Treatment as Prevention (TasP) Consultation
Lusaka, Zambia

13-14 March 2013

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- Clement Chela: Director General, NAC
- Jackie Makokha: Social Mobilization Adviser, UNAIDS
- Dr Landry Tsague: HIV/AIDS Specialist, UNICEF
- Dr Phillimon Ndubani: Public Health Specialist-HIV Prevention, CDC Zambia
- Dr Albert Mwango: National ART Coordinator, Ministry of Health
- Victoria Kalota: Country Project Manager, AHF – Zambia
- Susan Tembo: HIV Officer, WHO country Office
- Dr. Jonas Mwale: Prevention, Care and Treatment, CDC Zambia
- Anna Zackowicz: Co-chair – IAS Advisory Group, AHF – Europe
- Elizabeth Hendry: Project Coordinator, IAS
- Manoj Kurian: Senior Manager Policy & Advocacy, IAS
- Kenly Sikwese: Event Coordinator, NAC
Executive Summary

The Treatment as Prevention (TasP) Country Consultation in Zambia was organised by the International AIDS Society (IAS), the National AIDS Council (NAC) of Zambia, the Ministry of Health, Government of Zambia and the AIDS Health Care Foundation, with the support of various partners. Held on the 13 and 14 March 2013, it brought together 100 participants from different sectors, both from Zambia and abroad. The consultation generated a better understanding of the issues and potential challenges of TasP implementation at the country-level. It also highlighted real concerns to be taken into consideration for TasP roll out in other countries with similar epidemics, legal and policy frameworks. The consultation was framed by comprehensive presentations from 14 experts and leaders with ensuing discussions covering key topics that are relevant to TasP. Critical issues were discussed in depth by six sub-groups over two sessions. The findings were brought to the plenary and deliberated, informing proposals and recommendations for a way forward.

In 2004, only 3,500 Zambians were on ART. By end of 2012 that number increased to nearly 500,000 Zambians, with an ART coverage of more than 80% of those who require treatment (CD4<350). This has enabled Zambia to reduce the number of new infections by 58% -two years ahead of the global target. Despite these successes, only 15% of the country’s 13 million people (1 million of whom are estimated to be living with HIV) have been tested for HIV and know their HIV status. The majority of people only get tested when they seek medical help for health symptoms or pregnancy. Eight-five percent of HIV+ pregnant women receive option A for prevention of mother to child transmission. Most patients access care through urban facilities (69%) and at health center level (59%). The urgent need to address the existing bottlenecks in treatment, care and support services were also highlighted. These included inadequacies in staffing and workload; questionable quality of care and health worker attitudes; unacceptable waiting time, poor confidentiality and poor follow up. Difficulties in reaching people in rural areas and the urban bias in services were also emphasized. Steps to ensure efficiency and effectiveness of health service, task shifting of community health workers and the investment in long term security of drug supply to ensure diversity, sufficiency, affordable production/acquisition were identified as essential for the way forward.

New Zambian and international guidelines are shifting toward initiating treatment at higher CD4 counts for a greater number of HIV+ individuals. Zambia is on an enlightened path in its treatment strategy. This presents an opportunity for curbing the epidemic effectively. However, it also poses challenges for Zambian financial, infrastructure, and human resources. While the uniform expansion of testing and treatment is vital to overcoming the HIV epidemic, TasP requires a profound re-think on ART programmes. It also demands an analysis of how health systems will cope, considering the implications on funding and expansion of services.

The average cost of ART per patient per year in Zambia is estimated at $278 (median $250). The difference between current costs for ART and the costs if Treatment as Prevention is scaled up in Zambia, resulting in more patients being on treatment and for a longer period, will
need to be carefully considered. The unit costs may also change, considering the costs of patient groups and increased work in the community. While the key benefits such as the improved quality of life, increased self-esteem and subsequent enhanced social and economic productivity, will become evident over time, many of the costs will need to be met upfront. This will involve finding public and private investors (both at a national and international level), forging new partnerships and sourcing alternative funding mechanisms to provide upfront funding for TasP programmes to be delivered by the Ministry and co-partners. Possible funding opportunities such as mining licenses, corporate social responsibility programmes, as well as innovative financing schemes such as levies, lotteries, development impact bond were discussed, as was the need to track investment of the Government in treatment and systems.

In order to extrapolate global evidence supporting the case for TasP to the country specific context of Zambia, it was suggested that a national analysis on cost modelling based on the PopART model is undertaken. The PopART study would provide valuable comparison, risk benefit data and feasibility for this work. It was also recommended that current M&E systems are strengthened to gather data and evidence and that Option B+ is used as a proxy for TasP, to help us learn more from its implementation.

