marital status, political opinions color or creed.” The law also punishes rape and defilement. In penal code number 137 it is stated that “any person who unlawfully and indecently assaults any woman or girl is guilty of a felony and is liable to imprisonment for fourteen years.”

In the National HIV/AIDS Policy (MOH 2005) one key objective is to protect the rights of children and young people and ensure them access to information and services for HIV prevention and care. This is regardless of the HIV status of the child as per the African Charter, UN Convention on the Rights of Child, and relevant Zambian laws. Indeed the policy urges the

<sup>5</sup>[http://www.parliament.gov.zm/index.php?option=com\\_content&task=view&id=21&Itemid=49](http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=21&Itemid=49)

Ministries of Justice and of Youth and Sports to formulate more progressive penal codes on sexual abuse of children as well as mechanisms that can effectively protect children from practices and social and cultural norms that increase their vulnerability to HIV.

Effort is being undertaken to review current laws with the view of making them more compatible with a rights-based approach to HIV programming. The modes of transmission study (NAC 2009c) reports that the penal code was amended to protect individuals from the harmful cultural practice of sexual cleansing of widows (NAC 2009a). The UNGASS 2010 report states that there has been an effort to review the existing laws to ensure that they are consistent with AIDS policies. One example cited is the amendment of the insurance law to accommodate people living with HIV (PLHIV) who previously were denied health insurance.

In addition, Zambia is a signatory to a number of international conventions which are relevant to the protection of individuals from vulnerability to HIV. These conventions include: the Convention on the Elimination of All Forms of Discrimination against Women adopted by Zambia in 1985; the Convention on the Right of the Child ratified in Zambia in 1991; the Beijing Declaration and Platform for Action adopted by Zambia in 1995; the Millennium Development Goals adopted by Zambia in 2000; the Maseru Declaration on HIV/AIDS adopted by Zambia in 2003; the African Charter on Human and People's Rights ratified by Zambia in 2006; and the SADC Protocol on Gender and Development signed by Zambia in 2008 (NAC 2009a).

In summary, it is clear that the legal framework in Zambia, starting from the constitution and laws as well as key amendments moving on to international conventions that Zambia has ratified are all conducive for a human rights approach to HIV programming among young people. However there remain a number of gaps.

### Gaps in the current legal framework

Whereas there is a clear legal framework within which HIV programmes for young people are situated there are a number of gaps:

- **Current laws not are specific on discrimination due to HIV status.** According to the modes of transmission study there is currently no legislation that overtly bans discrimination based on actual or perceived HIV status (only no discrimination according to social status). For this reason the law on discrimination remains impotent in situations such as when military recruits are tested for HIV and those with results that indicate that they are HIV-positive are excluded from the army. This situation disproportionately affects young people because they form the vast majority of candidates seeking recruitment into the army. Another gap is that while there are laws against discrimination there is no mechanisms for documenting discrimination.

*Well this a bit tricky, I think if they had been implemented in the first place, maybe even the legal frame work would be in existence. From what I know, I have not heard of any employer who has been arrested for firing an employee on the basis of being HIV-positive, there has been cases where, especially domestic workers have been fired once their employer finds out that they are HIV-positive, but then, because they do not know that there are laws that are there to support them, they have not been able to make use of them. So I think the laws are there, but the thing is the people do not know of them.*

Key informant

- ***Some laws are repressive and are barriers to HIV programming among some vulnerable groups.*** The modes of transmission study also observed that there are some laws in Zambia that present obstacles to effective HIV prevention, treatment, care, and support for key populations, notably the laws on homosexuality and prostitution. The penal code No. 140 states that “Any person procuring a child or other person for prostitution, etc. commits a felony and is liable, upon conviction, to imprisonment for a term of not less than twenty years and may be liable to imprisonment for life.” The Penal Code Act, 1995 Edition Sections 155, 156, 158 states that “any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years.”

These laws effectively make it difficult to reach key populations with public health information and services that can protect them from HIV, provide them with care, support, and treatment, and enable them to effectively respond to the epidemic. As mentioned before, young people form a large proportion of people engaged in sex work and hence they are affected by these repressive laws.

- ***The law on age of consent could hinder some young people in accessing SRH services.*** In the definition of child as amended by Act No. 15 of 2005 it is stated that “In this part ‘child’ means a person below the age of sixteen years.” FGD participants expressed concern that the law requires parental consent for young people less than age 16 to seek SRH services, yet many young people are sexually active before that age and may want to seek services without parental involvement. A review of access to HIV HTC by young people indicated that young people below the legal age could only receive counselling, but not testing, if they did not have parental consent. The exception was pregnant young people who could receive HTC at any age (McCauley 2004).
- ***Existing laws insufficiently protect women and girls from harmful gender norms.*** The National Action Plan on Women, Girls and HIV/AIDS (NAP-WGHA) 2006–2010 states that existing legislation is weak while traditional laws are often in conflict with international conventions and instruments ratified and signed by the government that were aimed to protect the rights of women and girls. Indeed one of the suggested actions is to propose and advocate for legislation to protect women and girls from deliberate HIV infection, and from gender-based violence, and to advocate for the enforcement of such laws (GRZ Cabinet Office Gender Division 2007).
- ***Some laws require strengthening in their implementation.*** Some of the laws aimed at protecting vulnerable children are not effective because they lack sufficient structures and resources for their implementation. For example while the Juvenile Act provides protection children from exploitation, sexual abuse, and human trafficking, its implementation remains weak because there are no systems within the community to monitor child welfare and protect children from exploitation (NASF 2011–2015).

In summary the current laws have gaps in terms of being un-specific to HIV status with regard to prohibiting discrimination, and a lack of laws protecting women and girls from traditional social norms that are coercive could increase their vulnerability to HIV. In addition, there are laws that are repressive of most at-risk populations (MARPs), such as sex workers, thus making it difficult for them to be reached with public health programmes and services. The Juvenile Act protects children from exploitation and abuse but there are insufficient structures in the community to implement it.

## *Policy frameworks*

Zambia has a National HIV/AIDS Policy (MOH 2005) and one of its objectives is to protect the rights of children and young people and to provide them access to HIV prevention and AIDS care services. In addition the MOH review of adolescent health services in the country listed the following policies which are relevant to adolescent health: National Population Policy; the National Youth Policy; the National Child Health Policy; and the National Reproductive Health Policy. Taken together, these policies provide an appropriate framework for implementation of the specific rights, freedoms and commitments relevant to young people as enshrined in the Constitution of Zambia and in the international conventions to which Zambia is a signatory (MOH 2009).

The National Youth Policy of 2006 was developed after a review and feedback regarding the previous policy of 1994. The review comprised one conference held in each of the nine provinces as well as a questionnaire sent out to young people and other stakeholders. Altogether 3,400 people were consulted. A national youth conference was held in 2004 attended by stakeholders including 360 youth to develop consensus over findings from the feedback and over new policies. The conference was given the name: “Let the Youth Talk.” While highlighting HIV, the policy recognizes the broad problems of young people including poverty, alcohol and drug use, crime, lack of access to services, early marriage, unemployment and low access to education (MSYCD 2006). Regarding measures to address HIV among young people, the national youth policy recommends mainstreaming of HIV in all youth activities to reduce infections and mitigate impact by enabling access to information and services including care and antiretroviral therapy (ART) as well as reproductive health services especially in rural areas.

The National Youth Policy (MSYCD 2006) outlines the following package of strategies to address HIV among young people:

- STI care
- Training peer educators
- Providing ART
- Promoting youth friendly services
- Promoting life skills education in schools
- Conducting HIV information campaigns using print and electronic media and drama and sport
- Providing HTC

Young people participating in the FGDs of this current assessment emphasized that national HIV policies recognize the right to care for people living with HIV, and the government has appropriate strategies and programmes in that even poor people are accessing ART.

The National HIV/AIDS Policy (MOH 2005) highlights the following areas of HIV programming for young people. In the policy it is stated that the MOH provides information materials to the Ministry of Education to integrate into their curricula in order to impart life skills education on HIV in primary, secondary, and tertiary education institutions. In addition the policy states that life skills education on HIV has been developed for groups of out-of-school young people such as truck drivers, sex workers, and military personnel. Within the HIV prevention objective the policy clearly identifies the need to develop income generating activities for out-of-school young people thus recognizing that poverty is a key driver of the epidemic

especially among young people. In addition, in the policy it is stated that the government shall encourage parents and guardians to communicate with young people about sexuality and HIV. The policy also urges the Ministry of Youth and Sports to utilize sports to educate young people about HIV and to warn young people about the HIV risks associated with drugs and alcohol abuse. The policy also puts special emphasis on the training of counselors who can counsel young people about early sex, the risks of teenage pregnancy, and HIV.

### Gaps in policy framework

There are a number of gaps relating to the policies, the way they were formulated, or the way they are being implemented:

- ***Current policy framework does not highlight the specific needs of young people living with HIV.*** While the National HIV/AIDS policy has specific areas for HIV prevention focusing on young people, in the area of HIV treatment and care the policy does not single out young people as a group requiring special attention. The child policy also does not cover adolescent health (MOH 2009). Thus the health issues of young people living with HIV remain unaddressed by the current policy framework.
- ***Young people at the grassroots and the sub-national levels were not engaged in policy formulation.*** Key informants participating in this current assessment observed that the government should ask young people in all the districts, especially young people living with HIV, about their problems and use these views to develop policies.

*My experience has been, if you create policies from the top-down. usually they have very little effect on the grassroots and then we have technocrats in the conference rooms without knowing what's happening on the ground and develop these policies, so the people at the grassroots don't have much to say and as a result when it comes to influencing the actual programming on the ground, the policies have very little effect and you find that at the grassroots what involves programming are the needs at the grassroots what people say or what people are passing through or the problems they are going through.*

Key informant

- ***Young people at the grassroots are not being involved in the dissemination and operationalization of relevant policies at the grassroots level.*** FGD participants reported that while the Youth Policy was disseminated through non-governmental organization (NGO) workshops, radio and TV, copies are not easily accessible to youth organizations.
- ***Policies are not addressed to the needs of the younger age group of young people.*** The modes of transmission study highlighted that SRH issues of young people aged 10–14 were not covered by current policies.

### National strategies and action plans

In order to enable implementers to put the above policies into action, GRZ has put in place a number of strategic plans and action plans. These include the NASF, the latest version of which is NASF 2011–2015 and the NAP-WGHA 2006–2010.

Zambia NASF 2011–2015 underscores several programme areas relevant to young people's HIV issues. Under the prevention of new infections the strategy is focused on high impact programmes to reduce HIV infections especially among women, children, and young people. Key activities



are the scaling up of life skills based HIV education for both in and out-of-school young people, and the initiation of HIV youth friendly services which will be incorporated in on-going youth development and recreation programmes.

The NASF also makes reference to young people in the implementation of stigma and discrimination reduction strategies where schools are mentioned as one of the communities to be targeted. It is mentioned that young PLHIV will be trained as peer educators among in and out-of-school young people and as community mobilizers. It is expected that through meaningful involvement of young PLHIV they will contribute to the reduction of stigma and discrimination in families, schools, communities, and in the work place environment.

The HIV knowledge focus area of the NASF has four activities, of which two are devoted to young people. The NASF encourages an increase in quality and coverage of the sexuality education in schools as well as targeted behavior change programmes for young people, particularly young women. In the condom area of focus, one out of the four activities is the development of a campaign to promote condoms among young people. To increase the prevalence of male circumcision the NASF 2011–2015 promotes male circumcision for all young boys aged one year and above. The strengths, weaknesses, opportunities, and threats (SWOT) analysis of the NASF 2006–2010 indicated that one of the strengths was the high rates of acceptability and demand for male circumcision particularly for boys aged 7–13 (NAC 2010b).

The NAP-WGHA 2006–2010 includes as an objective to develop and support programmes that will promote and protect women and girls sexual rights and empower them to protect themselves from HIV infection by the end of the cycle. One of the key outcomes is a change in cultural practices that increase the vulnerability of girls and women to HIV infection and the impacts of HIV. One of the outputs is increased participation of adult men and boys in the protection of rights of women and girls (GRZ Cabinet Office Gender Division 2007).

In summary the current policy framework has strengths in the area of HIV prevention and AIDS care among young people and is explicit about the protection of rights of women and girls as well as people living with HIV.

### **Gaps in national strategies and action plans**

Within the strategic planning of HIV programmes for young people there are a number of gaps as follows.

