



Legal, Policy, and Socio-Cultural Barriers to HIV-Related Prevention, Treatment, Care, and Support for Key Populations in Zambia



February 2015

Prepared for NASTAD by:

Malala Mwondela, HIV, Health & Human Rights Consultant
Luisa Pessoa-Brandão, NASTAD
Anna Carroll, NASTAD

This report was commissioned by NASTAD. Funding was provided through the Centers for Disease Control and Prevention (CDC) Cooperative Agreement U2GGH000462. The views expressed in this report do not necessarily reflect the views of CDC.

Suggested Citation: NASTAD Zambia, The Legal and Socio-Cultural Barriers to HIV-related Prevention, Treatment, Care, and Support for Key Populations in Zambia (2015)

Acknowledgement: Special thanks go to Ms. Priscilla Banda, NASTAD Zambia Country Director, and Dr. Harold Witola, Zambia National HIV/AIDS/STI/TB Council (NAC) Director of Programmes, for their support and guidance in the completion of this report.

Table of Contents

| | |
|---|----|
| Acronyms..... | 4 |
| Executive Summary | 5 |
| Introduction | 8 |
| Global HIV Epidemic..... | 10 |
| HIV and Key Populations..... | 12 |
| Enabling Legal and Policy Environments..... | 17 |
| Laws in Zambia and their Impact on Key Populations | 19 |
| Law Review | 19 |
| Impact of Laws on Key Populations..... | 21 |
| Policies in Zambia and their Impact on Key Populations | 22 |
| Policy Review..... | 22 |
| Impact of Policies on Key Populations | 27 |
| Summary of Policies and Laws | 28 |
| Impact of Legal & Policy Environment on Zambian HIV Response..... | 30 |
| Criminalisation | 30 |
| Stigma and Discrimination..... | 31 |
| Limited or No Access to HIV-Related Services | 31 |
| HIV and Key Populations: Best Practices | 33 |
| Recommendations..... | 36 |
| Appendix 1: Excerpts of Legislation | 39 |
| Constitution..... | 39 |
| Penal Code | 41 |
| Appendix 2: Recommendations from the South to South Exchange to Kenya | 44 |
| References | 46 |

Acronyms

| | |
|--------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| CSW | Commercial Sex Worker |
| EID | Early Infant Diagnosis |
| FSW | Female Sex Worker |
| HIV | Human Immunodeficiency Virus |
| IDU | Injecting Drug User |
| JMTR | Joint Mid-Term Review |
| MOH | Ministry of Health |
| MSM | Men who have Sex with Men |
| NAC | National HIV/AIDS/STI/TB Council |
| NASF | National AIDS Strategic Framework |
| NASTAD | National Alliance of State and Territorial AIDS Directors |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| R-NASF | Revised National AIDS Strategic Framework |
| SAT | Southern African Aids Trust |
| SRH | Sexual and Reproductive Health |
| SW | Sex Workers |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| ZDHS | Zambia Demographic Health Survey |

Executive Summary

In Zambia, as in many other countries, key populations experience barriers in accessing HIV-related prevention, treatment, care and support. According to UNAIDS, key populations are those most likely to be exposed to or to transmit HIV.¹ The informed and targeted support of these populations is critical to halting the spread of HIV and mitigating its impact. Without targeted interventions for key populations, HIV will continue unabated and an AIDS-free generation will be beyond our reach. In order to facilitate better understanding of the legal, policy, and socio-cultural barriers that key populations face in accessing HIV services in Zambia, the National Alliance of State and Territorial AIDS Directors (NASTAD) as part of its Technical Assistance (TA) to National HIV/AIDS/STI/TB Council (NAC) commissioned a review of the Zambian laws, policies and practices that have a bearing on access to HIV services for key populations. The main outcomes of the report are twofold:

- A comprehensive review of Zambian laws and policies as they relate to key populations and HIV in Zambia; and
- Recommendations for addressing barriers to access to HIV-related health services for key populations.

There is limited and inconclusive data on Sex Workers (SW), Men who have Sex with Men (MSM) and People Who Inject Drugs (IDU) in Zambia. The available evidence suggests that sex workers, their clients and regular partners account for almost 7-11% of all new HIV infections.² It is estimated that Men who have Sex with Men (MSM) account for 1% of new HIV infections, with 0.05% of all new HIV infections estimated to occur in female partners of MSM.³ Another study estimated HIV prevalence among SW and MSM in Zambia to be over 60% and 33%, respectively.⁴ No data is currently available on people who inject drugs (IDU).

The 2013 Joint Mid-Term Review (JMTR) of the National AIDS Strategic Framework (NASF) acknowledged that key populations such as SW and MSM are among the most disadvantaged and high risk groups for HIV infection in Zambia. The report also noted that key populations face many challenges in accessing health care and other services, including stigma, discrimination, and criminalization.

In Zambia, there are a number of different laws in place that criminalise SW, MSM and IDU, and as such are not consistent with international guidance on enabling legal environments with regard to prevention of HIV transmission and the

1 UNAIDS, Terminology Guidelines (2011), p.18

2 NAC, Female Sex Workers in Zambia: A Systematic Review of Current Evidence (2014), p.12-13 (In draft)

3 NAC, Joint Mid-Term Review (2013), p.26

4 NAC, HIV Prevention Response & Modes of Transmission Analysis (2009), p.26

mitigation of the impact of HIV and AIDS.⁵ The denial of access to HIV services is also inconsistent with the Zambian Constitution, which states that the State will endeavour to provide adequate medical care and health facilities for all persons.⁶

HIV specific policies including the National AIDS Policy, the National AIDS Strategic Framework (NASF) and the Revised NASF 2014-2016 (R-NASF), provide guidance on addressing HIV among key populations in Zambia. They acknowledge key populations as key drivers of the HIV epidemic; the current legal, policy and social barriers to addressing the HIV epidemic among key populations; and the absence of sufficient evidence to provide targeted programming. However, there is need for greater clarity on how these policies will target programming to key populations, and, in the absence of legal and policy reform, what interim steps may be taken to ensure universal access to HIV-related services.

There is variation in definitions of key populations provided in the 2013 Joint Mid-Term Review (JMTR) and the Revised NASF 2014-2016 (R-NASF). The Revised NASF defines key populations as “People living with HIV, women and children, adolescents (10-14), young people (15-24), people with disabilities, prisoners, sex workers and their clients, migrant and mobile populations.”⁷ The JMTR defines key populations as these above-mentioned groups, as well as MSM and IDU. The lack of clarity in these critical HIV-specific national policies may lead to some vulnerable groups falling through the cracks and not receiving necessary HIV programming. The absence of a clear definition of key populations in national HIV policies also inhibits government accountability as it relates to key populations.

The barriers to HIV prevention, treatment, care and support for key populations in Zambia include criminalisation, lack of evidence for programming, stigma and discrimination, limited or no access to HIV information, limited capacity of health workers to deal with key populations, and human rights violations against key populations.

The recommendations of this report are directed at the Government of Zambia through the NAC. It is envisaged that the NAC will use this report as a tool to advance the NASF guiding principle of implementing a human rights based approach to reducing HIV/AIDS. Based on international guidance, review of legislation and policy in Zambia as well as best practice, this report recommends the following:

⁵ Human Rights and the Law, UNAIDS 2014 Guidance note (2014); http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_humanrightsandthelaw_en.pdf

⁶ Constitution of Zambia, Chapter 1, Part IX, 112(a)(d)

⁷NAC, Revised National AIDS Strategic Framework,2014-2016 (2014), p.60

Initiate Legal and Policy Reform

The legal and policy environment in Zambia has been cited as one of the major barriers for members of key populations accessing HIV services. The decriminalisation of key populations would redress a significant legal barrier to HIV services. While law reform is a timely process, additional short-term measures could include the suspension of criminal sanctions on key populations to allow for public health programming and interventions.

The ongoing review of the National HIV/AIDS/STI/TB Framework (R-NASF), which establishes the NAC and sets the policy and strategic orientation of the national response, provides an opportunity to provide stronger guidance on key populations. Stronger and clearer policies supporting human rights and health care access for key populations are necessary for the initiation of an effective, targeted HIV response in Zambia.

Assess National Institutional Capacity for Implementing Targeted Key Populations Programming

There is a need to assess the capacity of NAC, civil society, implementing partners, health workers, relevant ministries, and key population community representatives to develop, implement, and continuously monitor and improve HIV-related interventions for key populations. Based on the findings of such an assessment, capacity building interventions should be planned and resources identified to ensure that each constituency is able to contribute collaboratively and effectively.

Develop Key Populations HIV Strategy and Action Plan

NAC must articulate how the evidence on key populations will be used to inform public health programming and policy. A strategy and action plan for improving health care access among key populations must articulate how the non-legal and non-policy barriers will be addressed, and how community systems will be supported to facilitate access to services for key populations. This strategy and action plan must also clearly and consistently define the key populations in Zambia.

Address Protocol Approval Process for Research on Key Populations

Research is critical for the development of evidence informed interventions. The Research Ethics committee must provide guidance to facilitate further research on key populations for ongoing learning and evaluation of interventions targeted at key populations. The rejection of protocols relating to research of key populations in the past has resulted in the absence of current, quality data on barriers to care that key populations face, hindering a strengthened and targeted HIV response.

Introduction

In Zambia, as in many other countries, key populations face barriers and challenges in accessing HIV-related prevention, treatment, care and support. Legal, policy, and socio-cultural barriers prevent entire communities from accessing health and HIV care in Zambia. From a public health perspective, the national HIV response in Zambia will be ineffective if certain sub-populations continue to be ignored and criminalised.

The *Global Commissions Report on HIV and the Law: Risks, Rights and Health of July 2012* observes that “To safeguard their health and that of others, key populations—the people at greatest risk of HIV infection (including MSM, transgender people, sex workers, people who use drugs, prisoners and at-risk migrants)—must have access to effective HIV prevention and treatment and commodities such as clean needles and syringes, condoms and lubricants”.⁸

The Zambian government has demonstrated some commitment to addressing the legal and policy barriers faced by key populations. For example, The National AIDS Strategic Framework (NASF) 2011-2015 acknowledged that an enabling legal and policy environment is central to a rights-based approach to addressing HIV in Zambia; a Key Populations Technical Working Group was recently established by NAC; and the Ministry of Health (MoH) commissioned studies in 2012 to profile the HIV epidemic among key populations in Zambia.