Behavioural issues remain a central aspect of the response to the HIV epidemic and the need to continue to address behavioural change, and to invest efforts in prevention, was emphasized. In the context of the expansion of care and treatment, specific efforts need to be made to mitigate the rise of risky sexual behaviour and avert poor adherence of treatment. Efforts must continue to ensure that with the expansion of treatment, complacency does not set in. Achievements are only possible through a team effort, reinforcing accountability with resources and working across disciplines and departments. A major lesson in the experience of implementation of TasP in the region has been the need to avoid a lag period between testing and treatment initiation, to prevent losing people in the cascade, which in turn results in to HIV positive people in the community not being treated.

The importance of a patient centered approach, which encompasses active engagement with the community and expert clients, was emphasized. The key role of community engagement in making testing accessible and acceptable and the reduction of barriers to ART initiation was clearly identified, as was the importance of standardizing the eligibility criteria, drug regimens, monitoring and reporting. Opinion leaders, champions and ambassadors need to be mobilized to help promote adherence and retention of patients in care. Recruitment of mobile telephone companies to send out adherence message was proposed strategy.

The achievement of the earlier and successful uptake of HIV testing and counseling, and earlier, timely and successful access to HIV prevention, treatment, care and support will be undermined if human rights are compromised in Zambia. Examples of coercion and violation of individual rights were cited from mass testing campaigns in neighboring countries. HIV testing must always be voluntary and confidential. It was emphasized that individuals need to have a say in the decision about when their treatment is initiated. The importance of promoting public health without compromising human rights and ethical considerations was highlighted. The
criminalization of sex work, IDU and MSM were pinpointed as hindrances to progress and there was a call for political commitment to address this issue. Though the current legal framework addresses willful transmission, it was clearly felt that this needs strengthening. Overcoming laws that act as barriers to treatment and prevention; strengthening the capacity of communities to access justice and claim their rights where they have been infringed; investing in training health providers of key services on human rights and law; and supporting an enabling legal, policy and social environment, were identified as essential actions to ensure successful implementation of TasP.

Country ownership will be critical to Zambia’s response to the HIV epidemic. Treatment as Prevention has been adopted as a national policy and the Zambian government has tripled its budget for ART in three years. However, this is not just a question of budget, but political leadership as well. This initiative creates the possibility for expansion of ongoing HIV counseling and testing and community initiatives. Furthermore, it paves the way for establishing a National Health Fund and to further increased budgetary allocation to ART. It is an opportunity to consolidate policies and advocate for National HIV and AIDS guiding documents to be put in place. HIV is not constrained to the health sector and it was emphasized that the Ministry of Health needs to engage and involve other Ministries, such as the Finance, Commerce, Agriculture and the Ministry of Community Development and Social Services. It was also clear that the National AIDS Council would be the secretariat that coordinates the follow up these points in a holistic manner with all stakeholders.
Key findings and recommendations

Findings

1. The Commitment
   a. National
      Zambia is ahead of most countries in terms of its HIV treatment strategy and the
government is showing clear political and policy leadership, as well as budget
commitment to expanding treatment. TasP, with greater access to HIV services,
has been adopted as a national policy.
   b. Partners
      There is a strong and expressed commitment of international partners in
expanding treatment and comprehensive HIV care, guided by scientific evidence.

2. The Opportunities and Challenges
   a. Zambia with an ART coverage of more than 80% of those who require treatment
      (CD4<350) has the possibility to lead the way in the transformation of global
treatment and prevention strategies.
   b. While the key benefits of implementing earlier treatment will become evident over
time, many of the costs will have to be met upfront. There is a key need to raise
resources to provide upfront funding for TasP implementation.
   c. Only 15% of Zambian population has been tested for HIV and know their HIV
status.
   d. There is an urgent need to address the existing bottlenecks and disparities in
treatment, care and support services.
   e. In the context of the expansion of care and treatment, it was highlighted that
specific efforts needs to be made to mitigate the rise of risky sexual behaviour
and avert poor adherence of treatment.
   f. The importance of promoting public health without compromising human rights
and ethical considerations

3. Research and evidence
   The PopART study could provide comparison, risk benefit data and feasibility, if a TasP
financial modelling study for Zambia is undertaken. The implementation of Option B+
would also be a great opportunity to learn from and help to inform the implementation of
TasP.
Recommendations and Next Steps