- ***Lack of a specific care and support strategy for young people living with HIV.*** In the NASF it is notable that while youth are extensively discussed in the prevention objective they are hardly mentioned in the care aspects; yet many young people are living with HIV which they acquired either perinatally or sexually. In the ART area of focus children aged 0–14 are singled out and prioritized but there is no recognition of the special age group of young people (10 to 24). Young people participating in FGDs of this assessment raised the concern that the NASF does not address the rights of young people to information and services, or of young PLHIV (only adults). Indeed, the National Youth Policy 2006 also recognizes that youth are not specifically targeted by AIDS care and ART programmes and have poor access due to stigma (MSYCD 2006).
- ***Lack of a clear link between the HIV response and strategies for economic empowerment especially of women and girls.*** According to the NAP-WGHA 2006–2010 there is no link between programmes to empower women and girls economically and the AIDS response. It is further stated that even though it is clear that gender is at the centre



of the HIV epidemic the economic needs of women and girls are not strategically placed at the centre of the response (GRZ Cabinet Office Gender Division 2007).

## **Coordination of the AIDS Response among Young People**

### ***Coordination of the implementation of the National Youth Policy***

The coordination of the overall national youth policy implementation is through multi-sectoral committees led by the various line ministries. These committees ensure integration, consultation, feedback and monitoring. Coordination at the lower levels is by special sub-committees of the Provincial and District Development Coordination Committees. The National Youth Development Council was established by act of parliament and is responsible for registering development organizations working with young people, ensuring dialogue at provincial and lower levels with networks of young people and young people NGOs, advocating for and mobilizing young people, ensuring linkages with civil society organizations working with young people, and ensuring linkages with external NGOs and other agencies for support (MOSYCD 2006).

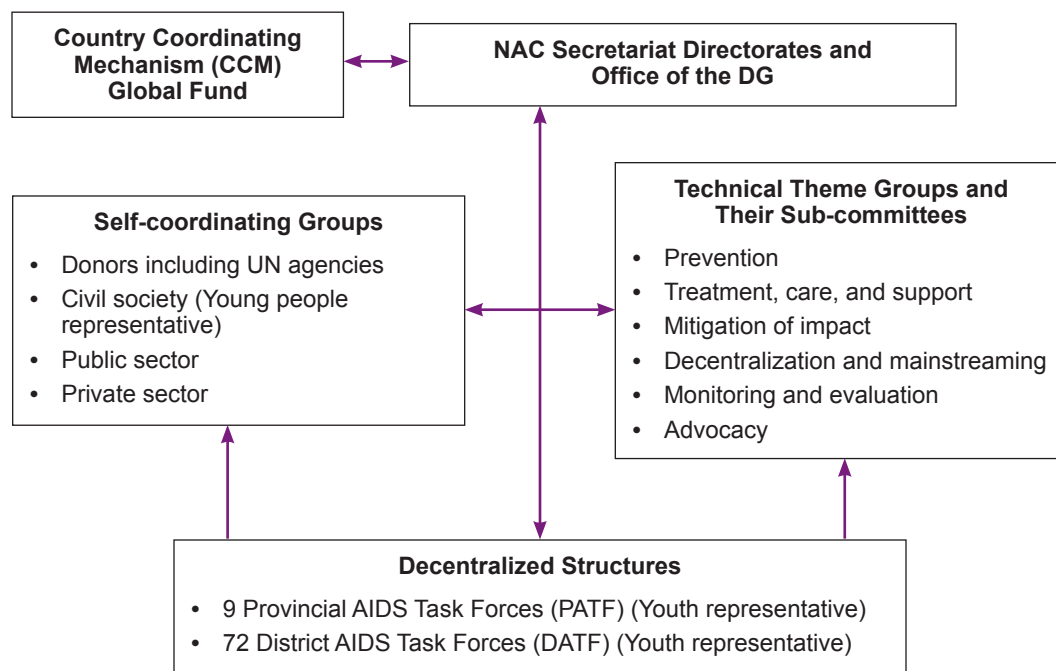
### ***Coordination of the AIDS response among young people***

This section reviews the current coordination of the response of the government of Zambia together with its partners to the HIV situation among young people.

In accordance with the UNAIDS principles of the “three-ones,” i.e., one agreed action framework, one coordinating authority and one national monitoring and evaluation system, the government has put up a coordination framework for the national HIV response. In the NASF 2011–2015 it is stated that the coordination of the national HIV response takes place at following levels: national, provincial, district, and community. At each of these levels coordinating structures have representation from government, civil society organizations, development partners, and the private sector, and from specific constituencies including public service employees, PLHIV, young people, people with disabilities, women’s groups, and community-based interest groups.

Figure 4 illustrates the coordination structure relevant to HIV programming among young people.

**Figure 4 Coordinating structures relevant to youth HIV programming**



Source: Adapted from NAC 2009b

### National-level HIV coordination

At the national level the NAC has self-coordinating groups of donors; private sector; public sector; and CSOs which specifically includes young people (NAC 2009c). The self-coordinating group of donors includes UN agencies and other donors.

Respondents to KIIs conducted in this assessment stated that the Ministry of Youth & Sports coordinates youth issues through the National Youth Development Council, and has an AIDS unit with a focal point person. However, because youth issues involve many other sectors, the Ministry of Youth & Sports liaises with other ministries such as Ministry of Agriculture on agricultural empowerment of young people, and with NGOs such as Planned Parenthood Association of Zambia for SRH services. Respondents also stated that the MOE works with NAC to develop policies and strategies relating to HIV life skills education in schools. The MOE also produces information, education, and communication (IEC) materials and distributes them in schools and carries out monitoring and evaluation of the programme. The National Youth Development Council is supposed to coordinate with these various ministries by chairing the National Youth Forum at NAC which is supposed to be attended by representatives from these ministries. Respondents to KII however reported that this coordination mechanism is not so functional.

With regard to SRH services the national level coordination is under the MOH which has the Adolescent Health Technical Working Group and the Sector Advisory Group. Within the MOH the Reproductive Health Unit is responsible for policy and technical guidance on the issue of SRH. The MOH liaises with several ministries, including MOE for School Health Nutrition and Ministries of Youth and Sports, Agriculture, Commerce, Finance and the Nutrition Commission

as well as NAC for various aspects of adolescent health. The MOH lists HIV testing and counselling and care for STIs as key components of SRH services. Hence coordination between the Adolescent Health Technical Working Group and NAC is vital for HIV programmes among young people. However, the ADH assessment report (MOH 2009) indicated that Adolescent Health Technical Working Group is currently non-functional.

In addition the MOH works with civil society including NGOs as well as cooperating partners who are members of the Adolescent Health Technical Working Group. The cooperating partners and NGOs in the ADH-TWG include WHO, UNICEF, Planned Parenthood Association of Zambia, and CARE International. Within the MOH structures, there are specific units and staff assigned to coordinate adolescent health (MOH 2009). Indeed, key informants of this assessment confirmed that the MOH has a national level coordinator of youth friendly health services.

Concerning orphans and vulnerable children (OVC), the NASF 2011–2015 states that the policies for mitigation of AIDS impact among young people, in the form of OVC support, are formulated by the MOSYCD while the Ministry of Community Development and Social Services coordinates social protection service provision.

### **Provincial- and district-level coordination**

Coordination at these levels is through the provincial and district AIDS task forces. Membership to these task forces includes a CSO representative, a young man and woman, faith-based organizations (FBOs) and traditional healers (NAC 2009b). Respondents to KIIs of the current assessment confirmed that the district AIDS task force coordinates the HIV response at the district and that youth organizations are represented on this task force. Through the task forces, various implementing organizations are allocated geographical areas of operation. SRH services are coordinated at the provincial and district offices by the provincial health offices and district health offices which oversee the health facilities and youth-friendly health facilities (MOH 2009).

*For example, the Ministry of Education coordinates with Ministry of Sport, Youth and Child Affairs. In combating HIV, we have various partners on board like those which promote sport.... As they promote sport, they are creating awareness amongst young people on HIV issues.... So in that line, because they have to go into the schools, and they are also dealing with the youths and sport which is under is Ministry of Sport, Youth and Child Development, they collaborate with each other.*

Key informant

### ***Coordination of Global Fund to Fight AIDS, TB and Malaria***

In-country decisions about the Global Fund are made by the Country Coordinating Mechanism (CCM). The CCM includes a range of interest groups including government, the private sector, researchers, service providers, non-governmental and affected communities and it has a young people representative.

The CCM is served by the NAC Secretariat (that includes a Global Fund Administrator) and its composition, roles and responsibilities are governed by Global Fund Guidelines. For each grant, the CCM nominates public, private or non-governmental organizations to serve as principal recipients (PRs). The Global Fund secretariat channels funding for the grant through the PR. The PR usually disburses some of this funding through sub-recipients and sub-sub-recipients (NAC 2009b).

The Round-8 proposal (January 2010 to December 2011) has four PRs:

- PR-1: Church Health Association of Zambia is the PR for FBOs.
- PR-2: Zambia National AIDS Network is the PR for non-faith-based civil society and the private sector.
- PR-3: Ministry of Health is the PR for the public health sector.
- PR-4: Ministry of Finance and National Planning is the PR for the government line ministries, departments, statutory bodies and quasi-government institutions.

Of specific interest to HIV programming among young people are the sub-recipients of PR-1 which include Young people Alive Zambia and Young Women Christian Association of Zambia (YWCA). Young people Alive Zambia sub grants to FBOs and young people organizations. And YWCA sub grants to her chapters throughout the country. YWCA has 27 branches in 8 provinces with 8 regional offices in Chipata, Kabwe, Kasama, Kitwe, Livingstone, Lusaka, Mongu, and Solwezi.

*The National AIDS Council and through the Civil Society Unit works closely with principal recipients in the private sector or civil society like ZNAN. The principal recipients I am talking about people who have the money like ZNAN and CHAZ. So we work together to make sure that the resources are given to the people up there those who supposed to receive it.*

Key informant

### ***Coordination of civil society at national level***

Alliance Zambia, together with Church Health Association of Zambia and Oxfam, has worked with 19 national level CSOs to establish the International Partnership for Health which is a coordinating mechanism with the government and donors on health. This resulted in the Zambia Civil Society Technical Working Group which developed a memorandum of understanding with the government in relation to international health partnership (International HIV/AIDS Alliance 2009). This is an effort to involve CSOs in the wider health agenda beyond HIV and it needs to be linked in with the CSO self-coordinating group of NAC since HIV is such a large component of activities in the health sector.

### ***Gaps and challenges in coordination***

In the area of young people HIV issues, the current HIV coordinating structure has the following gaps.

- ***Insufficient involvement of young people in the planning and coordination of activities.*** Despite the coordination structures having young people representation, one of the gaps in coordination is the insufficient involvement of young people in planning, programming, budgeting, and service delivery of HIV activities (NAC 2009b). Young people participating in FGDs of the current assessment stated that only a few young people are involved in designing and implementing HIV policies and programmes targeting young people. Yet there is much that young people at the grassroots level and their organizations could do to disseminate information and implement programmes, especially in the rural areas.

- ***Lack of defined target populations or communities for the various actors.*** Districts do not have targets for young people to be reached by the various programmes (NAC 2009b). In the FGDs the young people reported that some agencies operate isolated programmes that are not well coordinated with other partners and yet all target young people. Therefore at the district level there remains a gap in knowing how many young people in a community are targeted by an organization.
- ***Limited functionality of some coordination structures.*** A specific example offered of limited coordination is the ADH-TWG which was reported to be currently inactive (MOH 2009). This inactivity is likely to create a gap in coordination between the MOH's young people friendly services and NAC activities for young people.

*I think the ministry of youth sits in one of the forums under NAC so there is that coordination, but it probably needs to be strengthened and roles need to be made clear, like who is implementing, who is coordinating, who is monitoring what's going on.... Even ministries will probably say well we, they don't implement everything like they are supposed to provide the enabling environment, policy guidance, they are not implementing, so how do they coordinate with NAC who are also a coordinating body? So between the two of them, they need to sit and identify how the implementation is going to happen.*

Key informant

In summary, structures are in place at the national, provincial and district level to coordinate young people HIV programmes, SRH services, and OVC support. The coordination structures have young people represented but the young people are not satisfied with their level of involvement because the representation does not reach the grassroots level. Some of the coordination structures are not functional. Further, the coordination structures have not succeeded in setting district level targets of young people to be reached by the various programmes, nor have they succeeded in allocating and tracking implementers in terms of programmes and young people being targeted.

## Organizations and Agencies Providing Technical Support on HIV and Young People

### ***Role of technical support agencies***

Donors and technical support partners support NAC through the Cooperating Partners Self-Coordinating Group (established under the joint chairmanship of UNAIDS, USG and DFID). The Director General of NAC holds regular monthly meetings with the leads of the cooperating partners (NAC 2009d).

The United States Government Group comprising of United States Agency for International Development (USAID), Centers for Disease Control, Department of Defense, and Peace Corps provides technical and financial resources through a number of national and international NGOs. Other donor countries, including the European Union and its member states, Japan, Canada, Australia, and New Zealand and foundations also provide technical and financial resources through international and national NGOs which in turn provide support to community level CBOs, FBOs, and youth groups that are directly involved in service delivery. The financing and technical support is within the framework of the NASF and other national guidelines which provide policy and technical guidance.