In order to facilitate better understanding of these legal, policy, and socio-cultural barriers to care, National Alliance of State and Territorial AIDS Directors (NASTAD) signed a memorandum of understanding with NAC to provide technical assistance in this area to the Zambian government. NASTAD is a U.S. based public health organization that represents state health directors with programmatic responsibility for HIV healthcare, prevention, education, and supportive service programs. NASTAD’s Global Program leverages its US-based partners’ expertise to reinforce health systems of counterpart Ministries of Health around the world through peer-to-peer exchange of experience and skills. The Global Program uses a unique approach in that it does not provide direct HIV services, but rather, supports local governments to develop their own infrastructure and systems for the delivery of health services to ensure sustainable country ownership.

Since 2011, NASTAD has been providing technical assistance to NAC and MOH in order to build their capacity to engage with and support key populations in Zambia. NASTAD’s scope of work includes supporting the MOH and NAC to:

⁸UNDP, Global Commission on HIV & the Law: Risks, Rights & Health (2012), p.26

1. Assess the barriers to health care access for key populations in Zambia;
2. Understand the social and regulatory issues that contribute to barriers for these groups; and
3. Define and improve the referral processes for those testing positive.

As part of its technical assistance, NASTAD identified the need to conduct a review of the Zambian laws, policies and practices that have a bearing on access to HIV-related services for key populations.

For purpose of this review, key populations will refer to Men who have Sex with Men (MSM), Injecting Drug Users (IDUs) and Sex Workers (SWs).

This review is intended to support the NAC's mission to create an enabling environment for addressing HIV in Zambia, and will complement other pieces of work such as the Zambia AIDS Law Research and Advocacy Network (ZARAN) Review of Zambian Laws related to HIV and AIDS and Human Rights (2011), various Zambia UNGASS reports, national dialogue on HIV and the law, the study conducted by Panos Institute of Southern Africa (PSAF), and the ongoing study by Population Council/NASTAD on the challenges faced by key populations in accessing prevention and care services.

This review provides an overview of the global and Zambian HIV epidemic among key populations both globally and within Zambia, and reviews the different laws and policies in Zambia that impact the ability of members of key populations to access health services. This report concludes with recommendations for overcoming these barriers to facilitate health care access for all Zambians and strengthen the national HIV response.

Review Objectives

- Conduct review of relevant laws and policies
- Document legal, policy, socio-cultural barriers to access to HIV-related services for key populations
- Document best practice on HIV and Key Populations in other countries

Methodology

Information for this review was gathered through a desk review of documents, which included but was not limited to Zambian legislation, national HIV and health policies, UNAIDS reports, research studies, policy briefs as well as international publications on HIV and key populations.

Limitations

The major limitation of the review was the absence of conclusive data on key populations in Zambia.

Global HIV Epidemic

At the end of 2013, an estimated 35 million people were living with HIV globally.⁹ There was a 38% decline in new HIV infections from 2001 to 2013, and the number of AIDS deaths declined by 35% from 2005 to 2013.¹⁰ The UNAIDS GAP Report noted that since 2009, prevention of mother to child transmission of HIV had averted more than 900,000 new infections in children.¹¹ In addition, since 1995 access to antiretroviral therapy had averted 7.6 million deaths globally with 4.8 million deaths averted in Sub-Saharan Africa by the end of 2013.¹²

Despite the significant progress, the UNAIDS Global Report on the AIDS Epidemic (2013),¹³ notes that there are a number of challenges that need to be addressed in order to reach the 2015 global AIDS targets endorsed by 2011 the United Nations General Assembly Political Declaration and Elimination Commitments on HIV/AIDS. These challenges include the persistent low treatment coverage for children, the need for innovative financing, the continued role of gender inequalities in HIV-related vulnerability, the need to eliminate stigma and discrimination as well as the need to strengthen the integration of HIV in broader health and development efforts. What is more, many countries are not on track to reduce sexual transmission of HIV by 50% in 2015.¹⁴ In addition to reduced condom use and/or an increase in sexual partners, the report notes that efforts to reduce transmission related to sex work and men who have sex with men have remained insufficient. The report also concluded that not enough progress has been made to reduce HIV transmission among people who inject drugs, with HIV prevalence remaining high among this population with rates as high as 28 percent in Asian countries.¹⁵

The UNAIDS Global Report on the AIDS Epidemic (2013) further noted that criminalisation of key populations remains widespread, with 60% of countries reporting having laws, regulations or policies that criminalise key populations and therefore prevent effective HIV prevention, treatment, and care and support for key populations and vulnerable groups.¹⁶ The Global Commission on Law and HIV (July 2012) found that while there were instances where legal and justice systems were playing a constructive role in responding to HIV, many nations had squandered the potential of their legal systems by allowing punitive laws, discriminatory and brutal policing and denial of access to justice for people with and at risk of acquiring HIV

⁹UNAIDS, Report on the Global AIDS Epidemic (2014), p.17

¹⁰ Ibid. p.8

¹¹ UNAIDS, Zambia HIV Prevention Response and Modes of Transmission Analysis (2009)

¹²UNAIDS, Report on the Global AIDS Epidemic (2014), p.14

¹³UNAIDS, Report on the Global AIDS Epidemic (2013)

¹⁴Ibid, p.4

¹⁵ Ibid. p.5

¹⁶ Ibid. p.8

to fuel the epidemic.¹⁷ The UNAIDS GAP report also identified the criminalisation of same-sex sexual acts, sex work and people who inject drugs as a gap in the global HIV response.

In many countries there are legal barriers to addressing HIV among certain key populations. Due to the fact that the behaviours of MSM, SW and IDUs are criminalised in most countries, prevention, treatment, care and support programmes have often excluded these populations. This is despite the evidence that these groups are at high risk of both acquiring and transmitting HIV. Worldwide, key populations account for a significant share of new infections including in countries with generalized epidemics.¹⁸

In order to achieve the “Getting to Zero” objectives, a targeted and evidence informed approach to combatting HIV among key populations is essential. According to the UNAIDS GAP Report, in order to significantly avert new HIV infections and AIDS related deaths, HIV services should reach at least 85% of all sex workers, gay men and other MSM and transgender people. In addition, harm reduction programmes must reach at least 40% of people who use drugs by 2020.¹⁹

¹⁷UNDP, Global Commission on HIV & the Law: Risks, Rights & Health (2012), p.7

¹⁸ UNAIDS, AIDS at 30: Nations at the Crossroads (2011), p.59

¹⁹UNAIDS, Report on the Global AIDS Epidemic (2013), p.291

HIV and Key Populations

The HIV Epidemic in Zambia

The 2007 Zambia Demographic Health Survey (ZDHS) estimated HIV prevalence in the 15-49 age group at 14.3%, with prevalence among females (16.1%) higher than that among males (12.3%). More recently, in 2013, UNAIDS spectrum modelling estimates have calculated HIV prevalence in Zambia to be 12.3%,²⁰ with Zambia being among the countries that have recorded a drop in HIV incidence of over 25% between 2001 and 2011.²¹ The estimated mortality rate from HIV and AIDS among adults 15 years and older has reduced from its peak of 8% in 2002 to 2.1% in 2013.²² Retention of people on ART at 12 months has improved from 65% in 2010 to 81% in 2013.²³

Despite these improvements, the burden of HIV still remains high in Zambia as compared to other countries. The Modes of Transmission study by NAC in 2009 identified six key drivers of the HIV epidemic in Zambia as; multiple and concurrent sexual partners; low and inconsistent condom use; low levels of male circumcision; mobility and labour migration, sex workers and men who have sex with men, and; mother to child transmission.²⁴

Key Populations

UNAIDS provides guidance that each country must define their key populations based on the epidemiological and social context. This is particularly relevant in Zambia, where there is a need for clarity and consistency in the definition of key populations. The revised NASF, JMTR and the most recent Global Fund application all utilize different definitions of key populations.

The National AIDS Strategic Framework 2011-2015 clearly states that more empirical evidence on the size of the sex workers and men who have sex with men populations is needed to adequately inform policy and programming. Furthermore the revised NASF 2014-2016 notes the need to focus on high impact interventions targeting key populations.

However, there is no consistent, clear definition of key populations in Zambia in national health and HIV policies and strategies. Thus, for the purpose of this review, key populations will refer to Men who have Sex with Men (MSM), Injecting Drug Users (IDUs) and Sex Workers (SWs).

²⁰Spectrum Policy Modelling System, Version 5.03_500 (2014); Zambia Model March 2014

²¹UNAIDS, Report on the Global AIDS Epidemic (2012), p. 11.

²²Revised National AIDS Strategic Framework, 2014 - 2016

²³MOH, Health Management Information System

²⁴NAC, National AIDS Strategic Framework 2011-2015 (2010), p9-10

The following sections are intended to provide an overview of key populations in Zambia, their vulnerability to HIV, and what is known about how HIV is impacting these key populations. These sections summarize all data on HIV among these key populations in Zambia that was available at the time of writing. In the absence of such data, global or regional data is cited and described.

Sex Workers (SW)

Sex work can be defined as the provision of sexual services in exchange for money, goods, or other benefits.²⁵ Globally, female sex workers (FSW) are 13.5 times more likely to be living with HIV than other women.²⁶ It is estimated that 7-11% of new HIV infections in Uganda, Swaziland and Zambia occur among sex workers, their clients and clients' regular partners.²⁷ Additionally, two studies conducted in Ndola in 1991 and 2005 among sex workers found that the HIV prevalence was 69% and 65%, respectively.²⁸ A review of sex workers' experiences in public health facilities in four countries in Eastern and Southern Africa identified insufficient access to condoms and lubricants among their unmet health needs.²⁹

Criminal laws related to sex work are often covered under sexual offences, vagrancy, public order offences and human trafficking offences. While some countries criminalise the act of sex work itself, many countries criminalise certain aspects of sex work. These include living off the earnings of sex work, soliciting and the use of premises for sex work.³⁰ Apart from challenges with access to services, sex workers are often vulnerable to HIV because they are unable to report sexual abuse for fear of facing criminal sanctions themselves. In Zambia the law criminalises living off the earnings of prostitution as well as the use of premises for sex work, as described in greater detail later in this report.