The National AIDS Council (NAC)

- To exercise its convening power to bring together public, private, civil society and implementing partners to resolve issues identified and take forward recommendations from the group work (see below)
- Continue to bring together the various stakeholders, their experiences and concerns at national, provincial, district, community and individual levels regarding Treatment as Prevention (TasP), promoting common understanding of issues and potential challenges of implementation
- Ensure evidence and interpretation of research findings is shared in a clear and accessible way across the country.
- Working with public, private, civil society and implementing partners to develop national guidelines for TasP ensuring that it reflects solutions and concerns raised by all stakeholders
- Incorporate TasP and issues raised into HIV/AIDS Policy review and the NASF Joint Mid Term Review
- To address TasP and follow up the issues raised in the consultations, while convening meetings of the Technical Working Groups for PMTCT, Prevention and Treatment.
- To share the outcome of the consultation widely in Zambia, regionally and globally.

Summary of Findings and Recommendations from Break-out Groups

Individual, Social and Behavioral Issues

- TasP would improve quality of life, increase self-esteem, reduce stigma and subsequently enhance social and economic productivity.
- TasP provides the possibility for expansion of ongoing HIV counseling, testing and community initiatives and commitment. The establishment of a National Health Fund in the pipeline and increased budgetary allocation to ART were identified as key opportunities
- Recommended the quick implementation of TasP following piloting and policy dissemination countrywide with quarterly M&E to check on progress and by promoting task shifting at different levels. Important to ensure that emphasis on both behavioral change and community mobilization are not slackened.
- Promote Adherence week! Need opinion leaders, champions & ambassadors to promote adherence and retention of patients. To also negotiate with Mobile telephone companies to send out adherence message.
- The key risks noted were: adherence fatigue and the sustainability of treatment, drug reactions and drug resistance, increased risky sexual behavior, out of stock drugs or medicines and the possibility of increase in the prevalence of HIV drug resistance strains
due to non adherence. The possibility of increasing donor dependency, the worsening of the human resources situation with inadequate staff, increased workload for health workers and reduced time spent with clients and longer waiting hours were also identified as key risks to guard against.

**Economic issues**

- Implementation of TasP offers the possibility of the elimination of HIV and substantial long-term savings
- Advised Ministry of Health to cost the roll-out and cost-effectiveness of TasP
- Acknowledged that large upfront funding would be required. The global economic crisis, uncertainty about how much money is required and the anticipated out of pocket expenses for the public and opportunity costs incurred were cited as key challenges
- Foster and follow up of Private-Public partnerships to get the synergy and support of successful businesses for mobilizing sustainable resources
- Follow up mining licenses and their corporate social responsibility and contractual commitments in combating HIV
- Engage and involve other ministries - finance, commerce, agriculture - and ensure that HIV is not constrained to the health sector
- Promote innovative financing schemes: levies, lotteries, development impact bond etc.
- Track investment of Zambian government in treatment and systems
- Invest in long term security of drug supply - diversity, sufficiency, affordable production/acquisition
- Ensure efficiency and effectiveness of health service and implement task shifting at the level of community health workers

**Legal and Regulatory Issues, Ethics and Human Rights**

- Testing is an entry point, which needs careful thought and deliberations
  - Counseling and testing is a gateway to care and treatment services. Higher numbers will result in higher uptake of treatment;
  - Innovative expansion of facility based, mobile counseling and testing services and home based approaches will have to be used;
  - Strong push for compulsory testing can be anticipated. The tendency to compel people to test with the threat of sanctions for defaulters should be overcome;
  - The urgent need to clarify and understand the current policy and terminologies around testing e.g. compulsory, mandatory, universal, routine, Provider Initiated Testing and Counseling (PITC);
  - In the context of increase uptake, there is need to examine current testing options that has worked well, and build on that.
- Advocate for the political will to address the criminalization of sex work, IDU and MSM.
- Addressing willful transmission. The current legal framework provides for this but needs to be strengthened.
- Better understanding of the current legal provision to protect children whose guardians prevent their access to services.
• Expand information among health care workers and the communities about available services and legal provisions.
• Clarity around partner notification – policy/practice
• Protection of PLHIV who participate in research around TasP
• The other domain that needs to be addressed is Intellectual property- as Zambia has not been able to manufacture generic drugs. To investigate options into SADC production facility for drugs and promotion of production in the region

TasP: Implementation

• Ensure opportunity costs are reduced for those who are already eligible and accessing treatment. Phased implementation focus on clients “already committed to the service.”