## ***Role of UN agencies***

The goal of the United Nations Country Team is to prevent and continue to reverse the spread and impact of HIV and AIDS to achieve a 50 percent reduction in new HIV infections by 2015 by supporting the scaling up of the national response to the HIV epidemic. The UN team recognizes the need to work with stakeholders including young people (through the Youth Forum and Youth Networks) in order to achieve this goal (UN Zambia 2010):

*We are a coordination organization, we coordinate, we give support to the National AIDS Council to coordinate and to ensure that they include young people in all the policy issues, so we are not implementers.*

Key informant

### **Box 1 Joint outcome results for the UN family**

The new United Nations Development Assistance Framework (UNDAF 2011–2015) is the UN system's collective contribution to Zambia's Sixth National Development Plan (SNDP 2011–2015). It has identified prevention of new HIV infections and scaling up treatment, care, and support as a top development challenge for Zambia. The UNDAF Outcome 1 Group on HIV brings together 13 resident UN agencies, among them UNDP, UNAIDS, UNFPA, UNICEF, ILO, IOM, FAO, UNECA, UNESCO, UNHCR, UNODC, World Bank, and WHO with the aim of achieving the following outcomes:

- 1.1 Government and partners scale up prevention services to enable the reduction of new infections by 50 percent by 2015;
- 1.2 Government and partners scale up integrated and comprehensive ART services for adults and children especially in under-served rural and peri-urban areas by 2015;
- 1.3 Government and its partners develop and implement social protection policies and strategies to mitigate the impact of HIV among vulnerable groups by 2015; and
- 1.4 Government and partners coordinate a harmonized and sustainable multi-sectoral HIV response by 2015.

Source: UNDP ([http://www.undp.org.zm/index.php?option=com\\_content&view=category&id=1&Itemid=9&8e2474a80d13c9785641fc2923161380=obtvjhjb](http://www.undp.org.zm/index.php?option=com_content&view=category&id=1&Itemid=9&8e2474a80d13c9785641fc2923161380=obtvjhjb))

The UNAIDS Country Office for Zambia operates within the UN Resident Coordinator system to support the work of the United Nations Country Team. The primary role of the Country Team is to facilitate a coordinated UN system support to the national AIDS response through the efficient and effective functioning of the UN Joint Team on AIDS and implementation of the Joint UN Outcome Results Framework on AIDS.

The following is a common result area for the UN team that relates to young people:

- Prevention strategies for Young People
- Strengthened coordination
- Comprehensive knowledge
- Strengthened linkages between SRH human rights and HIV

Within the framework of the Joint UN Programme of Support on HIV and AIDS (2011–2015), UNDP convenes Outcome Group 1.4 on Governance of the Multi-sectoral and Decentralized Response to HIV and also actively participates in Outcome Group 1.3 on enhancing HIV-

sensitive social protection. The following outcome from the UNDP Country Programme Document for Zambia 2011–2015 is specifically focused on young people: To increase the percentage of young women and men aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission from 39 percent for men and 38 percent for women in 2009 to 65 percent in 2015.

According to the UNFPA Zambia Country Plan 2011–2015 UNFPA aims to work through NAC to implement the HIV aspect of the gender component of its strategic plan and Ministry of Youth and Sports along with youth networks to implement the young people SRH component. Outputs include:

- Strengthening SRH services for adolescents and sex workers,
- HIV prevention services for young people and other at risk populations, and
- Capacity to plan and implement gender and AIDS policies that empower and protect women and girls against HIV (UNFPA 2010).

Respondents to the KII of the current assessment reported the following roles of UN agencies:

- UNAIDS provides overall coordination of the UN response for AIDS.
- UNICEF supports MOE in school life skills and HIV education and NGOs in out-of-school HIV education.
- UNESCO supports MOE to address HIV among students and teachers by assisting in policy and strategy development within the UNAIDS framework, “EDUCAIDS,” but does not implement activities.
- UNFPA supports strategy formulation and implementers through the Ministry of Sports and through Planned Parenthood Association of Zambia.
- WHO plays a normative role by providing technical guidelines to the health sector, especially the MOH.

## Current Programmatic Response to HIV among Young People

### *National strategies for preventing HIV among young people*

HIV prevention among young people in Zambia is anchored in the NASF 2011–2015 under the following strategies:

- Increase quality and coverage of the sexuality education in schools for young people and targeted behavior change programmes/campaigns for young people, particularly young women.
- Scale-up evidence-based prevention programmes for women and men aged 15–24.
- Implement programmes that protect girls and boys from the risk of intergenerational infection.
- Strengthen programmes that facilitate and promote girls’ completion of the basic education programmes.
- Support links between the Poverty Reduction Strategy Programme and HIV prevention programmes to reduce structural factors such as gender inequality, poverty, income disparities that promote transactional sex, particularly for women and girls.



- Explore innovative strategies including strengthening mobile HTC facilities, establishing youth friendly HTC centers that will also offer adolescent friendly SRH services and complement counselling and testing services.
- Integration of condom distribution and education in other services and in particular male circumcision, SRH, young people friendly services, prevention of mother-to-child transmission (PMTCT), and STI services.

### ***Current HIV prevention programmes addressing young people***

The literature review, FGDs, and KIIs conducted during this situation assessment suggest that the HIV prevention response among young people in Zambia comprises the following, broad services:

1. HIV and life skills education are provided in primary and secondary schools, sometimes with the support of NGOs targeting young people from upper primary upwards, as well as school-based anti-AIDS Clubs.
2. Youth peer education is provided by NGOs and CBOs targeting young people in and out of schools, boys and girls, and younger and older young people.
3. Multi-media education campaigns including ICT provided by a variety of institutions including government agencies and NGOs targeting young people and the general population.
4. Edu-sports and theatre provided by NGOs and CBOs targeting young people and the general public.
5. Abstinence only campaigns conducted by NGOs, especially FBOs targeting all young people, but with special emphasis on young people who are younger who have not yet started sex.
6. Young people friendly health services comprising of SRH services provided in a separate space for young people in public health settings.

Following is a description of the above programmes using examples from the literature search, FGDs, and KIIs. While specific programme examples are mentioned by name, this review is not a comprehensive listing of HIV services or programmes for young people<sup>6</sup>. As mentioned in the methodology section some of the examples given below may only have limited data of effectiveness but they are included because they offer sufficient descriptions of the programmes.

#### **HIV and life skills education in schools including anti-AIDS clubs**

Life skills education aims to influence young people's behavior by increasing their autonomy, decision-making, and self-esteem. SRH and HIV are topics that can benefit from the life skills approach (Kesterton and Cabral de Mello 2010). The Zambia education policy of 1996 mandated schools to have a curriculum that addresses sexuality and personal relationships as well messages about HIV (UNESCO 2011). In addition a Life Skills Framework was developed.

According to UNESCO sexuality education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own

<sup>6</sup> Some implementers may not find their projects mentioned, but this is not to imply that their work is unimportant.

values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality (UNESCO 2009).

WHO defines life skills as abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life. WHO identifies four different types of life skills: livelihood and vocational training, practical health skills, physical skills, and psycho-social life skills (WHO 1993). Countries have incorporated HIV in the psycho-social competence life skills (UNESCO 2011). The school-based life skills education approach is particularly important for HIV education of young people since school-based programmes benefit a ready-made audience of young people (Kesterton and Cabral de Mello 2010).

The Zambia Life Skills Framework includes: self awareness, interpersonal relationships, effective communication, coping with emotions, empathy, decision making, creative thinking, critical thinking, and coping with stress. HIV is one of the cross-cutting themes covered under these life skills. Zambia has a Life Skills and HIV education curriculum for grades 1 to 7 developed in 2003. Other resources used in schools are: peer educators manual and interactive methodology for educators on HIV (UNESCO 2011).

According to the UNGASS report 2010, HIV education is part of the curriculum in primary schools, secondary schools, and teacher training. It is stated that under the Basic Education Sub-Sector Investment Programme, the MOE developed a comprehensive HIV strategy, which includes the mainstreaming of HIV issues in the curriculum and dissemination of information to both learners and teachers (MOH and NAC 2010).

### ***Status of life skills education in Zambia***

The NASF 2011–2015 states that in 2006, 60 percent (4,567 out of 7,611) of schools were providing life skills based HIV education and by 2007, a cumulative number of 1,102,637 young people were reached with life-skills based HIV education. The NASF annual report (2009d) indicated that of the 2,437,198 young people targeted for life skills education, only 277,982 (11 percent) were reached, a 17 percent reduction from 2007. The reason for this decrease was that although teachers had been trained in life skills and HIV in 60 percent of schools, some did not show interest in HIV education as they considered it extra work (NAC 2009a). The report does not however, specify whether the 60 percent was evenly distributed between primary and secondary schools. Since sexuality education is not an examinable subject it is often given lower priority or left to guidance and counselling teachers, who are not given the time, skills, and resources to address sexuality education (UNESCO 2011).

In addition to life skills education in class, another avenue for reaching young people in Zambia with education about HIV is anti-AIDS clubs. These clubs are one of the earliest responses to HIV among young people in Zambia. The first anti-AIDS club was formed in 1987 and by February 1992 1,150 clubs had been formed. Of these, 49 percent were in primary and secondary schools, 5 percent in post-secondary institutions and the rest in communities. Boys comprised 56 percent of the membership. Club members talk about AIDS with their friends and extended family members when they go home for holidays, spreading the idea and fostering the formation of additional clubs. Club members teach friends about how to help people who are infected or ill (Baker 1993). Anti-AIDS clubs are often supported by NGOs such as the Planned Parenthood Association of Zambia and the Christian Health Association of Zambia.

Some NGOs support schools and teachers to provide life skills education on HIV and anti-AIDS clubs. For example, in the first quarter of 2004, Youthnet reached 100 schools with 3,800 SRH

lessons and weekly anti-AIDS club meetings (Kapaso 2006a; YouthNet 2002). The Reaching AIDS Affected People with Integrated Development and Support (RAPIDS) programme had a life skills programme for increasing HIV prevention among young people mainly through abstinence messages. Part of the programme was to train peer educators in life skills. It is reported that in the first six months of 2008 the project's life skills programme reached 62,752 young people (World Vision 2005; USAID AIDSTAR-One 2009). The International HIV/AIDS Alliance has produced three books with a teacher's manual on HIV and life skills: *Our Future: Sexuality and life skills education for young people*. The three books target young people in grades 4 to 5; 6 to 7 and 8 to 9 respectively (International HIV/AIDS Alliance 2011). A review by UNESCO also reported that sexuality education in schools receives NGO support through clubs such as SAFE and other interactive activities. The review further reported that the education sector receives help from NGOs such as Restless Development for information on sex education, SRH, and life skills (UNESCO 2011).

Regarding quality of Life Skills Education in schools, the UNGASS 2010 report states that the MOE carried out an audit in 2009. The audit sampled five provinces of Zambia's nine and covered 15 districts and 45 schools. A total of 79 lessons were observed, using a check-list developed to capture seven critical elements of the classroom process. The audit showed that about two-thirds of the teachers (67 percent) exhibited an understanding of life skills which they were able to apply during lessons. Further, out of 79 lessons observed, 63 per cent were able to integrate life skills and HIV in their lessons. However, for most of these, the audit showed that the integration observed was not reflected in the lesson plans that teachers had prepared (MOH and NAC 2010).

In summary, schools are providing life skills-based HIV education. Some NGOs are working with the education sector to support life skills education in the class room as well as through anti-AIDS clubs. It is generally agreed that schools remain the best channel to reach the vast majority of young people with HIV and sexuality education, yet teachers may not prioritize the subject, and coverage and content may depend on the involvement of NGOs.

### **Young people peer education**

Young people peer education is a popular service that can be used in schools, communities and health facilities. The main activity is usually information giving but may include counselling, condom distribution and referral to clinics (Kesterton and Cabral de Mello 2010). The concept of peer education was introduced in Zambia in early 1986. In schools, peer education activities were conducted in anti-AIDS Clubs. In 1997/1998, the concept was integrated in the Ministry of Health in youth friendly health services (Lubasi 2006). According to Goodrich (1999), the Copper Belt Health Education Project was one of the NGOs that pioneered peer education in Zambia because it acknowledged young people not as passive clients receiving information and services but as active service providers and shapers of policy.

### ***Status of young people peer education in Zambia***

A number of organizations provide peer education in Zambia. For example, Student Partnership Worldwide, now Restless Development, is reported to have recruited and trained unemployed young college graduates as professional peer educators and deployed 850 of them to provide HIV education in villages and rural schools for a period of eight months every year (Kapaso 2006a). It is reported that this programme was reaching over 50,000 young people per week (Kapaso 2006b). Mutale (2006) reported a young people-led, peer-to-peer programme reached 1.2 million young people between 2000 and 2006 using an age-segmented life skills education with one programme designed for 8–14 year olds and another for 15–35 year olds.