In Zambia, there is currently no conclusive evidence on the size of the SW population. An undated briefing note by the International Organisation for Migration (IOM) indicated that Tasintha, an NGO working with sex workers, estimated that there are at least 6,000 full time sex workers in Zambia. The NAC strategic framework for 2001-2003 stated there were 17,000.³¹ A study conducted in Ndola in one urban site in 1998 estimated that 2.7% of the adult female population are Female Sex Workers (FSW).³² Two studies conducted in 1991 and 2005 in Ndola among sex workers found that the HIV prevalence was 69% and 65%

²⁵ NAC, Female Sex Workers in Zambia: A Systematic Review of Current Evidence (2014), p.23 (In draft)

²⁶ UNAIDS, Report on the Global AIDS epidemic. (2013)

²⁷ UNAIDS, Report on the Global AIDS Epidemic (2013), p.20

²⁸ Buve et al. 1991 and Kamanga et al. 2005 as cited by NAC (2014), p.8

²⁹ UNAIDS, Report on the Global AIDS Epidemic (2013) p.16

³⁰ International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth 2010, p.22

³¹ UNAIDS, HIV Prevention Response and Modes of Transmission Analysis (2009), p.57

³² Vandepitte J et al, Sex Transm Infect 2006;82(Suppl III):iii18-iii25

respectively.³³ The Modes of Transmission analysis in Zambia also reported that some FSW are married, and engaging in sexual relations with a steady partner in addition to ongoing clients.³⁴ Many sex workers are able to access condoms but experience challenges with correct and consistent use and FSW often report not using condoms with their regular partners.³⁵

Men who have Sex with Men (MSM)

MSM are 19 times more likely to be living with HIV than the general population in low and middle-income countries.³⁶ Studies conducted in Sub-Saharan Africa between 2000 and 2006 suggest that HIV prevalence among MSM in this region ranges between 6%-31%.³⁷

Table 1: HIV Prevalence among MSM Compared to the HIV Prevalence in the General Adult Population³⁸

| Country | HIV Prevalence Among MSM | HIV Prevalence in the General Adult Population (15-49 years) |
|-----------------|---------------------------------|---|
| Ghana | 25.0% | 1.67% |
| Kenya | 15.2% | 7.49% |
| Malawi | 21.4% | 11.46% |
| Tanzania | 12.4% | 5.88% |
| Zambia | 32.9% | 15.72% |

Worldwide, only 5% of MSM have access to the prevention, care and treatment services they need.³⁹ A 2012 survey in 165 countries among 5000 men who have sex with men also found that they had difficulties in accessing lubricants.⁴⁰

Criminalisation as well as legal and policy barriers play a key role in vulnerability to HIV. Fear of arrest and harassment drives MSM underground. Many public health interventions targeting MSM are not supported or prioritised and health personnel are ill equipped to address the specific needs of MSM.⁴¹ MSM experience further barriers to quality health care due to widespread stigma within health systems and

³³ Buve et al. 1991 and Kamanga et al. 2005 as cited by NAC (2014), p.8

³⁴ UNAIDS, HIV Prevention Response and Modes of Transmission Analysis (2009),Ibid. p.9

³⁵ NAC, Female Sex Workers in Zambia: A Systematic Review of Current Evidence(2014), p.15 (in draft)

³⁶ GNP+ and MSMGF, Advancing the Sexual & Reproductive Health Rights of Men who have Sex with Men Living with HIV: A Policy Briefing (2010), p. 4

³⁷ Ibid. WHO. p.16

³⁸ International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth (2010), p.32

³⁹ GNP+ and MSMGF, Advancing the Sexual & Reproductive Health Rights of Men who have Sex with Men Living with HIV: A Policy Briefing (2010), p. 4

⁴⁰ UNAIDS, Report on the Global AIDS Epidemic (2013), p.16

⁴¹ National AIDS Control Council of Kenya and Population Council. 2009. "The overlooked epidemic: Addressing HIV prevention and treatment among men who have sex with men in sub-Saharan Africa, report of a consultation, Nairobi, Kenya, 14-15 May 2008," *Consultation Report*.

the community. Stigma and discrimination are a major barrier to public services and undermine public health and human rights and ultimately the response to HIV. Social discrimination has also been described as a key driver of poor physical and mental health outcomes.⁴² MSM are also more likely to exhibit anxiety, substance abuse and suicide due to chronic stress, social isolation and disconnection from a range of health and support services.⁴³

In 2004, nearly 3,000 interviews were conducted with self-identified MSM in Zambia.⁴⁴ In this study, 40% of MSM interviewed thought that anal sex with another man was safer than having sex with a woman with regards to HIV transmission.⁴⁵ In the PANOS study of 2013, 57% of MSM identified as bisexual and 28 reported having sexual relations with married men.⁴⁶ The study also found that 50% of MSM indicated paying for sex, while 63% had received money for sex.⁴⁷ Half of the MSM who were married to women were HIV positive and only 32% of MSM reported consistent use of condoms with their regular male partner.⁴⁸ Those interviewed were also found to have multiple sexual partners, for example 54% of males identifying as bisexuals reported both multiple female and male partners in the previous six months.⁴⁹ In terms of HIV prevalence among MSM in Zambia, a study conducted between 2000 and 2006 reported HIV prevalence among MSM at 33%.⁵⁰

Injecting Drug Users (IDUs)

Globally, IDUs account for approximately 5-10% of people living with HIV. Over 40% and 68% of new HIV infections in some countries in Eastern Europe and Iran respectively are attributed to IDUs.⁵¹ Evidence from Kenya, Mauritius, Malawi, Namibia, Botswana and Tanzania (Zanzibar) suggests that there is an increasing incidence of injecting drug use and the associated spread of HIV.⁵²

IDUs are criminalized in most countries and this is considered to be fuelling the HIV epidemic in some parts of the world. Legal prohibitions on the provision of sterile needles and opioid substitution therapy (OST) impede HIV prevention efforts.⁵³ The range of criminal laws related to IDU includes laws on possession, use and aiding

⁴² WHO, Prevention and Treatment of HIV and other Sexually Transmitted Infections Among Men who have sex with Men and Transgender People: Recommendations for a Public Health Approach (2011), p.10

⁴³Ibid.p.10-11

⁴⁴ Zulu, P. K. Male to Male Sex : HIV and AIDS in Zambia. 2004. 30-4-2009

⁴⁵Ibid, p.8

⁴⁶ Lilian Keifer, Dewin Hansende, Nervious Siantombo, Harold Witola & Ray Handema, Report on the Study of HIV Prevention for Sexual Minority Groups in Zambia (2013), p.26

⁴⁷ Ibid. p.28

⁴⁸ Ibid. p.23

⁴⁹ Ibid, p.27

⁵⁰ Aidsmap, HIV & AIDS Treatment in Practice, Issue 138, June 2009, p.4

⁵¹ UNAIDS, Report on the Global AIDS Epidemic (2013), p.30

⁵² International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth (2010),p.38

⁵³ Ibid,p.38

and abetting drug use. The broad laws on drugs often lead to overcrowding in prisons, another risk factor for transmission of HIV and other diseases.

There is no data available on injection drug use in Zambia. However, given the increasing incidence of IDU observed in some Sub-Saharan countries, it is highly probable that there are IDUs in Zambia, which is likely contributing to HIV transmission.

Summary

Globally, key populations can serve as epidemiological bridges to the general population. For instance in Zambia, as mentioned above, sex workers are known to also have stable partners in addition to ongoing clients, while some MSM report being married to women or having female partners, as well as same sex partners.

Sex workers become part of the sexual networks of the highly mobile populations in Zambia such as migrants, miners, farm workers and truck drivers.⁵⁴

While research on these populations in Zambia is limited, key populations are present in Zambia and they are vulnerable to HIV infection. The obvious connection between the HIV epidemic among key populations and the HIV epidemic among the general population underscores a need for additional data on behaviours, risk, and exposures among key populations, which can help to target meaningful and impactful health programs for all.

“The law alone cannot stop AIDS. Nor can the law alone be blamed when HIV responses are inadequate. But the legal environment can play a critical role in the well-being of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save public money”

- Global Commission on HIV and Law, 2012

⁵⁴ UNAIDS, HIV Prevention Response and Modes of Transmission Analysis (2009)

Enabling Legal and Policy Environments

The importance of the role that law and policy play in creating an enabling environment for HIV cannot be overemphasized. A supportive and enabling legal environment complements HIV programming and lays the foundation for an effective HIV response.

UNAIDS and other agencies have provided various guidelines for creating an enabling legal environment in the international HIV response. These guidelines are informed by both human rights and public health considerations. From a human rights perspective, every human being has the right to highest attainable standard of health. Health is defined by the WHO as a complete state of physical, mental and social well-being and not merely the absence of disease.⁵⁵ From a public health perspective, an epidemic cannot be contained if there are sub-populations where it is allowed to thrive. In addition, a public health approach that advances public good while ensuring personal liberties is more likely to succeed, because people are more likely to adopt health promoting behaviours when given the freedom, resources and an enabling environment to do so on their own. For these reasons, it is imperative that an enabling legal and policy environment be established in Zambia to support an effective HIV response.

International Guidelines on HIV/AIDS and Human Rights

The International Guidelines on HIV and Human rights provide guidance to countries on how to protect human rights in the context of HIV. These guidelines provide a framework for that clearly outlines how human rights standards apply in the context of HIV/AIDS.⁵⁶ The twelve guidelines cover the need for effective national frameworks, the need for community consultation in all areas of HIV policy and program development, the review and reform of public health and criminal laws so that they are consistent with human rights and not misused in the context of HIV or targeted against vulnerable groups, as well as, the need for anti-discrimination and protective measures for those living with HIV. In dealing with the review and reform of criminal law and correctional systems, and in particular reference to SW and MSM, the guidelines state the following:⁵⁷

⁵⁵ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

⁵⁶ UNAIDS, International Guidelines on HIV/AIDS & Human Rights (2006), p.9

⁵⁷ Ibid

“Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.”

With regard to injecting drug use, the criminal law should be reviewed to consider the authorization or legalization and promotion of needle and exchange programmes, and the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes. These alterations would create a legal and social environment that would enable IDUs to safely and legally seek and receive health care.

UNAIDS

One of the UNAIDS’ Targets is to halve the number of countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality by 2015, in order to create legal environments that advance and safeguard dignity, health and justice in the context of HIV.⁵⁸ In its action framework on universal access to HIV services for MSM and transgender persons, UNAIDS puts forward three guiding principles, all which can be applied to other key populations as well:

1. Actions must be grounded in an understanding of and commitment to human rights.
2. Actions must be informed by evidence.
3. Action is required by a broad range of partners.

Global Commission on HIV and Law

The Commission recommends that countries repeal punitive laws and enact protective laws to protect and promote human rights, improve delivery of and access to HIV prevention and treatment, and increase the cost effectiveness of these efforts. An example of a protective law is a law that provides protection from violence against a particular population.