• Don’t go out proactively creating demand until ready. Start with patient demand for test and treat (look at Tete, Moz model of care) and possibly start with cluster groups (e.g. pregnant women, TB patients).

• Focus on addressing anticipated exacerbation of bottlenecks on scaling up:
  o Human resource (training and task shifting- especially at facility level utilizing services of CHW who have undergone standardized training);
  o Infrastructure improvement;
  o Commodity management and storage facilities.

• Dramatic switch in messaging because a lot of prior messaging focused on waiting for treatment.

• Need to decentralize a system that is currently centralized.

• Review model of care at both clinic and community level.

• Get baseline of where we are currently?
  o Data challenges;
  o Retention levels;
  o SmartCare model sites, Smartcards.

• PopART study will provide comparison, risk benefit data and feasibility but short term pilot TasP is required while awaiting mid-term of PoPART interim analysis which is expected in second half of 2015.

• Strengthen current M&E system to ensure have data – use Option B+ as a proxy for test and treat which we can learn from.
• Look at retrospective data from private clinics
  • Patient outcomes (retention, mortality, toxicity, CD4 response, viral load suppression)
• Aggressive public messaging (like male circumcision), emphasize community “buy in”
Proceedings of the Consultation

Outputs

- A better understanding of the concerns and challenges on the ground in Zambia;
- A collection of real concerns to be taken into consideration and to be fed into guidelines for TasP implementation;
- Recommendations, suggestions and best practices to be used in shaping TasP roll out in other countries with similar epidemics, legal and policy frameworks;
- A common understanding of the issues and potential challenges of TasP implementation at the country-level;
- Understanding the body of evidence for TasP.

Opening Ceremony

Bishop Joshua Banda, Board Chair, NAC

Bishop Banda emphasised the important role of HIV / AIDS research, arguing that scientific evidence helps to guard a nation against the progression of the AIDS epidemic. Previous national HIV / AIDS discussions in Zambia have highlighted a growing national interest and commitment to advancing a treatment as prevention approach. The Zambian government has also demonstrated its commitment to treatment as prevention.

Bishop Banda proposed five issues for consideration during the consultation:

1. Implications of manufacturing of drugs and the financial costs associated with scaling up of treatment
2. The need to work together, so that collaboration on TasP is not just an exercise in sharing, but an opportunity to learn from the best practice of others and to be flexible to other views and approaches.
3. Need to synthesise ideas from consultation discussions and to seek ways of turning this dialogue into practical action
4. The importance of community voices being heard. Research needs to be constantly grounded in the fact that our focus is on people, and the desire to save lives. Bishop Banda encouraged community representatives to speak so that the consultation does not become merely an academic exercise.
5. Behavioural issues need to be seriously addressed.

Anna Zakowicz-International Co-Chair TasP Steering Group, IAS/AHF

The International AIDS Society (IAS) is committed to working towards universal access and advocates for comprehensive treatment. The IAS seeks to ensure that a broad range of
perspectives in the AIDS response, for example, community, government and scientific voices, are heard at an international level and inform the global response to the AIDS epidemic.

IAS has chosen to focus on TasP as key priority area, focusing on the primary benefit of treatment, but also the wider benefits for the public. Implementing TasP poses a number of challenges, which vary at a country level. The TasP consultations are an opportunity to lift up country level experiences, and share successes and challenges. Zambia is the host of the first consultation of this kind. The key output will be the recommendations. The hope is that these recommendations can inform Zambia, as well as other countries working in similar contexts, on their work on Treatment as Prevention.

Helen Frary, Country Co-ordinator, UNAIDS

Dr Frary spoke about the benefits of ART in helping keep individuals alive and well being abundantly evident, and the more recent research which suggests that early ART initiation has wider benefits, in reducing the likelihood of opportunistic infections, as well as reducing the viral load to a level which prevents transmission.

Dr Frary emphasised the importance of not underestimating the challenge of what we are asking: for seemingly healthy individuals to start daily treatment. 500,000 Zambians were receiving ART by the end of 2012. However, figures from 2011 suggested that only 15% of Zambian population had been tested and knew their HIV status. The reality is that the majority of people only get tested when they seek medical help for health symptoms or pregnancy.

TasP requires a profound re-think on ART programmes. It will require us to examine how health systems will cope, and the implications on funding. Treatment as Prevention is not a panacea for the AIDS response. Efforts must continue to ensure that complacency does not set in. We will need to continue to address behavioural change, and to invest our efforts in prevention.