Lubasi (2006) described the YouthNet peer education programme and reported that the activities triggered more open discussion among young people on SRH topics. Young people became more aware of SRH services in their community and more young people visited young people friendly clinics. There was also an increase in the number of young people participating in peer education programmes. In addition peer education triggered the formation of young people CBOs.

Planned Parenthood Association of Zambia in collaboration with Christian Health Association of Zambia conducted a young people SRH project in 16 communities in Zambia, training 134 peer educators who offered SRH information to young people at locations where they congregate (e.g., football fields, schools, youth clubs and community events) (CPHA, PPAZ, and CHAZ 2007). The project reached 717, 000 young people in four years (2002 to 2006) through community-based distributors and peer educators with SRH information and services including oral contraceptives and condoms.

Svenson, Burke, and Johnson (2008) conducted an assessment of five peer education programmes in Zambia which included a population-based survey of young people aged 15–24 to assess the reach and impact of peer education projects. The study was carried out in seven public health clinics providing reproductive health services, and their catchments communities. One clinic was not linked to any peer education programme while two clinics were linked to one peer education programme and the remaining four clinics were each linked to one programme. They report that peer education exposure in Zambia was high (43 percent), more so in urban (45 percent) than rural areas (42 percent). The number of peer educators trained and deployed per programme ranged from 50 to 170. Young people attending clinics were more likely to report contact with peer education (75 percent), and 50 percent of young people attending clinics were referred by peer education programmes. Exposure to peer education was associated with increased knowledge and condom use (26 percent among exposed young people vs. 11 percent among non-exposed young people).

In summary, peer education is a widely used approach to provide HIV and SRH information and services to young people in Zambia. Peer education has been used to reach young people in various locations including schools, health centers, communities, and other locations where young people congregate. Youth peer educators can be trained to provide education, counselling, and services and can be vital in referring young people to seek services. Evaluation data is scarce but the one study with outcome data has shown that peer education increases uptake of young people friendly health services as well as increasing HIV knowledge and condom use among the population.

### **Multi-media education approaches**

Various media including IEC materials such as posters, mass media, and information and communications technology (ICT), as well as peer educators can be used to promote behavior change and utilization of services among young people. Mass media can reach a wide range of people especially if a variety of media are used. Sometimes information is combined with a social franchising element that brands products such as condoms and contraceptives and guarantees their quality. Multi-media campaigns can also be used to create community support for SRH services for young people (Kesterton and Cabral de Mello 2010).

### ***Status of multi-media approaches in HIV programming among young people in Zambia***

*Radio and television:* In a review of social marketing programmes in Zambia that specifically target young people, Van Rossem and Meekers (2007) describe the SFH NTG (New Teen Generation), a radio programme for young people on teenage pregnancy, HIV and condom use and *And Your*

*Health Matters*, a series of documentaries on TV and radio of Zambia National Broadcasting Corporation, which cover HIV prevention among young people and how parents and teachers can help young people improve their behaviour. Chanda (2006) described a multi-media project in which the University of Zambia youth leaders carried out education tours in rural areas during which they used radio programmes with live, phone-in information exchange with young people in the general population. Topics included life skills, safer-sex options, peer education and counselling and effective communication skills. This work was supported by the MOH.

However, there are only a few reports of media approaches in Zambia that have been evaluated for their impact on SRH behavior of young people. *Helping Each Act Responsibly Together* (HEART) uses a combination of TV spots, radio programmes, print stories and video dramas to reach young people aged 13–19 with abstinence, return to abstinence, and condom messages. The programme was designed by young people to reach their peers. They report that campaign viewers were 1.6 times more likely to report primary or secondary abstinence and 2.4 times more likely to have ever used a condom than non-viewers. Viewers who had seen the TV spots three or more times were more likely to use condoms at last sex than those who had viewed it fewer times (Underwood et al. 2006).

*Use of ICT as a media to reach Zambian young people with HIV education:* ICT in the form of internet and mobile phone technology is a special form of media which is becoming popular for reaching young people with HIV information. Proponents of ICT approaches have argued that with the current wide accessibility of mobile phones in Zambia, ICT will reach more people than printed material and young people have a keen interest in ICT (One World Africa 2011). They have also argued that use of ICT enables young people to confidentially access information on sensitive issues such as sexuality without the censure of other people. The downside to it could be that young people could access information that is inaccurate that may put them at risk (UNESCO 2011). While some examples of such ICT approaches exist in Zambia, there do not appear to be any reports of evaluation of the reach or impact of ICT as a media for educating young people on HIV in the literature reviewed.

The Rotary Club supported a project, e-Riding, which trained young people to use ICT to reach peers with HIV information. The ICT skills are reported to have helped some young people to gain employment (Sepiso 2006). However, some young people may find the cost of internet access prohibitive. To encourage young people to access information on the internet Planned Parenthood Association of Zambia is reported to have established a free internet café at its clinic in Lusaka and young people use it to access information.

ICT is sometimes used in combination with broadcast media to reach young people with HIV education messages. UNICEF Zambia reports using digital diaries which record interviews of young people as they talk about behavior change to avoid HIV, which are broadcast on UNICEF radio to reach young people. The interviews are also accessed on Voice of Youth, UNICEF's online community. It is reported that this approach enabled young people to discuss more controversial sexual behavior issues that are not discussed at school (UNICEF 2009). One World Africa (2011) conducted the School Youth AIDS Project targeting pupils in seven Zambian schools to discuss and debate HIV-related issues shared in a social group known as the D-group on the internet so that other young people can have access to it.

It is thus apparent that multi-media is a major approach being used in Zambia to reach young people with HIV information and includes TV and radio broadcast, interactive radio, ICT as well as mobile phones. Use of ICT and mobile phones has not been evaluated and yet they have the potential to attract more young people since they are new and modern. With the advent of ICT



social media such as Facebook, Twitter, and other e-platforms it is expected that ICT will play an increasingly important role in reaching young people with HIV and SRH information.

### **Edu-sports and theatre**

Edu-sports is the short form for educational sports, in which sports are used to deliver educational messages about HIV and SRH. According to Kesterton and Cabral de Mello (2010), events which attract the attention of the community such as sports and street theatre can both be used to promote positive behavior among young people and also generate community support for SRH in general. The sports and dramas are activities carried out by young people and hence have a high level of involvement enabling the young people to communicate to other young people about HIV prevention.

#### ***Status of edu-sports in HIV programming among young people in Zambia***

In Zambia soccer is a popular sport and a number of projects are using it to reach young people with HIV prevention messages. Peacock-Villada, DeCelles, and Banda (2007) reported the Grassroots Soccer project which used soccer to teach young people aged 10–18 in Zambia and South Africa about preventing HIV infection. Grassroots Soccer trained professional and youth players to reach other young people aged 8–18 with HIV prevention messages using a curriculum developed for the project. The activities were designed to meet the sports interest of young people while at the same time delivering HIV prevention messages.

Dunking AIDS Out uses peer coaches to engage young people in basketball. The peer coaches are trained in ethnographic methods to engage young people in a FGD that addresses HIV issues after a basketball drill. It is reported that young people become engaged in the HIV messages because of the competition and fun in the games (Banda 2006). Planned Parenthood Association of Zambia and Church Health Association of Zambia report that they conducted edu-sports for both girls and boys and use the sports to communicate HIV prevention and health promotional messages and that in communities where there is little else in the form of entertainment for young people the sports and games are very popular (CPHA, PPAZ, and CHAZ 2007).

However, reports of monitoring the reach of edu-sports and evaluating its impact are rare. Peacock-Villada, DeCelles, and Banda (2007) reported that evaluation in seven countries including Zambia in 2004 showed that Grassroots Soccer improved HIV knowledge, attitudes, and practices. The report does not provide specific data on Zambia, but for Zimbabwe the evaluation showed that young people who participated in Grassroots Soccer were six times less likely to report sexual debut compared to their matched peers, four times less likely to report sex in the past one year, and eight times less likely to report ever having more than one sexual partner.

#### ***Status of theatre in HIV programming among young people in Zambia***

Drama is another participatory communication channel that is conducted by young people while they gain education and information. Young people act out different roles in the drama and communicate HIV messages that reach the audience as well as the actors themselves. Theatre for Community Action reached 8,000 young people in 20 communities using theatre followed by FGDs. The resulting formation of community action groups sought to ensure that action plans were made for the participating young people and that the young people were linked to existing institutions for the sustainability of this response. The theatre activities were based on formative information collected from consultations with the community including young people in and out-of-school and NGOs and CBOs (Banda 2006). Planned Parenthood Association of Zambia and Church Health Association of Zambia also report that through their work drama groups are

organized by young people at beer halls and other gatherings to promote HIV prevention and delay of sexual activity among young people (CPHA, PPAZ, and CHAZ 2007).

In summary, sports and theatre are common approaches for reaching young people in Zambia with HIV information. They have the advantage of enabling young people to be involved in delivering the activity while simultaneously receiving information. The other advantage is that in communities where there is very little entertainment for young people sports and dramas find a ready void to fill. However, the number of young people being reached by these services/programmes has largely not been documented and the evaluation of impact is still limited.

### **Abstinence-only approaches**

One approach to HIV programming among young people in Zambia is the promotion of abstinence. In 2005, the Safe from Harm project initiated a programme of parent-child communication for young people aged 13–19 to delay sexual debut. Young people reported being empowered to resist peer pressure for sex, and parents reported increased communication with their young children about HIV (Greene et al. 2006). The Family Matter Programme used parent-child communication to conduct a pre-risk programme for young people aged 9–12 to shape their behavior intentions before sex begins. It is reported that parents were willing and able to abrogate taboos and talk to young children about sex (Miller et al. 2010). Church Health Association of Zambia also operates a programme to promote non-risky behavior among young people (Mwansa 2006). However, there is a paucity of data evaluating these programmes to determine their effectiveness.

### **Young people-friendly health services**

According to the MOH, young people friendly services help young people overcome barriers to accessing HIV services (see Box 2).

#### **Box 2 Young people friendly approach**

- Young people friendly services involve young people in all aspects of programme planning, operations, and evaluation
- Young people friendly services should be provided by health workers who are sensitive to young people and ethnic cultures as well as to issues of gender, sexual orientation, and HIV status
- Young people friendly services usually have flexible hours, convenient locations, and walk-in appointments

Package of services comprising young people friendly services (MOH 2009):

- Peer counselling on HIV and STIs
- Post-abortion care
- Family planning
- HIV testing and counselling
- Life skills education
- Antenatal care
- Edu-sports
- Edutainment
- Distribution of condoms and IEC materials

Source: MOH, CSO, and Macro International Inc. 2006



Creel and Perry (2003) in a review of studies on SRH services globally cites the two SEATS John Snow YFS pilot clinics in Lusaka, which implemented young people-friendly services in response to formative research showing that parents were too shy to provide SRH information. These clinics trained and used peer educators to provide SRH education in the clinics and communities. The peer educators also provided condoms, contraceptives, prevention education and counselling and antenatal care to young people (Senderowitz 1999). The clinics saw a rise in uptake of SRH by 10–24 year olds from 1998 to 1999: family planning users from 368 to 1,018; family planning revisits from 430 to 1,380; STI services from 207 to 468; antenatal care from 650 to 836 and post-abortion care from 9 to 29.

### ***Status of young people-friendly health services in Zambia***

A key objective in the NASF 2011–2015 is to explore innovative strategies including strengthening mobile HTC facilities, establishing youth friendly HTC centers that will also offer adolescent friendly SRH services and complement counselling and testing services. The MOH introduced the idea of young people friendly corners in health facilities in 1996 (MOH 2009). When the first reproductive health guidelines were developed in 1997, one of the 12 objectives focused on adolescent SRH (Klepp, Flisher, and Kaaya 2008). In the national health strategic plan for 2006 to 2010 it is stated that young people friendly corners were introduced in 50 health facilities and the new strategic plan aimed to expand to cover all health centers. Following the mid-term review of NASF 2006–2010 it was recommended to establish and scale up youth and adolescent friendly HTC services especially in rural areas (NAC 2009a). Further, the new NASF 2011–2015 states that in order to increase uptake of HTC by young people innovative strategies will be explored including the strengthening of mobile HTC facilities and establishment of young people friendly HTC centers that will also offer adolescent friendly SRH services. It was also stated that the new strategy was to involve district youth departments in developing district health plans (MOH 2005).

Involvement of district authorities is crucial to gain support for young people friendly health services. Mmari and Magnani (2003) reported a project where the Lusaka District Health Management Team worked successfully with development partners, CARE International, John Snow, and UNICEF to increase community acceptance of young people friendly services by educating parents and other adults in the community about the importance of reproductive health services for young people.

UNFPA in its new country plan for Zambia (2011 to 2015) has as one of its indicators to increase the percentage of young people aged 15–24 utilizing young people friendly services in programme sites (UNFPA Zambia 2010). Family life clubs at schools and youth friendly corners at health facilities were hailed as best practices by young people from Zambia participating in the UNGASS review meeting in 2005. They also reported that these health services were more available in urban areas (Banerjee and Grote 2005).