Specifically, the commission recommends that countries reform their approaches towards drug use, MSM and SWs. Rather than punishing people who use drugs, consenting adults engaged in sex work or involved in same sex activity, they must offer them access to effective HIV and health services and commodities, including harm reduction and voluntary evidence-based treatment for drug dependence.⁵⁹

⁵⁸ Getting to zero: 2011-2015 strategy Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010.

⁵⁹ Global Commission on HIV and the Law, Risks, Rights & Health (Summary Recommendations) July 2012, p.98

Laws in Zambia and their Impact on Key Populations

The review of laws in Zambia takes into account international guidance, as well as the Zambia AIDS Law Research & Advocacy Network (ZARAN) Law review published in 2011. The review considers whether the laws are discriminatory, whether they facilitate or hinder access to health services, and to what extent the behaviours of MSM, SW and IDU are criminalized. The review is specific to the key populations being considered in this report (men who have sex with men, injecting drug users, and commercial sex workers) and is not intended to be comprehensive of each piece of legislation as it relates to HIV generally.

Law Review

Anti-Discrimination and Protective Laws

Constitution CAP 1

The Constitution is the supreme law of the land and guarantees fundamental rights and freedoms. The immediately applicable rights to key populations include the right to life, freedom from inhuman treatment, the right to privacy, freedom of expression and freedom from discrimination.

Article 23 provides protection from discrimination on the basis of race, tribe, gender, place of origin, marital status, political opinions, and colour or creed. The term 'discriminatory' is used to describe treatment that subjects one to disabilities or restrictions. Though the grounds listed are limited, the spirit of the provision is to protect citizens from actions that impose a disability or restriction. The article does not provide for protection on the basis of health, economic status or sexual orientation.

Although the Constitution does not directly address key populations or people living with HIV (PLHIV), the provisions should offer protection for key populations as it pertains to the right to health, freedom of expression, freedom from inhuman treatment and freedom from discrimination. Discrimination in terms of access to HIV-related services imposes a disability or restriction for key populations as they seek to live a life of dignity and access to the highest standard of health. The denial of access to HIV-related services is also inconsistent with the spirit of the Constitution in Articles 110-112, the Direct Principles of State Policy, which state that the State will endeavour to provide adequate medical and health facilities for all persons.

NAC HIV/AIDS/STI/TB Council Act, No.10 of 2002

This Act establishes the National HIV/AIDS/STI/TB Council. The overall function of the NAC is the coordination of the HIV response in order to prevent the spread of HIV and mitigate its impact. According to the Act, it is the responsibility of the NAC

to develop policies and plans, advise the government on the policies and plans necessary to combat HIV, AIDS, STIs and TB, and mobilise resources for priority interventions including research. The NAC is also mandated to develop guidelines to secure the rights of PLHIV as well as strategies for appropriate interventions targeted at the most vulnerable populations.

The NAC has been at the forefront of developing guidelines, policy and research for HIV. Specifically with regard to key populations, the NAC has commissioned studies, established a key populations' technical working group and supported south-south learning in order to inform policy and programming in Zambia.

Punitive Laws – Penal Code CAP 87

Laws Related to Commercial Sex Work

Sections 144-149 of the Penal Code deal with offences related to prostitution. Sections 144-145 deal with forced detention of a child or any other person in premises or a brothel against their will for purposes of coerced sex. The report will focus on those engaged voluntarily in various aspects of sex work.

The actual act of prostitution is not criminalised in Zambia. Sections 146-147 of the Penal Code make it a crime to knowingly live off the earnings of prostitution and/or solicit for immoral purposes. Additionally, operating a facility for what the law would term an immoral purpose, more commonly known as a running of brothels, is also criminalised.

Due to the fact that sex work itself is not criminalised, FSWs are often detained by the police and charged with the offence of loitering. It is important to note that the laws on prostitution are not specific to either women or men.

Sections 47 and 48 of the Juveniles Act provide for imprisonment for causing or encouraging the prostitution of girls under sixteen and allowing persons under sixteen to be in brothels. This is intended to protect children from abuse.

Laws Related to Men who have Sex with Men

Sections 155 – 158 of the penal code are titled “Unnatural Offences,” and are those most likely to be applied to MSM. Sections 155 and 156 of the penal code criminalise what are termed “carnal knowledge against the order of nature”. It extends to carnal knowledge of an animal and a child. It attracts a penalty of not less than fifteen years with the possibility of imprisonment for life. Section 158 speaks directly to “indecent practices” between people of the same sex whether they be male or female as well as whether it’s in public or private. These sections criminalise homosexual acts, and under this piece of legislation, the age and consent of the participant are immaterial. Another law that deals with sex between men is the Prisons Act CAP 97, Section 91 which makes sodomy a major prison offense.

Laws Relating to Injecting Drug Users

The Narcotic Drugs and Psychotropic Substances Act, CAP 96 clearly criminalises IDUs, stating that *“Any person who, without lawful authority, takes a narcotic drug or psychotropic substance by smoking, injecting into his body, sniffing, chewing, drinking or otherwise administering such drug or substance shall be guilty of an offence and shall be liable upon conviction to imprisonment for a term not exceeding ten years.”* The Act also criminalises inciting another person to use drugs, as well as the use of premises for injecting drugs, in Sections 15 and 16, respectively.

Impact of Laws on Key Populations

Zambian laws criminalise sex workers, men who have sex with men, and people who inject drugs. Although sex work itself it is not criminalised, the criminalisation of certain aspects of it, such as, living off the earnings of prostitution, amounts to criminalisation. The punitive laws affecting these key, vulnerable populations are not consistent with clear international guidance on enabling legal environments that support the HIV response and mitigate the impact of HIV and AIDS on society. The impact of Zambian laws on key populations and the broader HIV response will be discussed further in subsequent sections.

Policies in Zambia and their Impact on Key Populations

The policy review assesses the extent to which national policies articulate the health needs of key populations, and interventions and programming that may be effective in addressing HIV among key populations. As with the law review, the policy review takes into account international guidance as it relates to services for key populations.

Policy Review

National AIDS Policy

The National HIV/AIDS/STI/TB Policy of 2005 provides the overall framework for addressing HIV, AIDS, STIs and TB in Zambia. The policy is guided by the public health approach, the promotion and protection of human rights, and the need for the response to be based on empirically sound research.⁶⁰ The policy seeks to create a conducive legal framework for addressing the HIV/AIDS epidemic; address stigma and discrimination; protect human rights; and facilitate a supportive environment for effective prevention of HIV.⁶¹

The National AIDS Policy includes a commitment to ensure that Zambia domesticates international declarations on HIV and AIDS. This would include the International Guidelines on HIV & Human Rights, as well as, many other UN declarations such as the United Nations Assembly Special Session on HIV/AIDS (UNGASS) Declaration.

The policy in its current form notes that while HIV is mainly transmitted through heterosexual contact, sex between men is also one of the ways in which HIV is transmitted in Zambia. The policy also states that the injection of drugs among people who abuse drugs enhances the risk of HIV infection.⁶² It also identifies commercial sex workers as belonging to a vulnerable group.⁶³

The National AIDS Policy only articulates measures targeted at one key population: CSW. These include interventions that education CSW and their clients on HIV/AIDS, the establishment of rehabilitation centres, free access to Voluntary Testing & Counselling services and the promotion of condom use.

The policy acknowledges a gap with regard to the legal framework conducive to a strong HIV response. However, the measures that the Policy outlines to create an enabling legal and regulatory framework (which is deemed to be essential to

⁶⁰ MOH, National HIV/AIDS/STI/TB Policy (2005), p.18

⁶¹ Ibid.p.19

⁶² Ibid.p.51

⁶³ Ibid.p.34

addressing HIV), are extremely limited as they only focus on ensuring effective implementation and monitoring of the National HIV/AIDS/STI/TB Act, as well as the amendment and harmonization of acts that are relevant to HIV such as the National Health Services Act CAP 315, the Public Health Act CAP 295 and the Employment Act CAP 268. However the policy does acknowledge the critical role of the governance and the justice sector in supporting changes in pieces of legislation that disadvantage people living with and affected by HIV and that encourage stigma and discrimination⁶⁴.

National AIDS Strategic Framework 2011-2015

The National AIDS Strategic Framework 2011-2015 (NASF) provides the overall strategy for operationalization of the HIV policy by describing the planning, coordination and implementation of the national HIV response. It articulates national priorities based on available evidence as well as emerging social and epidemiological evidence. The four priorities of the NASF are:

- Prevention;
- Universal access to treatment;
- Mitigation of socio-economic effects of HIV and AIDS; and
- Strengthened capacity for a sustained response.

The NASF acknowledges SWs and MSM as key drivers of the HIV epidemic but acknowledges the need for evidence, including size estimation, on these populations in order to inform policy and programming. The NASF also notes that the inadequate focus on key populations compounds the spread of HIV.⁶⁵ While there are no specific interventions proposed for key populations, the NASF supports the review and amendment of punitive laws and policies that marginalize them. Among the priority strategies for an enabling policy and legal environment is the promotion of public awareness of the legal barriers that prevent key populations from accessing and utilising health services and ensuring that human rights are adequately addressed to reduce stigma and discrimination to promote the dignity of PLHIV and key populations.

Joint Mid-Term Review of the National HIV/AIDS Strategic Framework on Key Populations

A Joint Mid-Term Review (JMTR) of the National HIV/AIDS Strategic Framework 2011-2015 (NASF) was done in 2013 to assess progress on NASF implementation and identify obstacles, challenges and opportunities in strengthening the national HIV response. The JMTR was informed by the UNAIDS Investment Framework which promotes a more focused and strategic approach to HIV investments. The

⁶⁴ Ibid.p.43

⁶⁵ NAC, National AIDS Strategic Framework 2011-2015 (2010), .p10

review therefore had a focus on the most strategic investments based on evidence of which interventions were yielding the desired results.

An enabling legal and policy environment is one of the service delivery areas for the NASF pillar on Response Coordination and Management, and was therefore subjected to the review. The JMTR identified the legal and policy environment as not being conducive for HIV programming for key populations. Further, the JMTR states that structural barriers such as punitive laws and policies that hinder HIV prevention efforts for marginalized and vulnerable populations will need to be addressed in the second phase of implementation of the NASF.⁶⁶ It acknowledges further that key populations such as SW and MSM are among the most disadvantaged and vulnerable groups for HIV infection, and that these communities face many challenges in accessing services.⁶⁷

The JMTR recommends targeted programmes and legal reform for key populations, specifically SWs and MSM, and it calls for the expansion and strengthening of research on key populations.