H.E. Mark C. Storella, US Ambassador

Ambassador Storella spoke about the renewed optimism in recent years. Even several years ago, the global community was not speaking about a HIV free generation. However, that possibility is something we now believe is possible. In 2004, only 3,500 Zambians were on ART; by end of 2012 that number has increased to 500,000 (one tenth of the population). Michel Sidibé recently highlighted Zambia’s achievement in reducing the number of new infections by 58%, two years ahead of the global target. In 2012, the past Secretary of State, Senator Hillary Clinton cited Zambia as one of two countries held up as a model of the AIDS response.

Ambassador Storella shared four key messages on TasP in Zambia:

1. More work needs to be done. The epidemic is not going to be solved by medication alone, because behaviour is a central part of the response e.g. condoms, circumcision, getting tested.
2. The USA is a strong and reliable partner in the fight against AIDS, and is guided in its work by scientific evidence
3. Achievements are only possible through a team effort: reinforcing accountability with resources.

4. Country ownership will be key to this response. This is not just a question of budget, but policy leadership as well.

Dr. Patrick Chikusu, Deputy Minister of Health

The Honourable Minister reflected on the fact that it is thirty years since the first cases of HIV were first reported. Since then, scientific research has guided the Zambian government’s response, and the Ministry of Health takes new scientific evidence seriously. The Minister advocated the need to cast the net widely, focusing efforts not only in identifying new cases but providing the best care for people living with HIV, which in turn, can help to reduce transmission rates.

The Zambian government has tripled its budget for ART in three years. Treatment as Prevention is a crucial issue, but needs to go hand-in-hand with efforts to change behaviour e.g. use of condoms. Myths about treatment, such as prayers overriding the need for treatment, also need to be dispelled.

The Minister argued that more still needs to be done. Recent research is proof of concept, now the country must now move to more advanced steps. Zambia needs to resolve some of the challenges that may impede the TasP approach. It needs to step up test and treat programmes.

*Treatment as Prevention has been adopted as a national policy.*
Treatment as Prevention in Zambia

Dr. Albert Mwango, National Antiretroviral Program Coordinator, Ministry of Health

Zambia has a population around 13 million people. Approximately 1 million Zambian are HIV positive and only 15% have been tested for HIV. The current estimated infection rate is about 1.2% annually. The HIV epidemic in Zambia is generalized, with transmission predominantly through heterosexual intercourse. There are currently 480,925 patients receiving ART. Eight-five percent of HIV+ pregnant women receive option A for prevention of mother-to-child transmission. Most patients access care through urban facilities (69%) and at health center level (59%).

New Zambian and International guidelines are shifting toward initiating treatment at higher CD4 counts for a greater number of HIV+ individuals. This presents an opportunity for curbing the epidemic and also increases the burden on Zambian financial, infrastructure, and human resources.

Treatment as Prevention (TasP) describes HIV prevention methods that use ART in HIV-positive persons to decrease the chance of HIV transmission independent of CD4 cell count

- Reducing HIV viral load early is the best approach for cutting HIV and TB morbidity, mortality and transmission.
- Reducing maternal HIV viral load is the best approach to preventing mother to child transmission.
- Reducing HIV+ partners viral load is the best approach to preventing HIV transmission in discordant couples.
- Reducing community viral load demonstrates measureable reduction in new community HIV infections.

Implementing these interventions has to be grounded in already proven strategies such as positively influencing behavioral change. Other challenges are: maintaining the “HIV care continuum” as patient is diagnosed HIV+, then linked to care, retained in care, begun on ART, and ultimately virally suppressed. It will be necessary to recognize that most costing data suggests that starting ART at a higher CD4+ count (>500 cells/mm³) could have potential cost savings but would require considerable “front loading”.

The Zambian government will have to invest in activities to make available the least toxic drugs, have systems for HIV drug resistance surveillance, ensure equity of access to care and services, and monitoring and evaluation of TasP. Successful implementation will require input of various stakeholder perspectives, emphasizing human rights and codes of ethics and community engagement. In conclusion, it must be emphasized that HIV is an infectious disease that can be prevented, managed and possibly be eliminated. It is every country’s obligation to
use all possible means to curb the epidemic. ART is one of Zambia’s successful opportunities that should be considered for prevention purposes.