Planned Parenthood Association of Zambia and Church Health Association of Zambia in their four year project (2002 to 2006) on reproductive health trained 16 health workers from their project sites to provide young people friendly services. This resulted in the peer educators becoming comfortable to refer clients to the health clinics. Further, Planned Parenthood Association of Zambia has established young people friendly services at its Rachel Lumpa Clinic in Lusaka and at the participating Church Health Association of Zambia sites at Nyanje, Chipembi and Mpika (CPHA, PPAZ, and CHAZ 2007).

Yet a survey of health facilities in all nine provinces of Zambia reported that only 15 percent provided youth friendly HTC/PMTCT services. The highest was 32 percent in Northern and 24 percent in Copperbelt and lowest was 7 percent in Southern province and Lusaka was at 16 percent. Young people friendly services were reported to be more available in government than in NGO facilities. Of the facilities providing YFS services, 75 percent had at least one provider trained in YFS guidelines (MOH, CSO, and Macro International Inc. 2006). The reasons for limited availability of Young people friendly services include lack of funds and space to provide separate services to young people.

*Health facilities, government clinics as well, I have been in some government clinics where they have youth corners, they are functional. In some because they say they do not have the funds or the clinic does not have the space to host a youth corner, they do not, but from other organizational clinics that I have been to youth friendly services are the focus, so they are definitely youth corners at all those clinics.*

Key informant

### **HTC and PMTCT services**

The data in ZSBS 2009 shows that the proportion of young people aged 15–24 who know a place to receive HTC has increased from 63 percent in 2000 to 90 percent in 2009. The proportion of men aged 15–24 who ever tested for HIV rose from 9 percent in 2000 to 21 percent. Their female counterparts experienced a much higher rise—from 9 percent in 2000 to 51 percent in 2009—thought to be largely due to PMTCT services. Indeed the 2007 ZDHS showed that in the age group 15–19 years, 22 percent of women had ever given birth to a child and in the age group 20–24 years 79 percent had ever given birth. The ZDHS also showed that 94 percent of all women aged 15–49 who had a live birth in the past five years had received antenatal care from a skilled health worker. This implies that HIV testing during antenatal care is one of the most important approaches to reaching young women with HTC.

PMTCT services are vital for young women because according to the 2007 ZDHS 28 percent of young women aged 15–19 have begun child bearing, i.e., they have ever had a live birth or are currently pregnant. This percentage increases to 55 percent of 19 year old young women. The 2010 UNGASS report indicated that in the year 2009 a total of 581,103 pregnant women were tested for HIV and received their test results of whom 74,191 or 14 percent, were HIV-positive. Thus PMTCT enables a high number of young women to learn their HIV status. The UNGASS report further states that 61 percent of HIV-positive pregnant women received antiretrovirals (ARVs) for PMTCT prophylaxis. The same report also states that 65 percent of pregnant women known to be HIV-positive received assessment for highly active antiretroviral therapy (HAART) eligibility either by CD4 testing or clinical examination and an estimated 16 percent of HIV-positive pregnant women received ARVs for their own health. Hence, since a high proportion of young women have begun childbearing, PMTCT provides an opportunity for them to be reached with HIV counselling, HIV testing, assessment for eligibility for HAART, and for those who are eligible to start ARVs for their own health.

A major gap within PMTCT efforts is the low level of male involvement thus resulting in missed opportunities for partner disclosure of HIV status and partner testing. The UNGASS report indicated that in 2009 only 10 percent of male partners of PMTCT mothers were reached with HIV testing and counselling through antenatal care.

With regard to recent HIV testing, the proportion of men aged 15–24 who tested for HIV in the past 12 months and received their test results increased from 3 percent in 2000 to 13 percent

in 2009. The same indicator showed a steeper rise among women of the same age group from 4 percent to 28 percent during the same time period. In the MOT study report it was confirmed that the higher proportion of women tested for HIV was due to testing at antenatal care clinics (NAC 2009).

Young people in Zambia have expressed the need for privacy when receiving HIV testing and counselling and for complete and accurate information (McCauley 2004). A qualitative study among young people aged 16–19 who knew their HIV status in Ndola showed that young people's decision to take the HIV test was influenced by family members. However, young people tended to go alone for HTC or were escorted by a friend to HTC, but not a family member. Disclosure of HIV status was common to family and friends but not to sexual partners (Denison et al. 2008).

McCauley (2004) conducted a review of HTC access for youth globally and reported that in Zambia the then providers of HTC included Kara clinic in Lusaka as a place where an increased number of young people were receiving pre-marital HTC, and that in general Kara HTC was seeing more young men than women. Kara HTC was also reported to have developed post-test clubs that helped young people to reinforce their preventive behavior. In Hope Humana HTC in Ndola 15 percent of the clients were reported to be aged 10–19.

HTC services are widely available in the country. The 2010 UNGASS report shows that in the year 2009, almost all health facilities in Zambia provided HIV testing and counselling services and reported a combined total of 1,800 HIV counselling and testing sites covering the whole country. It is reported that in 2009 a total of 1,050,137 people aged 15 years and older received HIV testing and counselling and learned their results. As mentioned above, there were more women (734,968) than men (315,169) because of women accessing counselling services through PMTCT. The number tested in 2009 is almost double the 511,299 reported in 2008. However, the data was not disaggregated by age.

### ***Condom distribution***

One of the objectives in the NASF 2011–2015 is to integrate condom distribution and education in other services and in particular male circumcision, SRH, young people friendly services, PMTCT, and STI services. Programme data presented in the 2010 UNGASS report indicated that in 2008 a total of 13,553,418 male condoms against 442,785 female condoms were distributed in 2008 from 15,252 condom outlets providing condoms to end users throughout the country. Coverage of condom distribution among sexually active individuals aged 15–49 was reported at only 2 percent. While this data is not segregated by age it can be assumed that coverage among young people is even smaller since many find it difficult to access condoms outside of young people friendly health services and only 15 percent of facilities in Zambia are providing young people friendly services.

In summary, young people friendly health services comprising SRH services provided in a separate space for young people in public health settings are the mainstay of the health sector response to HIV among young people. The government strategy is to establish youth friendly services in all health services in the country, yet coverage remains limited. Peer educators/ counsellors appear to be an integral component of young people friendly services as they can provide a number of SRH services once they receive the appropriate training and supervision. HTC is being promoted through youth friendly health services and the vast majority of young people are aware of where to seek HTC. Family support appears important for young people to make decisions to seek HTC. And although it appears young people prefer friends and peers, as

opposed to family, to accompany them to HTC, young people tend to disclose their HIV status to family rather than sexual partners. Many young women appear to be accessing HTC through PMTCT when they become pregnant.

### ***HIV treatment, care and support strategies***

The National Youth Policy 2006 lists ART as one of the strategies to address AIDS among young people and it also highlights that youth are not specifically targeted by AIDS care and ART programmes and have poor access due to stigma. Indeed, in the NASF 2011–2015 there are no treatment, care, and support strategies specifically focusing on young people. This should not be taken to imply that young people are not receiving AIDS care and support. Young people are receiving AIDS care and support together with adults and young children per the following two strategic areas of the NASF 2011–2015:

- Treatment, care, and support which includes increasing access and enrolment on ART, providing treatment for TB/HIV co-infection and community- and home-based palliative care.
- OVC care where the NASF focuses on strategic needs of OVC such as protecting their human rights and ensuring access to adequate food, shelter, basic education, and health care services, and providing an enabling environment to eliminate sexual and gender based violence.
- Meeting the psychosocial support needs of PLHIV.

### **ART**

In the NASF 2011–2015 it is stated that the priority strategy for ART is to ensure universal access to treatment, care, and support. This entails increased roll out of ART services to more health facilities coupled with adequate human and infrastructure resources to ensure that the supply meets the demand for ART. Demand for ART is likely to increase significantly with the adoption of a cut-off point for CD4 350 (up from CD4 200) as a criterion for starting therapy, an increase in PMTCT clients, and from the demand for ART for post-exposure prophylaxis (PEP) as more people become aware of the service. The number of ART sites in Zambia increased from 107 in 2005 to 355 in March 2008. The NASF output target for this area is: health facilities dispensing ART will have increased from 355 in 2008 to 400 in 2013 and 500 by 2015.

According to the 2010 UNGASS report, the percentage of adults and children with advanced HIV infection who are on ARVs rose from 11 percent in 2005 to 39 percent in 2007, 55 percent in 2008 to 68 percent in 2009. In 2009, from an estimated 382,569 people aged over 15 years needing ARVs, 69 percent were accessing treatment while 62 percent of children (less than age 15) were on treatment out of the estimated 33,964 in need. This data however, does not show what proportion were young people aged 10–24.

### **OVC support**

In practice, care and support for orphaned children comes from families and communities. Extended families have provided support for many affected children and adults, although this capacity is in many areas over stretched. In order to strengthen this support, it is important that households are connected to additional support from external sources. In the 2010 UNGASS report it is shown that 16 percent of orphaned and vulnerable children aged 0–17 years in Zambia were living in households that received free basic external support in caring for the child. Partners involved in providing OVC support include the government, Christian Health

Association of Zambia, Zambia National Aids Network, RAPIDS, and Zambia Prevention Counselling and Testing, bilateral and multilateral institutions.

Within the government, the NASF 2011 to 2015 states that the Ministry of Community Development and Social Services is responsible for social protection service provision including OVC care and support. Civil society organizations and the private sector also contribute to social protection programmes through interventions to assist OVC and low capacity-households to acquire skills and micro-finance opportunities. More than 418 registered CSOs are working with OVC. The NASF 2011–2015 output target for OVC is: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last 12 months will increase from 16 percent in 2009 to 25 percent in 2013 and to 40 percent by 2015. In addition to ensuring that OVC receive these basic services the NASF 2011–2015 states that OVC should receive life skills education to ensure that they are able to cope with the challenges of HIV. Life skills are aimed to help them at the individual level to start positively addressing issues related to social and sexual abuse, exploitation, access to services, and to improve their self-esteem.

### **Meeting the psychosocial needs of PLHIV**

The NASF 2011–2015 promotes greater and meaningful involvement of PLHIV in the national response, particularly in prevention of new infections through innovative strategies including promoting sexual reproductive health rights and access to services, gender equality, social and economic empowerment, ensuring an uninterrupted and comprehensive package of treatment care and support. The NASF also promotes PLHIV to play a critical role as peer educators especially among in and out-of-school youth and in community mobilisation. It is anticipated that by meaningfully involving PLHIV, they will contribute to stigma and discrimination reduction at health facility, community, and workplace settings. The NASF plans to strengthen the capacity of PLHIV as individual or organized forms of support groups.

In the NASF it is stated that at the community level more PLHIV are accessing community care and support through support groups. By the end of 2008, the Zambia Network of PLHIV (NZP+) had a membership of 3,500 support groups with approximately 50,000 members in all districts. It is through these support groups that PLHIV access psychosocial support. However, the membership is not segregated by age. Hence it is not possible to determine the proportion of PLHIV accessing these support groups that are young people.

The 2010 UNGASS report highlights the weakness of not addressing the full range of sexual information and reproductive health needs of young people living with HIV (MOH and NAC 2010). Young people living with HIV often have psychosocial needs that cannot be met in support groups of adult PLHIV. The International HIV Alliance carried out a study to understand the SRH needs of adolescents (10–19 years) living with HIV in Zambia and identify gaps between these needs and existing SRH and HIV-related initiatives and services currently available to young people. The study reported that HIV support services vary in their capacity to meet the needs of this group. Treatment support is generic, but addressing the social and psychological needs is more fragmented. Respondents in the lower age groups have relatively limited insights into some aspects of SRH, and what support is available. Services that are welcoming, empowering and willing to share specific information about individual needs are highly valued (Hodgson 2011).



Counselling perinatally infected young people about their sexuality needs is beginning to receive attention. A *PlusNews* article of 30 September 2009<sup>7</sup> describes a sexuality counselling service being provided to these young people by the Pediatric Department of the University Teaching Hospital in Lusaka. It is reported that young PLHIV are coming out with issues that they had not had a chance to discuss before such as their desire to get married and have children and their difficulty disclosing their HIV status to their partners.

## Gaps in Programmatic Response for Young People

### *Gaps in content of HIV prevention programmes for young people in Zambia*

The data reviewed has shown that while many programmes are implementing HIV prevention activities for young people there are a number of content deficiencies that run across the programmes as follows.