Revised NASF (R-NASF) 2014-2016

Based on the findings and recommendations of the JMTR, a revised NASF for the period 2014-2016 has been developed. The revised NASF makes a distinction between basic programme activities (which include behaviour change programmes, eliminating HIV in children both through PMTCT and EID, condom promotion, and antiretroviral treatment) and critical enablers (which include the legal and policy environment, political commitment and advocacy and community mobilisation). The R-NASF includes interventions with key populations as one of the main strategies to reduce new HIV infections in Zambia.⁶⁸

However, the R-NASF 2014-2016 defines key populations as “People living with HIV, women and children, adolescents (10-14), young people (15-24), people with disabilities, prisoners, sex workers and their clients, migrant and mobile populations.”⁶⁹ While this definition includes sex workers, it excludes MSM and IDU and is in conflict with the definitions of key populations used in other documents, more specifically the JMTR, which led to the revision of the NASF 2011-2015, and the Global Fund application which will contribute approximately \$229 million to Zambia’s HIV/AIDS response for 2014-2016.⁷⁰ Consequently, the priority interventions and strategies included in the R-NASF 2014-2016 do not speak directly to MSM and IDU and ignore the impact of the HIV epidemic on these populations.

⁶⁶ NAC, Joint Mid-Term Review (2013), p.54

⁶⁷ Ibid. p.109

⁶⁸ NAC, Revised National AIDS Strategic Framework, 2014-2016 (2014), p.54

⁶⁹ Ibid.p.60

⁷⁰ <http://www.theglobalfund.org/en/fundingmodel/allocationprocess/allocations/> accessed February 2015

The R-NASF 2014-2016 proposes the development of a comprehensive package of services for each key sub-population. This includes outreach and support, social and behaviour change, access to sexual and reproductive health (SRH) services, as well as access to testing and treatment. Interventions will further be implemented according to the priorities in the different regions.

Additional priority strategies included in the revised NASF 2014-2016 are:

1. Encourage dialogue on HIV and the law at national and sub-national levels
2. Enhance the implementation of human rights and equal access to services.
3. Facilitate community-based advocacy on stigma and discrimination.
4. Advocate for legal reform to ensure all Zambian citizens are equally able to access HIV health and social services.
5. Improve access to justice and legal services for key populations.

While there is some on-going research and HIV programming targeting MSM and IDU, the interventions outlined above are specific to the key populations as defined in the R-NASF 2014-2016, which does not include MSM and IDU.

Under the critical HIV programme enablers, namely community systems strengthening, one of the priority interventions is to advocate for an adequate legal, social and policy framework to protect key populations.

In addressing laws, legal policies and practices, the R-NASF 2014-2016 vaguely mentions that 'some' groups of people are marginalized from mainstream services and specific mention is made of SWs. The R-NASF programme priority is to strengthen an enabling social, policy and legal environment where all people including vulnerable groups and key populations at higher risk of HIV infection have their basic human rights protected, respected and fulfilled.⁷¹

The revised NASF 2014-2016 has outlined priority interventions for laws, legal policies and practices that include the following:

- Analyse if any laws impede the HIV response and advocate for legal reform; this needs to include analysis of structural barriers to access to HIV services and support for all citizens, including key populations such as punitive laws and policies that hinder HIV prevention.
- Improve key populations' access to legal support.
- Promote human rights for all citizens including PLHIV and key populations.
- Promote the development and implementation of anti-discrimination legislation for PLHIV and other key populations.
- Improve training of HIV-related service providers in equitable access to all community members including adolescents, and other key populations.

⁷¹ NAC, Revised National AIDS Strategic Framework, 2014-2016 (2014).p.68

The revised NASF also emphasizes that cooperation and coordination between government sectors are critical to effectively addressing HIV. There is often a conflict between the Ministry of Health (health care providers), the Ministry of Home Affairs (the law enforcers), and the Ministry of Justice (the law, because each ministry has differing mandates with regard to providing a conducive legal environment without compromising health care access.

National Health Policy 2013

The National Health Policy outlines the Zambian Government's direction for the development of the health sector. The policy speaks to ensuring access to health care for all the people of Zambia, regardless of their geographical location, gender, age, race, social, economic, and cultural or political status.⁷² Cost effectiveness in the delivery of health services is another guiding principle which highlights the need for strategic investments. These two principles imply that key populations should be included in national HIV strategies in order to ensure equity of access to services and the investment in interventions that will have a broad impact on the HIV epidemic.

With regard to HIV, the policy speaks broadly to strengthening HIV prevention and HIV case detection, the management of HIV, AIDS, STIs and opportunistic infections and strengthening of access to palliative care services. The policy also makes reference to scaling up prevention and control services among vulnerable and high risk groups. However, these vulnerable and high risk groups are not specifically defined in this policy.

National Health Strategic Plan 2011-2015

The National Health Strategic Plan (NHSP) is the strategic framework for efficient and effective organization, coordination and management of the health sector in Zambia for the period 2011-2015. HIV is one of the public health priorities of the NHSP. The objectives related to HIV are to reduce the spread of HIV and STIs and increase access to treatment and care.

Comprehensive Condom Programming and Operational Plan 2010-2015

The goal of the Comprehensive Condom Programming and Operational Plan is to make quality condoms available, accessible and affordable to all sexually active individuals throughout Zambia by 2014.

This plan includes advocacy for review of laws on sodomy, wilful infections, prohibition of the distribution of condoms in tertiary institutions, and prisons, and calls for targeting special groups like MSM, mobile populations, persons with

⁷²MOH, National Health Policy (2013), p.27

disabilities and prisoners.⁷³ Reference is also made to conducting regular collection and reviews of relevant evidence for effective programming.

National Prevention Strategy

The National Prevention Strategy of 2009 identifies the prevention of sexual transmission of HIV as the principal priority area. Under Core Strategy 1.8, expand coverage of a core package of comprehensive prevention interventions for vulnerable groups, specifically including prisoners, persons living with disability and other “high risk” groups, defined as IDU, MSM and SWs, it specifically mentions exploring strategies such as needle exchange, provision of condoms to prisoners, and advocating appropriate strategies for MSM.⁷⁴

Impact of Policies on Key Populations

The HIV specific policies reviewed here including the National AIDS Policy, the NASF and the R-NASF, provide some guidance on addressing HIV among key populations. They acknowledge key populations as key drivers of the HIV epidemic in Zambia, and they describe the current legal, policy and social barriers to supporting the key populations, as well as the absence of sufficient evidence to provide targeted programming to these key populations. The R- NASF takes a step further by providing more detail around a comprehensive package of services for key populations as well as priority interventions to address law, policy and practice related to these populations.

However, one of the major challenges is the lack of consistency in the definitions of key populations in the JMTR and R-NASF. While the JMTR includes MSM and IDU in its definition of key populations, the R-NASF excludes MSM and IDU from its definition of key populations. As such it is unclear to what extent MSM and IDU may be included in the priority interventions outlined in the R-NASF for key populations. This needs to be clarified.

The National Health Policy and Strategic plan speak very broadly about prevention and “vulnerable groups”. The Comprehensive Condom Programming and Operational Plan 2010-2015 speaks to targeting special groups like MSM and for advocacy on sodomy laws. The National Prevention Strategy, 2009 speaks to interventions for MSM, IDU and SWs, however it will need to be revised to incorporate recent developments and discussions on key populations.

⁷³NAC, Comprehensive Condom Programming Strategy & Operational Plan 2010-2014 (2009), p.28

⁷⁴ NAC, National HIV Prevention Strategy (2009), p.38-39

Summary of Policies and Laws

A summary of the laws and policies pertaining to key populations is presented in Table 2 below.

Table 2: Summary of Laws and Policies Pertaining to SW, MSM and IDU

| Law / Policy | Key Population(s) Affected by Policy | Provision Relating to Key Population(s) |
|---|---|--|
| Constitution of Zambia | | 1. The Constitution of Zambia does not address key populations directly |
| Penal Code | SW and MSM | 1. The Penal Code CAP 87, Sections 146-147 makes it a crime to knowingly live off the earnings of prostitution and to operate a brothel. 2. The Penal Code CAP 87, Section 158 criminalises "indecent practices between people of the same sex whether they be male or female as well as whether it's in public or private. The Prisons Act CAP 97, Section 91 makes sodomy a major prison offense. |
| Narcotic Drugs and Psychotropic Substances Act | IDU | 1. The Narcotic Drugs and Psychotropic Substances Act, CAP 96 criminalises injecting drug use as well as the use of premises for the purpose of injecting drug use. |
| National AIDS Policy 2005 | SW | 1. Provides measures for addressing HIV among SWs and acknowledges a gap with regard to the legal framework for addressing HIV. |
| National AIDS Strategic Framework 2011-2015 | SW and MSM | 1. NASF acknowledges SWs and MSM as key epidemic drivers of HIV and the need for evidence on size estimation of these populations in order to inform policy and programming. 2. Among the priority strategies for an enabling policy and legal environment is the creation of public awareness of the legal barriers that prevent key populations from |

| | | |
|--|-----------------|--|
| | | accessing and utilising services adequately and ensuring that human rights are adequately addressed to reduce stigma and discrimination to promote the dignity of PLHIV and key populations. |
| Revised NASF 2013-2016 | SW | 1. Key populations have been prioritized as part of the strategy to reduce new HIV infections. The interventions for key populations are well articulated, including for SWs. MSM and IDU are not included in the definition of key populations. |
| National Health Policy 2013 | | 1. Broadly addresses equity, cost effectiveness in delivery of health services and ensuring access to all the people of Zambia. There is no specific mention of key populations |
| National Health Strategic Plan 2011-2015 | | 1. No mention of key populations |
| Comprehensive Condom Programming & Operational Plan 2010-2015 | MSM | 1. Includes a strategy to advocate for review of laws on sodomy, targeting special groups like MSM, mobile population, persons with disabilities and prisoners |
| National Prevention Strategy | IDU, MSM and SW | 1. One of the core strategies is to expand coverage of a core package of comprehensive prevention interventions for vulnerable groups specifically including prisoners and persons living with disability, as well as, other "high risk" groups, defined as IDUs, MSM and SWs. |

Impact of Legal & Policy Environment on Zambian HIV Response

This section provides an overview of the impact of the laws and policies described above on key populations. However, due to the lack of research on key populations in Zambia, this section relies heavily on information of barriers identified or experienced in other countries, but Zambian data is presented if available.