**Setting the Scene: A Regional Perspective**

**Pride Chigwedere, Coordinator, Universal Access, UNAIDS (RST-ESA)**

34 million people are currently living with HIV across the globe (2011) and there are 17.1 million people living with HIV in Eastern and Southern Africa, which is half the epidemic. UNAIDS vision is to achieve zero new infections, zero discrimination and zero AIDS related deaths. Mr Chigwedere spoke about UNAID’s strategic pillars to work towards achieving this vision, as well as the UN goal for 15 million people to be on ART by 2015.

Currently eight million people are eligible for ART using CD4 350 guidelines, 5.2m (64% coverage) of people were on ART in 2011, leaving an unmet need of 2.9 million people who are not on ART. Epidemiological projections suggest that if the 15x15 target is to be met by 2015, 80% of those in need of ART will be receiving therapy.

UNAIDS have proposed a number of suggested actions to increase ART coverage. For example, promoting testing campaigns for early diagnosis and commencement of therapy, considering Treatment for Prevention, especially in countries that have achieved universal ART coverage, improving supply and gaining better intelligence by fore-casting on medicines and commodities to prevent stock-outs.

In the Southern and Eastern Africa, there are varying levels of performance in terms of ART coverage. Zambia along with Swaziland, Namibia and Rwanda have a coverage of more than 80% of those who are eligible for treatment (using the less than CD4 count of less than 350). In comparison, countries such as Eritrea, Tanzania, Angola, Madagascar, South Sudan and Mozambique have less than 50 % coverage. In many ways, countries such as Zambia are leading the way.

Mr Chigwedere also shared a framework for translating scientific discovery on TasP into policy and action. He argued that we need to consider what TasP related challenges will we face, and what outcomes we are looking to achieve.

- What is the right thing to do? (science)
- Did I choose to do the right thing? (economics, politics)
- Did I do the right thing right? (implementation)
- Is it right for everyone? Who is being discriminated and who is being left out? (human rights)
- Did everything turn out all right? (outcomes)
Enhancing Prevention Benefits Current WHO Guidelines and Next steps

Dr Susan Tembo, HIV Officer, WHO and Charles Holmes, Executive Director, CIDRZ

The current WHO recommendation to initiate antiretroviral therapy at a threshold of 350 cells/mm³ is based on compelling evidence that maintaining a relatively high CD4 count reduces the risk of opportunistic infections, cancer, non-AIDS diseases (for example, cardiovascular, hepatic and renal disease), HIV progression and death. Other potential benefits of earlier therapy include a greater likelihood of achieving a normal CD4 count, reductions in immune activation and inflammation and a decreased risk of HIV transmission.

Dr Tembo spoke about the current WHO guidelines for serodiscordant couples, which recommend that couples get tested and counseled together in all settings. The rationale for the guidelines are that co-habiting relationships are common and that less than 5% of people currently test with their partners even though Sero-discordancy is common. Up to 50% of couples, where one partner has HIV, have a partner who is not infected. The majority of people in serodiscordant relationships are unaware and transmission within serodiscordant relationships is common. In Zambia, 87% of transmissions are genetically linked to a cohabitating partner.

In a situation of limited resources, people living with HIV should always be the priority for treatment. A few years ago, HIV was seen as an individual problem. There was little understanding of partner intervention, or disclosure. Today, WHO advocates for couples testing and counselling, which can help to increase openness, reduce stigma and reduce the likelihood of transmission within relationships. Dr Tembo shared a number of suggested next steps: the need to document successes and challenges, assess longer term follow up of the efficacy of ART for prevention, ensure that CHTC is always voluntary and be careful not to disadvantage or exclude those not in couples.

Charles Holmes, Executive Director of CIDRZ

Dr Charles Holmes spoke about the progress in developing the WHO’s comprehensive treatment guidance which is scheduled to be released in June 2013. WHO are working to ensure there is no discrepancies between updated and existing guidelines.

WHO are strongly considering some major changes in their HIV / AIDS guidance. This will include directional changes such as an increase the CD4 count for treatment initiation to 500 and Treatment B+ becoming the approved approach to PMTCT. There are still discussions on how strong these recommendations will be. The revised guidelines will be formally announced at IAS 2013 in Kuala Lumpur in July.
**Treatment as Prevention: Economic Vision**

**Els Sweeney-Bindels, Health Finance Programme Manager, Clinton Health Access Initiative and Dr. Charles Holmes, Executive Director of CIDRZ**

Information exists on the costs of providing anti-retroviral treatment in Zambia under the current circumstances; a recent study by the Ministry of Health and Clinton Health Access Initiative estimated that the costs at facility level of providing ART are on average $278 (excluding above facility costs, such as overhead and MOH staff at central level). To analyze the costs of treatment as prevention, the costs will change in several ways:

- Increase in the number of patients on treatment for a longer period of time
- Unit costs are likely to increase due to intensifying efforts of patient identification, tracking, retention and adherence, and increased use of 2nd line drugs
- Long term impacts are mainly positive, with expected cost savings due to a reduction in new infections, reduced morbidity and mortality and increased productivity.