- *Lack of emphasis on vocational skills.* While life skills have been introduced in many schools throughout Zambia, young people are also in need of vocational skills to address idleness which has been associated with increased high risk (NAC 2009). It is important to note that the NASF 2011–2015 has clearly identified the need for income generating activities for young people as part of HIV prevention programming.
- *The lack of consensus in messaging about condoms use versus abstinence-only is confusing to young people.* Respondents during FGDs of the current assessment observed that while the NASF promotes condoms for young people, some FBO programmes are against condoms. Data from the literature review confirmed that it remains a challenge to reconcile the abstinence-only messages with condom promotion messages. Yet NAC strongly supports condom promotion, and the SWOT analysis of the NASF 2006 to 2010 cited increased condom distribution among young people aged 15–19 as a strength of the national response (NAC 2010b). This apparent lack of consensus has been interpreted by some young people to imply that the implementers of abstinence-only programmes have their own agenda different from the national strategy.

Zambian young people participating in the UNGASS review meeting in 2005 also reported that some internationally funded programmes for young people insisted on their own policies such as “abstinence-only” (Banerjee and Grote 2005). Gordon and Mwale (2006) also commented that resources were being spent on promoting abstinence-only programmes for young people and discouraging condoms, and they called for a balanced approach. The NASF 2011–2015 highlights low levels of condom use among young people above 15 years of age as a gap.

Furthermore, the NAP-WGHA 2006–2010 identified gaps in terms of messaging about abstaining in the sense that girls are told to say “no” to sex but they are not taught how to say “no” to sex. Further, messages about condoms were conflicting with messages to abstain, thus leaving the girls confused. One of the action points recommended is to review the messages on the ABC campaign and ensure that “faithfulness” is applied to both men and women (GRZ Cabinet Office Gender Division 2007). The FGD participants for this situation analysis also confirmed that HIV prevention messages were not consistent on condoms versus abstinence.

- *Messages and messengers are not sensitive to the needs of young women.* Female FGD participants for this situation assessment reported that they were concerned about the HIV messages they received on radio and TV, which did not present the information

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<sup>7</sup> <http://www.plusnews.org/Report.aspx?ReportID=86356>

frankly and because the messages were presented by older people. Messages have also been perceived as being distant and cold (WLSO2006). These findings can be interpreted to mean that the designers of the current HIV prevention messages apparently do not take into consideration the concerns of the young female segment of their audience. The findings also indicate that there is limited involvement of young women in the design and communication of HIV messages targeting young women.

- *Current HIV education approaches are indirect and tend to avoid the issues.* Borg et al. (2010) conducted a survey of knowledge, attitudes, and practices among young people in Zambia and reported that about one-third of respondents preferred a change in methodology of HIV education from “beating about the bush” to a straightforward and frank approach. They also preferred alternative methods of education such as drama, song, poem, sketches, sport, TV, and radio, or a combination of these alternative methods.
- *Teachers of HIV and life skills education do not sufficiently cover condoms and sexuality.* Young people participating in FGDs in the current assessment acknowledged that schools are providing HIV education but were concerned that it does not include sexuality education and condom promotion. In a study among young people aged 11–22 in four secondary schools in Zambia, Warenius (2008) reported that students lacked information about human reproduction, HIV and STIs, and that they wanted to know more about love and relationships. Another study (UNESCO 2011) found that pupils clearly saw gaps in the curriculum and instead get sexuality education from NGOs such as Youth Forum, Edu-Sport, and the Anti-AIDS Teachers Association of Zambia. In class, they seemed to receive sexuality education as part of other subjects such as biology lessons. The gaps in content could be because teachers find it difficult to teach sensitive topics. Zambia young people participating in a meeting to review UNGASS progress in 2005 reported that life skills based education was not consistently available in Zambia and where it was it depended on the initiative of individual teachers (Banerjee and Grote 2005). Sexuality education in schools is therefore scant and selectively taught in the school curriculum.
- *The curriculum for Life Skills education is deficient on sexuality issues.* While the curriculum of the lower grades 1 to 7 sets the foundation on sexuality education it is not followed up by the curriculum for the higher grades 8 to 12. Rasin (2003) confirms that while HIV education has been part of the school curriculum since mid-1990 it usually consisted of biology, Christian values, and self esteem. Hence there is a content gap in information provided especially to older young people who are otherwise receiving other information of unknown quality from peers and the media (UNESCO 2011).

*We are a Christian nation. Am not saying we teach our children explicit sex, no. What am saying is say like if you are dealing with people who are likely to be involved in HIV I mean in sex, people over 16, I don't see why they know about abstaining; if they can't abstain, they should have access easily to preventive technologies including condoms, male circumcision and other things but we are not very keen on such things; we are Christian nation.*

Key informant

- *Parents are not sufficiently empowered to discuss and/or to address sexuality issues with their children.* Apart from teachers the other potential source of HIV and SRH information is parents. However, parents are increasingly expecting the schools to teach sexuality education (UNESCO 2011). Traditionally, parents have not talked to their children about sex, while grandparents were expected to do so; yet increasingly children do not live near their grandparents. Religious leaders have recognized this gap and are promoting the teaching of parents how to discuss sexuality with their children (Kalunde 1997;



Senderowitz 1999). Rasin (2003) carried out ethnographic research in the Copperbelt to understand the issue of parent-child communication. The study showed that communication about sex was limited to warnings to avoid sex before marriage because of the dangers of HIV and pregnancy. Young people reported that they did not have adults they could talk to about issues such as love. Moreover, young people were eager to have straightforward sexuality information in a Western modern way almost like other topics taught in school. Traditional initiation rites provided the only vehicle to teach young people about sex but these usually did not include HIV.

- *Anti-AIDS clubs do not sufficiently address girls' information needs.* Female participants in a study by the WLSA stated that some, but not all, had participated in anti-AIDS clubs. In general they felt the information given in these clubs dealt with general issues and only addressed a small fraction of their needs (2006). Girls may need more information on feelings of sexuality and this was not provided in the clubs.
- *Current messaging is not sufficiently grounded in research evidence.* The current assessment found few reports of formative research prior to the development of young people HIV education programmes. This implies that many of the messages being given to young people are top-down and are not based on understanding their issues and concern. Further, while there are quite a few reports of knowledge, attitudes, and practices of young people it is not clear whether any of the current programmes took these findings into consideration. Finally, the assessment found few reports of programmes that had obtained feedback or evaluation data that could be used to refine and improve programmes, or to measure impact.

It is apparent that HIV prevention programming for young people should consider research findings such as these and feed them into the design of programmes to improve content. Indeed, following the mid-term review of NASF 2006–2010 it was recommended to scale-up evidence-based prevention for young people (NAC 2009a).

### ***Gaps in strategy and approach of HIV prevention programmes for young people in Zambia***

Another set of gaps in current youth HIV programmes relate more to strategy and approach than to content.

- *There is insufficient gender segregation in HIV prevention programmes for young people.* While gender inequality has been widely acknowledged as a key factor in young women's vulnerability to HIV, there is little evidence for gender segregation in current HIV prevention programming for young people and there is limited girl-focused programming (NAC 2009c). Svenson, Burke, and Johnson (2008) conducted an assessment of five youth peer education projects in Zambia and reported that women were less exposed to the projects than men. Respondents to FGD and KIIs of the current assessment highlighted a key concern that most programmes focused on women as victims but not on men as perpetrators of sexual coercion with the aim to change male behavior. As a way forward they mentioned the promising practices of some CBOs that have boys' clubs that engage boys in discussions of gender, or promote couples' communication to both boys and girls.
- *Limited involvement of young people in programme design and implementation.* Young people participating in the FGDs of this assessment confirmed that young people were represented in the development of the NASF but they raised concerns that the representation was tokenism as it did not include young people at the grassroots level. In the National HIV/AIDS Policy (MOH 2005) it is stated that a key gap is that the IEC

materials for young people are not developed with the involvement of young people and hence there is no sense of ownership from the young people and often the materials are not well targeted to young people and may not be culturally appropriate.

- *Insufficient targeting of sub-groups of young people such as sexually active children.* The NASF 2011–2015 identifies key gaps in behavior change programmes to include: inadequate targeted programmes for sexually active children and young people. For these reasons the SWOT analysis of the NASF 2006–2010 recommended conducting operational research as well as a size-estimation and mapping exercise to support targeted programmes for young people and other special groups such as cross border traders and migrants requiring focused attention (NAC 2010b).

### ***Gaps in coverage and access of HIV prevention programmes for young people in Zambia***

Another theme emerging from this assessment is that many HIV programmes targeting young people have challenges relating to coverage and access.

#### **Insufficient coverage**

The NASF 2011–2015 blames the low level of comprehensive HIV knowledge among young people on the failure of current HIV education programmes to cater to new cohorts of young people entering the sexually active age group. These new entrants may require information on the basics of HIV. A number of success stories of young people friendly services are reported but there is limited evidence of coverage of the target audience and there are several reasons for this. First, a main theme running throughout the programmes described above is the lack of monitoring data to show outputs and rigorous evaluation to measure impact. Second, apart from school life skills and HIV education, there are hardly any targets set in terms of young people aimed to be reached by the programme. It is thus difficult to judge programme achievement in terms of coverage. Nonetheless, the available assessments have shown that the coverage remains low and this is mainly due to resource constraints and lack of awareness of young people friendly facilities by some young people.

- *Coverage is limited by demand due to young people's lack of awareness of services.* In the UNGASS review meeting of 2005 young people from Zambia reported that young people friendly services were more available in urban areas than rural areas and emphasized that young people were largely uninformed about these services (Banerjee and Grote 2005). This can result in limited utilization. Programmes such as Service Expansion and Technical Support (SEATS) that used peer educators to inform young people in the community about services recorded increases in service utilization in family planning, STI care, antenatal care and post-abortion care.
- *Coverage is limited by supply type service-site related barriers.* Dixon-Mueller (2009) reviewed SRH services in developing countries, including Zambia, and observed that there were gaps in quantity, quality, accessibility, and availability of these services. Barriers to effective service delivery included erratic supplies and staff shortage; lack of specialized training in SRH; reluctance of staff to provide SRH to certain groups without parental consent; as well as legal or administrative constraints denying SRH services to certain groups of young people.

*Some [services] are not available. If they are available the distance is a challenge particularly those in rural areas. Trained personnel in some of these facilities, qualified human resource as you know that the Ministry of Health for instance operates under less than 50 percent capacity of human resource. So already that is an impediment to the provision of quality health care service. So already those are some of the challenges that are around access to these youth friendly services. They are few, they are not available to all and they are only in specific areas and again in those areas they are equally overwhelmed because of the big number of people that want to access the services.*

Key informant

Young people participating in FGDs of the current assessment were of the view that some adult care providers have negative views about young people's sexuality and the provision of SRH services to young people.

*We've realized that most health workers are not youth friendly. There's a time I went to the clinic, I had stomach problems and she started asking "what have you done"? So these health practitioners are not friendly, that's why we decided to establish youth friendly corners. ...by our very own young people.*

Female FGD participant

A study in Kenya and Zambia regarding health workers' attitudes towards SRH revealed that nurse midwives disapproved of young people's sexual activity including masturbation, contraceptive use, and abortion. The same study showed that young people preferred SRH services where they were attended by providers of same sex, providers who respected them, examined them, and asked questions. The study further showed that health workers with more education and more participation in continuing medical education were more likely to have friendly attitudes toward young people (Warenius et al. 2006).

- *Lack of adequate resources.* Resource constraints have hampered the scale up and roll out of services/programmes that are considered effective among young people. For example, as mentioned before, the coverage of school-based life skills and HIV education dropped because of poor motivation of teachers who wanted extra pay for this assignment and yet this programme has the potential for enormous impact since it takes advantage of the well established nation-wide schools structure (NAC 2009). Another programme that could use a well established nation-wide structure is the young people friendly services in health facilities. Unfortunately, due to insufficient funding young people friendly services have limited functionality and only 15 percent of the health facilities in Zambia are reported to be providing young people friendly services (MOH 2009). Furthermore, FGD respondents of the current assessment confirmed that many grassroots organizations for young people have poor funding and weak management structures.

In addition to hampering programme implementation and coverage, lack of resources has also hampered systematic evaluation of programmes to determine their effectiveness and thus do not impact decisions on further investments in these programmes. If programmes such as life skills education, peer education, and young people friendly services were backed by hard impact data it is conceivable that they could generate the same level of attention from donors as ART or male circumcision.

### ***Gaps in meeting the needs of young people living with HIV***

As mentioned before, the current strategies do not highlight the special needs of young people living with HIV. Similarly, there are gaps at the programmatic level as follows.

- *Young people living with HIV experience stigma different from adults with HIV and yet they are expected to seek care with adults.* Young people participating in FGDs of the current assessment reported that stigma deters young people from seeking HIV care, especially where services are provided separately and clients can easily be identified as HIV-positive. They felt that while an adult can afford to be seen in a public ART clinic, young people seeking HIV care more often have to explain their presence to several other people who have authority and influence over their lives such as parents, teachers, and peers.
- *Young people living with HIV have sexuality issues that are not addressed by current services.* It is also acknowledged that HIV-positive young people have SRH needs that cannot be met by pediatric or adult AIDS care clinics (Cataldo et al. 2010). These needs may include the need to balance the desire to express their sexuality as well fertility desires versus the need to disclose their HIV status to their lovers and use condoms (Birungi et al. 2009).