Criminalisation

As demonstrated earlier, in Zambia, SW, MSM and IDU are criminalised, which has a number of implications for HIV prevention and care. Criminalisation drives these populations underground where interventions cannot reach them and unsafe practices are perpetuated. Fear of prosecution means these populations are unlikely to regularly seek medical attention which can lead to poor health outcomes, or they may resort to unconventional and unregulated medical interventions with a heavy reliance on traditional medicines.

Some sexual minorities in Zambia also attribute their multiplicity of partners to the hostile legal and social environment. In the Panos study, for example, it was stated that the unfriendly social and legal environment made it difficult to maintain committed relationships.⁷⁵

Lack of Evidence for HIV Programming

The criminalisation of key populations has created barriers for understanding the size, behaviours and HIV-related risks for key populations. Historically, research protocols on key populations have been rejected in Zambia based on the criminality of these groups' behaviours. As a result, there has been insufficient evidence to inform effective, targeted HIV programming. It is only in 2012 and 2013 that the Panos Institute Southern Africa (PSAf) and the Population Council/NASTAD studies were approved.

The NAC, Panos and the Tropical Diseases Research Centre (TDRC) was conducted in 2012. The purpose of the study was to characterize sexual minorities, who are considered to be at high risk for HIV transmission and acquisition, their relationship with national HIV epidemic in Zambia and to identify opportunities for interventions.

The Population Council/NASTAD was given approval in 2013 to conduct a formative assessment and bio-behavioural survey, including population size estimation of sex workers, clients of sex workers, men who have sex with men, and injecting and non-injecting drug users. The overall purpose of the proposed research is to

⁷⁵ Lilian Keifer, Dewin Hansende, Nervious Siantombo, Harold Witola & Ray Handema, Report on the Study of HIV Prevention For Sexual Minority Groups in Zambia (2013),p.27

describe the characteristics of these key populations which place them at risk for HIV transmission, collect information to better understand their networks, sexual preferences and practices, and estimate population sizes to better understand the extent to which these populations contribute to the HIV epidemic in Zambia.⁷⁶ It is hoped that the study will contribute to a better understanding of these key populations in order to develop targeted interventions to mitigate the HIV epidemic within their communities. To date the lack of evidence has resulted in the absence of interventions and resources targeting key populations. The study will provide a better understanding of the context within which HIV risk occurs among MSM, sex workers, sex worker clients, and drug users as well as identify factors that affect their use of services for preventing and treating HIV/STI.

Stigma and Discrimination

Key populations often experience stigma and discrimination in society in general and particularly within health care settings. The Stigma Index, conducted by the Network of Zambian People Living with HIV, found that key populations including sex workers, ex-prisoners, men who have sex with men and people who use drugs had experienced discrimination.⁷⁷ When stigma and discrimination occur in a health care setting, this can negatively impact the effective and safe delivery of services. Members of key populations may be uncomfortable disclosing their sexual practices and behaviours for fear of prosecution, which impedes effective care. In addition, health care workers do not have access to information and/or trainings to build their capacity to understand risky behaviour or sexual orientation. All of these factors lead to members of key populations delaying in seeking health care or avoiding the health care system altogether.

Limited or No Access to HIV-Related Services

In terms of access to and use of HIV prevention information among key populations, the Panos study found that in Zambia targeted HIV prevention information was almost non-existent, and that most communication that is available on HIV prevention is geared towards those in heterosexual relationships, which creates a gap in health communication for sexual minorities.⁷⁸

The study found that stigma, socio-legal homophobia, unavailability of targeted services for sexual minorities and limited access to HIV prevention and information services were among the factors inhibiting effective HIV prevention among sexual minorities. 8.4% of respondents (across all key populations) in the Stigma Index study indicated that they had been denied access to health services.⁷⁹

⁷⁶ Protocol for the Zambia Formative Assessment and IBBSS Among Populations Most at Risk in Zambia (2012), p.6

⁷⁷ NZP+, GNP+, People Living With HIV Stigma Index, Zambia Country Assessment 2009 (2011), p. 28

⁷⁸ Lilian Keifer, Dewin Hansende, Nervious Siantombo, Harold Witola & Ray Handema, Report on the Study of HIV Prevention For Sexual Minority Groups in Zambia (2013),p.31

⁷⁹ NZP+, GNP+, People Living With HIV Stigma Index, Zambia Country Assessment 2009 (2011), p 32

Limited Capacity of Health Workers to Address Health Needs of Key Populations

In addition to fear of discrimination by health workers, respondents in the Panos study noted that health workers had shown inadequate capacity to assist them when asked to provide assistance specific to sexual minorities.⁸⁰ Medical personnel in Zambia are not trained or prepared to address the health needs of sexual minorities.⁸¹ For instance, health providers may fail to conduct appropriate sexual history interviews and physical examinations which may lead to misdiagnosis and ineffective or even harmful treatment.

Lack of Sustainability of Services Provided by Non-governmental Organisations

In Zambia, the majority of services for key populations are provided by non-governmental organisations, in part because the legal and policy environment hinders the government's ability to support and implement health care services for these populations. This poses challenges for sustainability as most of these non-governmental organisations are funded by external sources without any support from the Zambian government.

Limited Access to Appropriate and Accurate Information

Zambia has not developed or disseminated educational materials about HIV that are appropriate for key populations. As such, as indicated in the Panos study, many key population community members gather information about HIV from friends and acquaintances, which may not always be accurate. For instance, the Panos study found that some MSM believe that anal sex with a man is safer than sex with a woman in terms of HIV infection. Limited access to appropriate and correct information increases vulnerability to HIV infection for key populations in Zambia.

Human Rights Violations against Key Populations

FSWs in Zambia are often subject to abuse, violence and rape. Clients refuse to pay them and steal from them. Such complaints cannot be reported for fear of persecution and even further abuse from the police. In some instances, instead of enforcing the law, police have been reported to ask for sex from sex workers as blackmail to avoid arrest, which adds to the vulnerability sex workers face when it comes to HIV infection.⁸²

⁸⁰ Lilian Keifer, Dewin Hansende, Nervious Siantombo, Harold Witola & Ray Handema, Report on the Study of HIV Prevention For Sexual Minority Groups in Zambia (2013),p.32

⁸¹ Ibid.p.37

⁸² NAC, Female Sex Workers in Zambia: A Systematic Review of Current Evidence (2014), p. (In draft)

HIV and Key Populations: Best Practices

The targeting of HIV programming and services to key populations can help to ensure that all of those affected by or living with HIV are supported in accessing care. Despite the many challenges of combatting HIV among key populations globally, there are some examples that Zambia can draw from, both within non-criminalised and criminalised settings. There are also some successful interventions within Zambia that can and should be scaled up.

According to a policy brief published by amFAR in August 2013, evidence suggests that condom promotion has been most successful among sex workers and that the increased uptake has contributed to averting new infections.⁸³ Among IDUs, there has been drastic decline in drug-related infections on account of harm reduction approaches, such as syringe and needle exchange. Using these approaches some countries are nearly eliminating this type of transmission.⁸⁴ In San Francisco, an effort to reach MSM with HIV testing and referral to treatment services led to a more than 40% decline in new infections in this population.⁸⁵ Clearly, there are interventions that are yielding results among key populations, and the benefits of these interventions translate to the general population.

Decriminalisation of Sex Work

Decriminalisation refers not to the legalization of adult sex work, but simply to the removal of laws that criminalise the behaviour. Decriminalisation advocates believe that the decriminalisation of adult sex work will lead to an environment that will allow sex workers to be protected and allow governments to more easily deliver public health interventions, including HIV prevention and treatment interventions.⁸⁶

Two examples of decriminalisation are New South Wales (NSW) in Australia and New Zealand, the only two places globally where decriminalisation of sex work has been implemented. The regulation of sex work in Australia is territorial therefore there are places within Australia where sex work is still criminalised. Sex work in NSW was decriminalised in 1995. A comparative study found that sex workers within a decriminalised environment exhibited high condom use, extremely low rates of HIV and other sexually transmitted diseases.⁸⁷ The legislative framework has allowed sex workers to exert more control over their work and they are able to

⁸³ UNAIDS Global Report, 2012

⁸⁴ Ibid

⁸⁵ Das M et al. (2010). Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. *PLoS ONE* 5:e11068.

⁸⁶ Sex Work and The Law: The Case for Decriminalization, www.worldaidscampaign.org

⁸⁷ http://www.afao.org.au/library/hiv-australia/volume-13/vol.-12-number-2/sex-work-legislation-stands-in-the-way-of-australias-commitments?utm_content=buffer2114f&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

achieve better health outcomes. Contrary to popular belief, the decriminalisation of sex work has not led to an increase in the numbers of people engaged in sex work.

Government / Civil Society Partnerships

India

In India, the government and civil society organization called Avahan partnered to address HIV and sexual and reproductive health and rights for SW in three districts. The programme began in 2004 and its main focus was HIV/STI prevention. The programme combines components such as behaviour change communication, condom promotion, family planning, STI prevention and cervical cancer screening. Clinical facility services are complemented by outreach through 'hot spots' using SW and other key population peers. Results of the program include increase in the uptake of services by SW, sensitivity of doctors to key population issues and an increase in access to services for SW.

The program found that community ownership was necessary to ensure that the programs are of high quality and are 'key population friendly' and adequately and appropriately address the needs of these populations.⁸⁸

Another successful key population intervention in India was a programme devised by The Family Planning Association in India that targeted MSM, female partners of MSM and transgender people in Mumbai, Chennai, Kolkata and Kohima. The Sexual and Reproductive Health (SRH) clinics in these areas integrated HIV services for MSM and their female partners. Apart from provision of SRH and HIV services, referrals were made for ART, TB, income generation, legal issues and surgical procedures. Results included the welcoming of MSM clients and non-discrimination in the provision of information on both HIV and SHR. One of the challenges faced was that some MSM were reluctant to bring their female partners for fear of outing themselves.⁸⁹

Kenya

Kenya has provided leadership for addressing the HIV-related needs of key populations in an environment where these populations are criminalised. The criminalisation of key populations has not hindered targeted interventions reaching these populations. In 2011, The AIDS Population and Health Integrated Assistance plus (APHIAplus), and the Nairobi-Coast Health Service Delivery Project (APHIAplusNC) supported the government of Kenya and local partners to increase availability of, demand for, and use of quality services to prevent HIV with and

⁸⁸ India HIV/AIDS Alliance, HIV/SRHR Integration for Key Populations: A Review of Experiences & Lessons Learned in India and Globally (2012), p.34-35

⁸⁹ Ibid.p.52-53

among key populations.⁹⁰ The project has been implemented at the provincial and facility levels. It includes the reinforcing of national policies and training programs, and engagement with health service providers at the facility level to improve the quality of biomedical and behavioural health services provided to key population community members. Civil society activities supporting the health care needs of key populations have been integrated into government systems with outreach services managed by local NGOs in conjunction with District AIDS Coordinators and public health providers. The project has also facilitated the paralegal training of peer educators, enabling them to support clients as they navigate the medical and legal systems and strengthen referral networks.