Recent literature provides evidence for the cost-effectiveness of TasP in general, but also points out that a combination of interventions, such as MMC and ART is likely to be most cost-effective.

TasP requires significant upfront funding. However, at the same time, funding levels are leveling off. Innovative financing methods might be required to ensure funding for TasP is available. A global working group led by the Centre for Global Development is researching the option of a Development Impact Bond. This would involve upfront funding by private investors, who would provide funding to the TasP Programme. Based on the performance of the programme, the investors would be paid a financial return (in addition to the social return of programme outcomes) based on the program outcomes. This return could be paid by government or by an external donor.

The next steps are to ensure that a local analysis of costs and benefits of TasP in Zambia is done, using local data and academic literature.

**Ethical & Human Rights considerations for TasP**

**Malala Mwondela Executive Director, ZARAN**

Malala Mwondela said that the benefits of TasP would be undermined if human rights are compromised. For example, during mass testing campaigns in Lesotho and South Africa there were reported cases of people being coerced into being tested. Ms Mwondela advocated for the need to work together. She spoke of health and human rights leadership are often pitted together but interests of health and human rights practitioners are the same.

It is not a question of public health or human rights. Though there are some specific human rights considerations, the issues are essentially the same. The common agenda is earlier and
successful uptake of HIV testing and counselling, and earlier, timely and successful access to HIV prevention, treatment, care and support.

Ms Mwondela called for the need to address this from both top down and bottom up. She said that Zambia needs to address laws that act as barriers to treatment and prevention and strengthen the capacity of communities to access justice and claim their rights where they have been infringed. She concluded with a call for investment in dignified health systems, which includes training health providers of key services on human rights and law and supporting programmatic interventions to create and strengthen an enabling legal, policy and social environment.

Access to Care, Retention and Support

Dr Dhally Menda, Director of Programmes, CHAZ

Dr Menda’s presentation focused on points of care, the package of treatment, care and support, bottlenecks and the way forward. Key treatment, care and support services in Zambia include HCT, Palliative Care, STI Management, ART, HCT for TB patients, and TB screening for PLHIV. Dr Menda contended that testing and counseling are an important entry point for treatment and care. Static and mobile services are offered in all 1,563 health facilities. HIV testing rate in Zambia is 15.4% of the population.

Menda spoke about the bottlenecks in treatment, care and support services, which include inadequacies in staff (not enough staff, under-trained and lack of motivation), the storing, distributing of drugs, lack of opportunistic infection medication; lack of services / difficulties in reaching people in rural areas, poor confidentiality; poor active follow up; bad attitudes amongst providers and side-effects of ARVs.

Community Perspectives

Kunyima Banda, NZP+

Since 2006, the Zambian government has been providing ART, and have made strides in increasing treatment coverage. However, stigma is still a major issue in Zambia. There are traditional and religious beliefs which have a bearing on treatment and high levels of poverty with 78% of population still live on less than a dollar a day. Geographical barriers such as islands, water plans and mountains mean that it can make it difficult for people to reach medical centre for treatment. There are currently 500 ART treatment centres in Zambia, compared to 1800 health centres. Some people have to travel in the region of 25-100km to reach an ARV centre, and have to find the money to fund these journeys.

Supply issues mean that the minimum waiting time at treatment centres is 3 hours. Patients can wait for up to 16 hours only to find that their medical files are missing and results not being received. Health practitioners are over-burdened which makes it difficult for them to give time to individuals to give information.
TasP HIV testing must be voluntary and confidential. It is important that testing does not become mandatory, or that people are coerced. Priority should be given to those who need treatment and people need to be counselled before treatment. Decision about treatment should be made by the individual. The community role in TasP in advocacy, engagement, and mobilisation, there was a formal recognition of the work of the community.

**NGO Experience (Health Care Foundation Experience in TasP Implementation)**

**Dr. Lydia Buzaalirwa, Director Quality Management AHF Africa Bureau**

The AIDS Healthcare Foundation is currently operating in 25 countries worldwide. They are primarily a care and treatment organization, but also work on advocacy. Annually, the AHF offer testing to 1 million patients. After results presented at the AIDS 2010 conference in Vienna, the AHF developed the test and treat strategy, which was implemented in Uganda and South Africa. Initially rolled out as “test and treat”, which aimed at increasing access to testing and enrolling 80% positives into care and treatment.