### ***Gaps in monitoring and evaluation of HIV prevention programmes for young people in Zambia***

A major gap that cuts across the HIV programmes for young people described in this assessment is the lack of systematic monitoring and evaluation. Out of the 32 reports of young people HIV programmes included in this situation analysis 16 (50 percent) of the reports contained only programme description without output data, 11 (34 percent) included output data, and five (16 percent) had some form of evaluation data. Failure of some programmes to indicate the number being reached could be because the programmes were not properly recording the young people being reached or because the data was available but was not reported. For some programmes such as multi-media approaches and edu-sports and theatre it may be difficult to document the reach while for others such as clinic-based services it is possible to have good service statistics. Furthermore, even fewer reports described any measure of quality or impact of the programmes described. Rigorous evaluation is expensive and may require funding and expertise separate from programme resources and these kinds of resources are usually harder to come by over and beyond the resources for conducting the programmes. Yet evaluation is critical to ensuring that limited resources are strategically invested in efforts most likely to deliver results.

A key issue is the lack of disaggregation of output data by age and sex in the national output data reported to UNGASS. Without this data it remains difficult for the policy makers to determine what proportion of young people are being reached by key services such as PMTCT, HTC, condoms, family planning, and ART. Furthermore, the data is also not disaggregated by rural versus urban or by risk group. Thus policy makers are not able to determine service coverage for young people in rural areas compared to urban areas and young people among the most at risk populations such as sex workers.

## **Human Resources for Young People HIV Programming**

In the KII conducted in the current assessment respondents were requested to provide information about the number of staff focusing on youth and HIV activities. Among the government of Zambia agencies the MOE and the Ministry of Youth & Sports each have at least

one person who is 100 percent dedicated to young people HIV activities. While NAC does not have a person 100 percent dedicated to young people HIV activities it is reported that the roles are spread over a number of key staff who focus on young people. At the provincial and district levels the number of government staff working on young people HIV activities were reported to be in the range of 10 to 15 although they were rarely 100 percent dedicated to young people HIV issues. Within the UN agencies, each reported to have at least one staff working on young people HIV issues with UNICEF reporting two staff 100 percent dedicated. Among the youth organizations that participated in these interviews the number of staff working on young people HIV issues ranged from 6 to 17 staff working 100 percent.

In summary, each of the key groups of stakeholders namely, the government, the cooperating partners, and civil society have human resources dedicated to young people HIV activities. It is however, difficult to judge the adequacy of the human resources since their functionality depends on the availability of funds for activities.

## Financing of Young People HIV Programmes

The first National AIDS Spending Assessment was conducted in 2007–2008 and covered the years 2005 and 2006. The study showed that most of the funding for HIV activities in Zambia was from external funding sources. It was reported that overall Zambia spent US \$141 million in 2005 and US \$208 million in 2006 on HIV activities. Of these funds, 23 percent were from domestic sources while 77 percent were from external sources. According to the Zambia report to the United Nations General Assembly Special Session on AIDS (UNGASS) for 2008 to 2009 (MOH and NAC 2010) the three main sources of external funding were the Global Fund to Fight AIDS, TB and Malaria, the World Bank Multi-country AIDS Programme and the US government through the President's Emergency Plan for AIDS Relief (PEPFAR).

Over the two years 2005–2006 combined, prevention was the second largest expenditure at 27 percent (US \$93,505,912). It should be noted that in the NASF young people are mainly targeted through the HIV prevention objectives. The NASA report does not provide a breakdown of prevention spending by beneficiary populations, so it is impossible to determine what proportion was spent on programmes for young people. The only indication of the level of spending on young people HIV activities comes from the statement that HIV programmes for special groups including children and young people in school, STI and SRH clients, students, military, police and other uniformed services, factory workers, health care workers received about 2 percent of total spending (NAC 2009). This implies that at the national level the documented specific spending on young people is between 0 and 2 percent but it is impossible to separate young people from the other groups.

*We haven't carried out a manifest of how much funding is going to what, we haven't done that analysis, because even if you look at the national budget, the allocation to the three line ministries, education, youth and child development and ministry of community development and social services they is always contention. It's going to be hard to draw out which of those resources were allocated to them specifically for young people. The best way is now to do a mapping of service providers across the country who are providing young people related services and response to HIV and I think from there on we will be able to determine how much resources will allocate.*

Key informant

With regard to the financing of young people friendly health services, as mentioned before, a number of NGOs have provided support to these services on a case by case basis and there was no data indicating the level of funding through this source. Zambia young people participating in the UNGASS review meeting in 2005 organized for young people by UNFPA reported that most SRH programmes are provided by NGOs that are funded by international donors (Banerjee and Grote 2005). Within the MOH the young people friendly services are considered to be part of the MCH budget in MOH. The overall MOH budget in 2008 was Zambian Kwacha 1.5 trillion (about US \$300 million) which is 11 percent of national budget and this is considered insufficient as it falls below the 15 percent as recommended by the Abuja declaration (MOH 2009). In general, there is limited support to young people friendly services from cooperating partners. In 2008 the overall MOH budget received about US \$200 million from development partners mainly the USG/PEPFAR and the Global Fund but it is not clear what proportion was allocated to HIV activities for young people.

A large proportion of AIDS funding in Zambia comes from the Global Fund. Information from the website of the Global Fund to Fight AIDS, TB and Malaria indicates that Zambia has had three successful proposals to the Global Fund: Round-1 (US \$92.8M for HIV five years); Round-4 (US \$253.6 million for HIV five years) and Round-7 but the amount for HIV is not indicated. In round-8 of the Global Fund for Zambia (Jan 2010 to Dec 2011) the HIV activities prioritize prevention and specifically highlight behavior change communication through community outreach and schools. The proposal intends to reach 200,000 young people in and out of school per year. This activity was allocated a budget of US \$2.5 million per year for Year 1 and Year 2.

Another major donor for HIV activities in Zambia is PEPFAR. The PEPFAR Country Operating Plan for Zambia for the financial year 2010 allocated US \$31.3 million for HIV prevention in Zambia and under this objective the activities include: expansion of evidence-based prevention for young people. It is also stated that efforts will target sub-groups of young people (ages 15–24) and adults (older than 24) to meet their unique needs. Further it is emphasized that activities for adults as well as high-risk and sexually active young people will promote secondary abstinence, mutual monogamy, partner reduction, correct and consistent condom use, and responsible alcohol consumption. Thus it can be assumed that a good proportion of the US \$31.3 million was allocated to young people HIV prevention activities but the exact amount cannot be deduced from this information.

USAID (2011) also has several centrally funded projects that focus on providing care and support to OVC including: World Concern project on OVC support; Opportunity International project for OVC shelter; CRS CHAMP OVC Project; Christian Aid OVC project; FHI FABRICS OVC project; Hope Worldwide OVC project; Hope for African Children Initiative; PCI BELONG OVC Project.

Key informants from the current assessment were not able to provide precise information regarding the actual budgets allocated to young people HIV activities in spite of being sent the questionnaire in advance. This is because their budgets included costs of other activities and hence it was not easy to determine what proportion was dedicated to young people HIV activities. Consequently, they were requested to estimate the annual budgets of their organizations that were allocated to young people HIV activities for the past 12 months. Within the youth NGOs the estimated budget for the last one year on young people HIV activities ranged from \$80,000 to \$181,545. The government key informants estimated that at the province the government spent about \$4,000 and at the district it spent \$2,200 on young people HIV



activities in the past one year. Estimates from the UN agencies varied widely from \$90,000 to \$1.4 million spent on young people HIV activities in the previous year.

In the literature review, information on actual cost of a young people programme in Zambia was also scarce but Svenson, Burke, and Johnson (2008) conducted an assessment of the cost of five youth peer education projects in Zambia. The cost per peer educator varied across the five programmes ranging from \$209 to \$1,219. Across the five programmes the largest proportion of the costs, more than 50 percent, was on training. Other cost elements included supplies, incentives, and supervision.

This information was not obtained in a systematic way and hence should not be used as a basis to make funding decisions; rather it sheds light regarding what funding information is out there and highlights the importance of a systematic effort to obtain this information in order to inform future HIV programming for young people.

## Country Baseline (Levels) and Future Targets for Key Comprehensive Services

### ***Bold results within UNAIDS Business Case for the priority area on young people***

HIV prevention among young people is a priority area for UNAIDS within the UNAIDS Outcome Framework 2009–2011 (2010). The goal is a 30 percent reduction in new HIV infections among young people aged 15–24 years contributing to UNAIDS’ overall goal of achieving a 50 percent reduction in sexual transmission of HIV by 2015. This goal will be achieved through the provision of comprehensive sexual and reproductive information, skills, services, and commodities in a safe and supportive environment tailored to the specific country and epidemic context. In order to achieve this goal, UNAIDS has proposed to support selected countries to achieve the following three bold results (UNAIDS Aug 2010):

- At least 80 percent of young people in and out of school will have comprehensive knowledge of HIV.<sup>8</sup>
- Young people’s use of condoms during their last sexual intercourse will double.
- Young people’s use of HIV testing and counselling services will double.

To assist countries to achieve the above goals and bold results UNAIDS will employ, but not limit itself to, two primary strategies:

- Strengthening the availability and use of strategic information on young people and HIV.
- Developing essential capacities among service providers and establishing strong civil society partnerships (particularly with youth-led and youth-serving organizations) while keeping young people at the centre of the response and enabling them to act as leaders and change agents to create a movement (UNAIDS 2010).

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<sup>8</sup> Defined as knowing that condom use and having just one HIV-negative, faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission—that HIV can be transmitted by mosquito bites and by supernatural means (MOH and NAC 2010).



In the UNAIDS 2011 strategic plan it is further stated that:

*UNAIDS will support the attainment of these goals, including by: 1) generating commitment to prevention throughout society by improving its political palatability; 2) ensuring that strategic information on epidemics, socioeconomic drivers and responses serves to focus prevention efforts where they will deliver the greatest returns to investment; 3) incorporating new technologies and approaches as they are developed; and 4) facilitating mass mobilization for transforming social norms to empower people to overcome stigma and discrimination and their risk of HIV infection, including through comprehensive sexuality education and the engagement of networks of people living with HIV and other key populations. (UNAIDS 2011)*

In order to establish Zambian baselines and targets for the above indicators it is important to relate them to the NASF targets. The NASF has the following targets for 2013 and 2015 that most closely relate to the above indicators in the Bold Results within the UNAIDS Business Case for the priority area on young people.

- Outcome-1: Women and men with comprehensive knowledge of HIV have increased from 35 percent in 2007 for people aged 15–24 years to 51 percent in 2013 and 70 percent by 2015.
- Outcome-4: Women and men aged 15–49 who received an HIV test in the last 12 months and know their results have increased from 15.4 percent in 2008 to 30 percent in 2013 and 50 percent by 2015.
- Outcome-5: Women and men aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 37 percent for women and 50 percent for men in 2007 to 45 percent for women and to 60 percent for men in 2013 and 55 percent for women and 70 percent for men by 2015.

The above NASF targets are not all specific to the age-group 15–24 years and are not all segregated by gender. Further, the baselines are not consistently from the same year. The targets in Table 3 have addressed these two issues using the 2007 ZDHS data. The targets for 2015 have been based on the UNAIDS bold results targets, i.e., attaining 80 percent for the knowledge indicator and doubling of the condoms and HIV testing indicators from baseline. The intermediate targets for 2011 and 2013 are a rough estimate based on the increments projected by the NASF in its targets above.

Thus the study team has proposed the following baselines and targets based on targets in the NASF 2011–2015 and the data in 2007 ZDHS. These figures are tentative pending discussion by a high level advocacy meeting on young people HIV programmes in Zambia for which this report has been prepared.

**Table 3 Bold results within the UNAIDS Business Case for the priority area on young people and national HIV prevention indicators for young people**

| UNAIDS bold results indicators   | Baseline |     | 2011 Target |     | 2013 Target |     | 2015 Target |     |
|--|----------|-----|-------------|-----|-------------|-----|-------------|-----|
|  | M %      | F % | M %         | F % | M %         | F % | M %         | F % |
| Young people aged 15–24 yrs with comprehensive knowledge of HIV  | 37*      | 34* | 45          | 43  | 55          | 55  | 80          | 80  |
| Young single people aged 15–24 yrs who used a condom at last sex among those who had sex in the past 12 months | 47*      | 39* | 60          | 50  | 70          | 60  | 94          | 78  |
| Young people aged 15–24 yrs who received an HIV test in the last 12 months and know their results              | 10*      | 17* | 12          | 20  | 15          | 25  | 20          | 34  |

\*2007 ZDHS

## DISCUSSION

According to the UNAIDS Business Case for Young People (UNAIDS 2010), characterizing the HIV epidemic and the response for young people is a vital first step to inform and improve programme planning and implementation for this population. The process of characterizing should be guided by a situation assessment, aimed at identifying gaps in HIV programmes for young people, and potential directions for their improvement as well as assessing the availability of supportive policies and the legal issues. This information should be used to develop essential actions necessary to achieve the bold results. Essential actions that could significantly reduce HIV among young people include:

- Promotion of responsible sexual behaviour, including reducing the number of sexual partners, delaying sexual debut and using condoms for dual protection from STIs/HIV and pregnancy.
- Revision and enforcement of policies that meet human rights standards and remove legal barriers to access HIV prevention and care services including condoms.
- The implementation of evidence-informed, skills-based comprehensive sexuality education.
- Mass media programmes to influence harmful social and cultural norms and the provision of young people-friendly health services for the prevention, treatment and care of HIV within the country context.
- The full engagement of young people in the design, implementation, monitoring and evaluation of HIV prevention programmes and services, together with the engagement of parents and adults in the community as supportive partners.