The government of Kenya has provided leadership and support in the implementation of the activities described above through the National AIDS & STI Control Program (NAS COP). By June 2013, grantees of the project had reached more than 78,000 participants through small group and individual behaviour change sessions. They were also able to maintain a consistent supply of condoms at over 500 targeted service outlets.

Zambia

Since August 2012, the Southern African AIDS Trust (SAT) has been implementing the Emerging Voices Project, targeting Female Sex Workers (FSW) aged 18-24 years in Chipata District in the Eastern Province of Zambia. The project seeks to improve access to integrated HIV and SRH Services among FSW between the ages of 18 and 24 years. The project combines capacity building of partners and community agents to support HIV and SRH services among key populations, community mobilization of FSW, stakeholder dialogue and the establishment of a community support mechanism for FSW. The project has resulted in public health workers having an improved attitude towards FSW, an increase in access to HIV and SRH services among FSW, reduced stigma and discrimination against FSWs and safer sex practices among FSWs.⁹¹

⁹⁰ Pathfinder International, Bolstering Combination HIV Prevention with Key Affected Populations in Kenya's Coast Province (2013), p.1

⁹¹ SAT, HIV Prevention with Female Sex Workers: Experiences and Perspectives from Emerging Voices Project in Chipata, Zambia (2014) (Powerpoint Presentation)

Recommendations

Sex workers, men who have sex with men, and people who inject drugs exist in Zambia and are disproportionately affected by HIV. These populations interact with the general public and are part of the sexual networks through which HIV is transmitted. Unless there are targeted interventions for SW, MSM and IDUs, the national HIV response will not succeed and the national vision of 'a nation free from the threat of HIV' will not be achieved.

The review of the legal and policy environment illustrates that the criminalisation of key populations has a bearing on the ability of key populations to access quality prevention, treatment, care and support programs and also hinders an effective national HIV response. It is notable however, that countries with comparable regulatory environments, including Kenya, have succeeded in effectively and appropriately addressing HIV among key populations. It is recommended that Zambia learn from the example set by these countries and implement a clear policy for improving access to HIV-related services among key populations.

The recommendations of this report are directed at the Government of Zambia through the NAC. It is envisaged that the NAC will use this report as a tool to advance the NASF objective of creating an enabling legal and policy environment for the national HIV response.

Initiate Legal & Policy Reform

The legal and policy environment in Zambia has been cited as one of the major barriers to access to HIV-related services for key populations. While it is acknowledged that law and policy reform are not sufficient to deal with all the barriers to access, it is nonetheless critical to creating an enabling environment. It is also notable that in Kenya successful programming for key populations began before supportive and inclusive policies were developed and continues to exist in an environment where key populations are criminalised.

The global guidance including that of the Global Commission on HIV and Law is that punitive laws such as those that exist in Zambia on SW, MSM and IDU should be repealed. While they continue to exist, these laws should not impede access to HIV prevention, treatment, care and support.

Decriminalisation

Decriminalisation of some of the behaviours that key populations engage in, such as prostitution and sodomy laws, would address the legal barriers to access. Decriminalisation refers to the repeal or amendment (undoing) of statutes which made certain acts criminal, so that those acts no longer are crimes or subject to

prosecution.⁹² Decriminalisation is often not well understood. It is often confused with legalisation which refers to the process of making a legal provision for an act.

Suspension of the criminal sanctions on key populations for a given period to allow for public health programming and interventions

This is a form of decriminalisation that should be considered in the short term to facilitate programming for public health and HIV interventions for key populations. This would entail the suspension of criminal sanctions on SW, MSM and IDUs for a period. In Malawi, when former President Joyce Banda came into power, she ordered that the laws on homosexuality be suspended to allow for Malawians to debate the subject. A similar approach can be adopted in Zambia to allow for planning and implementation of targeted interventions over a period sufficient to measure results and the efficacy of the interventions.

Make Use of Policy Review Opportunities

The review of the National HIV/AIDS/STI/TB policy provides an opportunity to provide stronger guidance on key populations. Similar opportunities should be identified and taken advantage of in order to achieve coherence among policies that impact key populations.

Develop Key Populations HIV Strategy and Action Plan

The absence of comprehensive evidence has been a major barrier in ensuring access to HIV services for key populations. The current studies being undertaken are intended to be used to inform policy and programming for key populations. These include the Panos study, Population Council/NASTAD study, and the Legal Environmental Assessment that has been proposed to be done in Zambia's most recent concept note to the Global Fund. There is need for the NAC to articulate how the results of the studies will be used as well as the steps and processes that will be taken. The strategy must articulate among other things, how the non-legal and non-policy barriers will be addressed, including how community systems will be supported to facilitate access to services for key populations. Critical to this process will be the establishment of one consistent definition on who the key populations in Zambia are.

Assess Institutional Capacity for Dealing with key populations Programming

There is need to do an assessment of the capacity of NAC, civil society, cooperating partners, health workers as well as key populations themselves to develop and implement HIV-related interventions for key populations. Based on the findings, capacity building interventions should be planned and resources identified to ensure

⁹² <http://legal-dictionary.thefreedictionary.com/decriminalization>

that each constituency is able to contribute. Institutional arrangements between the Ministry of Health and the Ministry of Community Development Mother & Child Health (MCDMCH) will also need to be clarified particularly as they relate to key populations.

In addition, there is need for dialogue between the Ministries of Health and Community Development Mother & Child Health on one hand and the Ministries of Justice and Home Affairs on the other hand. Beginning at the level of legislation and policy, they are at cross purposes in terms of dealing with HIV among key populations. While the MOH and MCDMCH have been engaging the subject of key populations through NAC with some involvement of the Ministry of Home Affairs in the technical working group, there is need for dialogue to ensure a more coordinated approach that enables an appropriate response to HIV.

Address Protocol Approval Process for Research on Key Populations

Research is critical for the development of evidence informed interventions. The Research Ethics committee must provide guidance to facilitate further research on key populations for on-going learning and evaluation of interventions targeted at key populations. The rejection of protocols in the past has contributed to creating barriers for access to services.

Appendix 1: Excerpts of Legislation

Constitution

Article 17 – Right to Privacy

(1) Except with his own consent, no person shall be subjected to the search of his person or his property or the entry by others on his premises. (2) Nothing contained in or done under the authority of any law shall be held to be inconsistent with or in contravention of this Article to the extent that it is shown that the law in question makes provision: (a) that is reasonably required in the interests of defence, public safety, public order, public morality, public health, town and country planning, the development and utilisation of mineral resources, or in order to secure the development or utilisation of any property for a purpose beneficial to the community; (b) that is reasonably required for the purpose of protecting the rights or freedoms of other persons; (c) that authorises an officer or agent of the Government, a local government authority or a body corporate established by law for a public purpose to enter on the premises or anything thereon for the purpose of any tax, rate or due or in order to carry out work connected with any property that is lawfully on those premises and that belongs to that Government, authority, or body corporate, as the case may be; or (d) that authorizes, for the purpose of enforcing the judgment or order of a court in any civil proceedings, the search of any person or property by order of a court or entry upon any premises by such order; and except so far as that provision or, as the case may be, anything done under the authority thereof is shown not to be reasonably justified in a democratic society.

Article 20 – Freedom of Expression

(1) Except with his own consent, no person shall be hindered in the enjoyment of his freedom of expression, that is to say, freedom to hold opinions without interference, freedom to receive ideas and information without interference, freedom to impart and communicate ideas and information without interference, whether the communication be to the public generally or to any person or class of persons, and freedom from interference with his correspondence.

(2) Subject to the provisions of this Constitution no law shall make any provision that derogates from freedom of the press. (3) Nothing contained in or done under the authority of any law shall be held to be inconsistent with or in contravention of this Article to the extent that it is shown that the law in question makes provision: (a) that is reasonably required in the interests of defence, public safety, public order, public morality or public health; or (b) that is reasonably required for the purpose of protecting the reputations, rights and freedoms of other persons or the private lives of persons concerned in legal proceedings, preventing the disclosure of

information received in confidence, maintaining the authority and independence of the courts, regulating educational institutions in the interests of persons receiving instruction therein, or the registration of, or regulating the technical administration or the technical operation of, newspapers and other publications, telephony, telegraphy, posts, wireless broadcasting or television; or (c) that imposes restrictions on public officers; and except so far as that provision or, the thing done under the authority thereof as the case may be, is shown not to be reasonably justifiable in a democratic society.

Article 23 - Freedom from Discrimination

Subject to clauses (4), (5) and (7), no law shall make any provision that is discriminatory either of itself or in its effect. (2) Subject to clauses (6), (7) and (8), no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority. (3) In this Article the expression "discriminatory" means, affording different treatment to different persons attributable, wholly or mainly to their respective descriptions by race, tribe, sex, place of origin, marital status, political opinions colour or creed whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description. (4) Clause (1) shall not apply to any law so far as that law makes provision: (a) for the appropriation of the general revenues of the Republic; (b) with respect to persons who are not citizens of Zambia; (c) with respect to adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law; (d) for the application in the case of members of a particular race or tribe, of customary law with respect to any matter to the exclusion of any law with respect to that matter which is applicable in the case of other persons; or (e) whereby persons of any such description as is mentioned in clause (3) may be subjected to any disability or restriction or may be accorded any privilege or advantage which, having regard to its nature and to special circumstances pertaining to those persons or to persons of any other such description, is reasonably justifiable in a democratic society. (5) Nothing contained in any law shall be held to be inconsistent with or in contravention of clause (1) to the extent that it is shown that it makes reasonable provision with respect to qualifications for service as a public officer or as a member of a disciplined force or for the service of a local government authority or a body corporate established directly by any law. (6) Clause (2) shall not apply to anything which is expressly or by necessary implication authorised to be done by any such provision or law as is referred to in clause (4) or (5). (7) Nothing contained in or done under the authority of any law shall be held to be inconsistent with or in contravention of this Article to the extent that it is shown that the law in question makes provision whereby persons of any such description as is mentioned in clause (3) may be

subjected to any restriction on the rights and freedoms guaranteed by Articles 17, 19, 20, 21 and 22, being such a restriction as is authorised by clause (2) of Article 17, clause (5) of Article 19, clause (2) of Article 20, clause (2) of Article 21 or clause (3) of Article 22, as the case may be. (8) Nothing in clause (2) shall affect any discretion relating to the institution, conduct or discontinuance of civil or criminal proceedings in any court that is vested in any person by or under this Constitution or any other law.