The current situation assessment was commissioned by the JUNTA in Zambia and was carried out by the Population Council under the overall guidance of the Zambian NAC as part of UNAIDS support to Zambia to characterize the HIV epidemic and the response for young people as a first step to achieving the bold results. This report will be used for high level advocacy and will inform the operationalization of the NASF 2011–2015 and identify essential actions necessary to achieve the bold results.

The situation analysis has demonstrated that while the young people of Zambia are subject to the traditional vulnerability factors of lack of information, poverty, gender inequities and cultural factors and norms there is a complex form of vulnerability that requires further understanding. The 2007 ZDHS data showed that among the young people aged 15–24 those in the fourth wealth quintile had better comprehensive knowledge about HIV compared to those in the second quintile. And a higher proportion reported condom use at last higher risk sex contact in fourth quintile compared to the second quintile. However, those in the higher wealth quintiles had a higher HIV prevalence than those in the lower wealth quintile. The same trend was observed regarding the level of education. Those with secondary education had better comprehensive knowledge about HIV compared to those with primary education and a higher proportion reported condom use at last higher risk sex contact. However, those with secondary education had a higher HIV prevalence compared to those with primary education.

This data suggests a much more complex HIV risk context for young people in the Zambia setting. The 2007 ZDHS showed the same trend for adults. Speculations can be put forward but they will require further study to validate. For example, it is possible that the increased knowledge

and higher condom use are not achieved before sexual exposure. It could be that the wealthier and more educated Zambians are more vulnerable to HIV exposure due to high HIV prevalence in the urban areas and hence if they happen to have unprotected sex they have higher chances of acquiring HIV infection. And that because they are in urban settings they tend to acquire higher levels of knowledge about HIV as well as higher levels of condom use than their less wealth and less educated counterparts but they will already have been HIV infected.

Within its stated limitations, the situation analysis has also been able to provide a cursory look at the current status of the following HIV programmes in Zambia which are all prevention programmes: HIV and life skills education in schools including anti-AIDS clubs; young people peer education; multi-media education approaches; edu-sports and theatre; abstinence-only approaches; and young people-friendly health services.

The situation analysis has shown that apart from support provided to OVC and an emerging effort to provide psychosocial support for young people living with HIV there are limited care and support efforts targeting young people in Zambia. Other programming gaps identified by the situation analysis include gaps in content, strategy or approach as well as coverage and access of HIV Prevention Programmes for Young People in Zambia. Of notable significance were the gaps in monitoring and evaluation since strategic information indicating coverage, quality, and effectiveness is necessary to focus and prioritize the response to the most vulnerable young people that have lowest access to essential HIV prevention and care information and services.

In the policy area the situation analysis has shown that there is still room for improvement and for making linkages between the legal and policy framework; strategic plans and priorities; and youth HIV programmes. The strategic plan (NASF 2011–2015) is written using a rights-based language that encourages protection of rights of the most vulnerable as well as empowering them to be involved in the design and implementation of young people HIV policies and programmes. However, the laws have loopholes for discrimination against HIV-positive people such as during military recruitment; repression of certain MARPs such as sex workers, a high proportion of which are young people; and a legal age of consent for services which may restrict sexually active young people from privately seeking services without parental consent. The UNAIDS business case 2009–2011 is titled, “We can empower young people to protect themselves from HIV” which suggests that if young people are empowered they can protect themselves.

There is also a dichotomy between the strategic plan and programmes. On one hand the language of the NASF 2011–15 calls for a roll out of evidence based programmes as a priority to reach all young people in the country. On the other hand, the country wide structures to reach these young people such as the young people friendly services at the public health facilities or the school-based life skills and HIV education are not highly functional resulting in limited coverage especially for the rural young people. While there are examples of feasible projects that are being implemented by civil society organizations these are often limited in their coverage and duration due to intermittent donor funding. There is limited effort by government to scale them up or to learn lessons from them and disseminate them to other implementers. There is also limited use of strategic information to monitor and document coverage and hence highlight areas requiring prioritizing in order to reach the underserved young people. Thus, as this report has shown, there is a long list of HIV programmes for young people in Zambia in the literature but the literature is barren of data on coverage, quality and effectiveness of these programmes.

It is thus recommended that the UN Joint Country Team should collaborate with other partner, under the leadership of government to work towards a more inclusive HIV response that

addressed the needs of young people as a priority. The baselines and targets as proposed in this report should be discussed at a high level meeting at the earliest opportunity. It may be too late to provide new activities and targets for Zambia since those proposed in the NASF have been validated and agreed and based on resources and capacity on the ground. Indeed the proposed strategies in the NASF 2011–2015 can go a long way in achieving the bold results if they are fully funded and if there is increased coordination towards a more sustained response. It is however, important for discussions to be held regarding what needs to be done differently in the areas of legal and policy reforms, programme coordination, financing, and strategic information.

## CONCLUSIONS AND RECOMMENDATIONS

This report reflects a self-examination and stocktaking exercise of the HIV response among young people in Zambia. The following recommendations are aimed at further strengthening this response by all stakeholders including the Government of the Republic of Zambia, the UN, faith-based organizations, civil society organizations, donors, young people, and youth led organizations towards “Zero New HIV Infections”, “Zero Discrimination” and “Zero AIDS Related Deaths”.

### ***There is need to amend and strengthen current laws, and create new ones, relating to HIV programming among young people.***

The data reviewed by this assessment suggests that Zambia has supportive laws for HIV programs for young people but there are a number of key gaps. The current legal framework is not strong enough to prevent discrimination based on HIV status. The law on legal minors is a hindrance to young people seeking SRH services without parental consent. And there are no laws that can protect women and girls from sexual and gender-based violence. The UNAIDS business case 2009–11 calls for the following action as a necessity for achieving the bold results, “Revision and enforcement of policies that meet human rights standards and remove legal barriers to access HIV prevention and care services including condoms; and the implementation of evidence-informed, skills-based comprehensive sexuality education.”

In addition to advocating for new laws or amending existing ones, stakeholders should advocate for structures and systems to implement existing laws that are relevant to HIV programming among young people. For example some of the laws aimed at protecting vulnerable children are not effective because they lack sufficient structures and resources for their implementation. For example while the Juvenile Act provides protection children from exploitation, sexual abuse, and human trafficking its implementations remains weak because there are no systems within the community to monitor child welfare and protect children from exploitation.

- Amend current laws to protect people with HIV from being discriminated against and enable sexually active young people (emancipated minors) to access SRH services without requiring parental consent.
- Enforce legislation to protect women and girls from gender-based violence.
- Strengthen structures and systems to implement existing laws, such as the Juvenile Act, that protect children from exploitation, sexual abuse and trafficking.

### ***Young people should be meaningfully involved in HIV policy and programme design and implementation.***

The assessment has shown that structures have been put in place for the involvement of young people. However, the views of young people interviewed in this assessment were that the structures are either non-functional or they do not enable a fair representation of young people across the spectrum especially the rural dwellers. There was also a strong view that organizations led by young people at the community level were not receiving funding and information resources for the implementation of programmes. The findings also indicate that there is limited involvement of young women in the design and communication of HIV messages targeting young women.

- Ensure meaningful engagement and participation of young people in the AIDS response, including policy and programme design.

***Young people friendly health services and life skills HIV education are priority programmes for scaling up.***

Based on the data reviewed in this situation analysis a key priority programmes area is the scale up of young people friendly health services to be functional in all public health facilities, as a minimum. Young people friendly health services are a medium for young people to access crucial SRH services including: HIV testing and counselling, PMTCT, treatment of STIs, antenatal care, family planning and condom supply.

- Revitalize the Ministry of Health (MOH) Adolescent Technical Working Group to enable better coordination of SRH services and integration of HIV in SRH.

Another priority programme requiring scale up is life skills HIV education in and out of school. Life Skills HIV education will empower young people to make decisions to protect themselves from HIV, STIs, and teenage pregnancy. It is the methodology of teaching that eventually enables young people to have critical thinking skills that help them connect what they learn to their lives.

- Develop a comprehensive evidence-informed package of sexuality education for young people that includes life skills for young people who are both in and out of school.
- Apply methods of communication of messages to young people, especially women that are evidence-informed.
- Strengthen the life skills HIV education curriculum with more lessons about sexuality issues.
- Identify and address concerns of teachers who are presenting sexuality topics.
- Support parents with information and skills to educate young people about HIV.

***A comprehensive package of programme guidelines for addressing HIV among young people should be developed.***

The National Youth Policy provides the following list of key services necessary for HIV programming among young people: STI care; training peer educators; providing ARVs; promoting young people friendly services; promoting life skills education; HIV information campaigns using print and electronic media and drama and sports; and providing HTC. Indeed the programmes revealed by this assessment concur with this list. However, the document review did not reveal any guidelines that further elaborate this list into a comprehensive package of HIV programmes for young people in Zambia together with guidelines for implementers.

- Develop a programme package with guidelines for HIV programming for young people basing on the list of key services provided in the National Youth Policy.

***Monitoring, evaluation, and operations research are required.***

There is a general lack of systematic monitoring, evaluation, and feedback and as such young people programme content and strategies are not evidence-informed and do not have proof of effectiveness or outcome. A key issue is the lack of disaggregation of output data by age and sex in the national output data reported to the UN General Assembly Session on AIDS (UNGASS).



Without such data it remains difficult for policy makers to determine what proportion of young people are being reached by key services such as PMTCT, HTC, condoms, family planning and ART. Furthermore, the data are also not disaggregated by rural versus urban or by risk group. Thus policy makers are not able to determine service coverage for young people in rural areas compared to urban areas and young people among MARPs such as sex workers.

- Undertake systematic monitoring and evaluation of HIV programmes for young people in order to refine the programmes and feed into advocacy for more resources to be directed into this area.

The current assessment found few reports of formative research prior to the development of young people HIV education programmes. There is also no ready source of information about specific funding for HIV programmes for young people. Rather, the information available is for HIV activities that target young people together with the general population.

- Conduct operational research and socio-behavioral studies and use results to inform programme design.
- Carry out a costing study to determine the cost of HIV programmes for young people as well as the current spending on these programmes in Zambia.

***Approaches to HIV programming for young people should be revised to meet the different needs of young people.***

Overall, the policies, strategies and programmes on HIV prioritize young people as targets for HIV prevention but do not focus on the special care and support needs of young people living with HIV, young people aged 10 to 14 years and young people out of school, as well as the economic needs of young people.

- Revise policies to highlight the special needs of young women, young people living with HIV, young people aged 10–14, and young people out of school.
- Establish links between socioeconomic empowerment of women and the HIV response.
- Integrate vocational skills in HIV programmes for young people.
- Commission a survey to identify priority prevention areas for programmes targeting young people out of school by identifying venues where young people socialize and meet sexual partners. Where possible apply innovative methods such as the Priorities for Local AIDS Control Efforts (PLACE) methodology.

***The United Nations team should play a leading role in supporting the government and its partners to achieve the targets for the UNAIDS Business Case for young people.***

The Joint United Nations Team on AIDS in Zambia is strategically placed to work with the government of Zambia through NAC and key ministries to provide technical assistance to strengthen actions that can empower young people to protect themselves from HIV.

Specifically the UN team should work with the government to:

- Strengthen the capacity to provide strategic information by supporting the collection, analysis, and dissemination of data necessary to support HIV and adolescent SRH programmes, policies, and advocacy. This report is one of the first steps towards this

goal. This report will be discussed at a high level policy meeting at which the proposed UNAIDS business case targets will be reviewed by national stakeholders and considered for adoption as national targets.

- Provide technical guidance to strengthen the delivery of HIV and SRH services to increase young people's access to rights-based information and services.
- Promote a supportive legal and policy environment for the implementation of evidence-informed prevention and care service for HIV among young people.

These actions should be aimed to enable a range of actors to maximize their contributions to an expanded response for achieving the UNAIDS business case targets for young people in Zambia.

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