Penal Code

Sex Work

146. Person living on earnings of prostitution or persistently soliciting

(1) A person who- (a) knowingly lives wholly or in part on the earnings of prostitution; or (b) in any public place, persistently solicits or importunes for immoral purposes; commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fifteen years; Provided that a child who commits an offence under subsection is liable to such community service or counselling as the court may determine in the best interests of the child. (2) Where a person is proved to live with or to be habitually in the company of a prostitute or is proved to have exercised control, direction or influence over the movements of a prostitute in such manner as to show that the person is aiding, abetting or compelling the prostitution with any other person, or generally, that person shall, unless the person shall satisfy the court to the contrary, be deemed to be knowingly living on the earnings of prostitution. (As repealed and replaced by Act No. 15 of 2005)

147. Person living on aiding, etc, prostitution of another for gain

(1) Every person who knowingly lives wholly or in part on the earnings of the prostitution of another or who is proved to have, for the purpose of gain, exercised control, direction or influence over the movements of a prostitute in such manner as to show that such person is aiding, abetting or compelling that person's prostitution with any other person, or generally, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fifteen years. (2) Where a person compels a child to become a prostitute that person commits an offence and is liable, upon conviction, to imprisonment for life. (As repealed and replaced by Act No. 15 of 2005)

148. Power of search

If it is made to appear to a magistrate, by information on oath, that there is reason to suspect that any house or any part of a house is used by a woman or girl for purposes of prostitution, and that any person residing in or frequenting the house is knowingly living wholly or in part on the earnings of the prostitute, or is exercising control, direction or influence over the movements of the prostitute, the magistrate

may issue a warrant authorizing any police officer to enter and search the house and to arrest such person.

149. Brothels

Any person who keeps a house, room, set of rooms, or place of any kind whatsoever for purposes of prostitution commits a felony and is liable, upon conviction, to imprisonment for a term of not less than fifteen years and not exceeding twenty five years. (As repealed and replaced by Act No. 15 of 2005)

Laws on Men who have Sex with Men

155. (Unnatural Offences)

Any person who- (a) has carnal knowledge of any person against the order of nature; or (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature; commits a felony and liable, upon conviction, to imprisonment for a term not less than fifteen years and may be liable to imprisonment for life: Provided that where a person- (i) has carnal knowledge of a child against the order of nature; (ii) causes a child to have carnal knowledge of an animal; or (iii) permits a male person to have carnal knowledge of a male or female child against the order of nature; that person commits an offence and is liable, upon conviction, to imprisonment for not less than twenty-five years and may be liable to imprisonment for life.

156. (Attempt to Commit Unnatural Offences)

Any person who attempts to commit any of the offences specified in section one hundred and fifty-five commits a felony and is liable, upon conviction of not less than seven years but not exceeding fourteen years.

Section 158 (Indecent practices between males)

(1) Any male who, whether in public or private, commits any act of gross indecency with a male child or person, or procures a male child or 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 child or person, whether in public or private, commits a felony and is liable, upon conviction, to imprisonment for a term of not less than seven years and not exceeding fourteen years. (2) Any female who, whether in public or private, commits any act of gross indecency with a female child or person, or procures a female child or person to commit any act of gross indecency with her, or attempts to procure the commission of any such act by any female person with himself or with another female child or person, whether in public or private, commits a felony and is liable, upon conviction, to imprisonment for a term of not less than seven years and not exceeding fourteen years. (3) A child who, whether in public or private, commits any act of gross indecency with

another child of the same sex or attempts to procure the commission of any such act by any person with the child's self or with another child or person of the same sex, whether in public or private, commits an offence and is liable, to such community service or counselling as the court may determine in the best interests of the child.

Appendix 2: Recommendations from the South to South Exchange to Kenya

Based on the findings above the following recommendations are proposed for implementation in Zambia:

| Recommendation | Implementing Body |
|--|-------------------------------------|
| a) Agreement of a definition of key populations for Zambia on the basis of an MOT/epidemic synthesis study, to include population size estimates, mapping of hot spots and prevalence rates, and building on existing and ongoing work such as the PANOS and CDC studies. | NAC with support from UN Joint Team |
| b) Creation of a National Key Populations Steering Committee and revision of the membership of the existing technical working group to include e.g. affected communities, service providers, traditional and religious leaders and the media. | NAC |
| c) Creation of a National Key Populations Technical Working Group for all service providers including members of the MARPs community. | Ministry of Health |
| d) Establishment of an AIDS Tribunal using the Kenyan model supported by the necessary statutes. | Cabinet Office, NAC |
| e) Creation of a minimum package for services for key populations for dissemination through the decentralised structure and to non-governmental service providers. Also with an emphasis on phased implementation and on the integration of services for key populations into health programming: no standalone services. Civil society to be fully engaged from the outset in the development of the package. | Ministry of Health |
| f) Development of guidelines for health workers on working with key populations and programmes for sensitising health workers including internships. | Ministry of Health |
| g) Establishment of a position in NAC dedicated to HIV programming for key populations including a mandate to mobilise civil society groups and stakeholders, and to carry out resource mobilisation. | NAC |
| h) Strengthen the role of NAC communication officer to include media sensitisation and programming, media campaigns, and proactive placement of feature articles and programmes. | NAC |

| | |
|---|--------------------|
| i) Investigation of the need to establish an awareness campaign around the risks of anal sex. | Ministry of Health |
| j) Analysis in due course of the Zambian Constitution post-referendum to assess the legal environment/space within which programming for key populations will take place. | NAC |

References

1. Aidsmap, HIV & AIDS Treatment in Practice, Issue 138, June 2009
2. Buve et al. 1991 and Kamanga et al. 2005 as cited by NAC (2014)
3. Constitution of Zambia, Chapter 1, Part IX, 112(a)(d)
4. Das M et al. (2010). Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. *PLoS ONE* 5:e11068.
5. Getting to zero: 2011-2015 strategy Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010.
6. Global Commission on HIV and the Law, Risks, Rights & Health (Summary Recommendations) July 2012, p.98
7. GNP+ and MSMGF, Advancing the Sexual & Reproductive Health Rights of Men who have Sex with Men Living with HIV: A Policy Briefing (2010)
8. <http://legal-dictionary.thefreedictionary.com/decriminalization>
9. http://www.afao.org.au/library/hiv-australia/volume-13/vol.-12-number-2/sex-work-legislation-stands-in-the-way-of-australias-commitments?utm_content=buffer2114f&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer
10. <http://www.theglobalfund.org/en/fundingmodel/allocationprocess/allocations/> accessed February 2015
11. Human Rights and the Law, UNAIDS 2014 Guidance note (2014)
12. India HIV/AIDS Alliance, HIV/SRHR Integration for Key Populations: A Review of Experiences & Lessons Learned in India and Globally (2012)
13. International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group, Enabling Legal Environments for Effective HIV Responses: A Leadership Challenge for the Commonwealth 2010
14. Lilian Keifer, Dewin Hansende, Nervious Siantombo, Harold Witola & Ray Handema, Report on the Study of HIV Prevention For Sexual Minority Groups in Zambia (2013)
15. MOH, Health Management Information System
16. MOH, National Health Policy (2013)
17. MOH, National HIV/AIDS/STI/TB Policy (2005)
18. NAC, Comprehensive Condom Programming Strategy & Operational Plan 2010-2014 (2009)
19. NAC, Female Sex Workers in Zambia: A Systematic Review of Current Evidence (2014), p.12-13 (In draft)
20. NAC, HIV Prevention Response & Modes of Transmission Analysis (2009)
21. NAC, Joint Mid-Term Review (2013), p.26
22. NAC, National AIDS Strategic Framework 2011-2015 (2010)
23. NAC, National HIV Prevention Strategy (2009)
24. NAC, Revised National AIDS Strategic Framework, 2014-2016 (2014)

25. National AIDS Control Council of Kenya and Population Council. 2009. "The overlooked epidemic: Addressing HIV prevention and treatment among men who have sex with men in sub-Saharan Africa, report of a consultation, Nairobi, Kenya, 14–15 May 2008," *Consultation Report*.
26. NZP+, GNP+, People Living With HIV Stigma Index, Zambia Country Assessment 2009 (2011)
27. Pathfinder International, Bolstering Combination HIV Prevention with Key Affected Populations in Kenya's Coast Province (2013)
28. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
29. Protocol for the Zambia Formative Assessment and IBBSS Among Populations Most at Risk in Zambia (2012)
30. SAT, HIV Prevention with Female Sex Workers: Experiences and Perspectives from Emerging Voices Project in Chipata, Zambia (2014) (Powerpoint Presentation)
31. Sex Work and The Law: The Case for Decriminalization, www.worldaidscampaign.org
32. Spectrum Policy Modelling System, Version 5.03_500 (2014); Zambia Model March 2014
33. UNAIDS Global Report, 2012
34. UNAIDS, AIDS at 30: Nations at the Crossroads (2011)
35. UNAIDS, Report on the Global AIDS Epidemic (2012)
36. UNAIDS, Report on the Global AIDS Epidemic (2013)
37. UNAIDS, Report on the Global AIDS Epidemic (2014)
38. UNAIDS, HIV Prevention Response and Modes of Transmission Analysis (2009),
39. UNAIDS, International Guidelines on HIV/AIDS & Human Rights (2006)
40. UNAIDS, Terminology Guidelines (2011)
41. UNDP, Global Commission on HIV & the Law: Risks, Rights & Health (2012), p.26
42. Vandepitte J et al, Sex Transm Infect 2006;82(Suppl III):iii18–iii25
43. WHO, Prevention and Treatment of HIV and other Sexually Transmitted Infections Among Men who have sex with Men and Transgender People: Recommendations for a Public Health Approach (2011), p.10
44. Zulu, P. K. Male to Male Sex: HIV and AIDS in Zambia. 2004.