The AHF noted high/ significant LTFU within the pre-ART category. A major lesson was the need to avoid lag period between test and treatment initiation, otherwise you lose people in the cascade, and so have HIV positive people in the community who are not being treated. Have to make testing accessible and acceptable. Posters and radio talk shows to communicate why testing is important.

Strategy was to make testing widely and easily accessible to communities – Pillars of demand creation, community engagement (VHTs, CBOs), rapid and mass testing. The aim was for 80% linkage into care. Reduce barriers to ART initiation - patient centered involve community and expert clients. Standardize – eligibility criteria, drug regimens, monitoring and reporting.

**Update on PopART**

The PopART study is being funded by NIH, MAC and others. Research is being carried out in South Africa by the Desmond Tutu Foundation and in Zambia by ZAMBART. The study addresses universal voluntary HIV testing, delivered through door-to-door engagement. It is a cluster randomized study in two countries (randomized communities not individuals). There are twenty one clusters: 12 in Zambia and 9 in South Africa. This translates to approximately 50,000 people per community or cluster. It is a challenge to measure incidence in communities. A representative community sample will be taken to measure incidence rates. In Lusaka, three clinics are participating. Secondary objectives are to explore drug resistance, disease progression, retention, and stigma amongst other factors. Staff and system costs for the study will be covered independently and will not take away from existing health systems.
Break-out Groups (short presentation followed by group discussion.)

GROUP A: Individual and Social Issues

Benefits and Risks at Individual Level

The key benefits would be the improved quality of life and increased self esteem, reduced stigma and subsequent social and economic productivity. There would also be fewer children who are infected and there would be fewer orphans in society. The situation would help reduce drug resistance and opportunity infections.

The key risks were noted as adherence fatigue and the sustainability of treatment, drug reactions and drug resistance.

Benefits and Risks at the Community Level

Benefits

- Less orphans, fewer children born HIV free, reduced stigma and discrimination, reduction in burden of care, morbidity and mortality
- Would lead to more productive communities

Risks

- Prevalence of HIV drug resistance strains due to non adherence,
- Stock out of drugs or medicines and increased risky sexual behavior

Solutions and Next Steps

- Quick implementation of TasP following piloting and policy dissemination countrywide. Quarterly M&E to check on progress. Promote task shifting at different levels. But ensure that emphasis on behavioral change is not slackened and community mobilization. More focus on research for cure.
- Training on EMTCT

Opportunities and Challenges to Society

Opportunities

- TasP to become part of other prevention strategies, with greater access to ARVs, the possibility of mobilizing political will and international solidarity.
- Expansion of ongoing HIV counseling and testing and community initiatives and commitment.
- Establish a National Health Fund in the pipeline and increased budgetary allocation to ART.
- Consolidate policies and advocate for National HIV and AIDS guiding documents to be put in place.
**The Challenges**

- Risk of increasing donor dependency.
- The worsening of the human resources situation with inadequate staff.
- Increased workload for health workers and reduced time spent with clients centers.
- Give the long distance to inadequately equipped ART centers, it can also lead to the worsening of service delivery with low HIV testing and long waiting hours.

**Group B: Economic Questions**

**Opportunities**

- Elimination of HIV: long-term savings.
- Private-Public partnerships: tap successful businesses:
  - Mining licenses (to follow up)
  - Corporate social responsibility.
- Advocacy:
  - Engage with high level leadership.
- Engage and involve other ministries:
  - Finance, commerce, agriculture.
  - HIV is not constrained to the health sector.
- Innovative financing schemes: levies, lotteries, development impact bond.
- Work closely with faith communities.
- Track investment of Government in treatment and systems.
- Invest in long term security of drug supply: diversity, sufficiency, affordable production/acquisition.
- Ensure efficiency and effectiveness of health service.
- Task shifting of Community health workers (low cost).

**Challenges**

- Large upfront funding required.
- Global economic crisis.
- Uncertainty about how much money is required.
- Out of pocket /opportunity costs: if people are feeling well they might not go to clinics due to high costs of accessing treatment (travel, etc).
- Not enough human resources and training.
- Task shifting: legal and policy barriers.
- Coverage access for ongoing programmes – not to be compromised.
- Only 500 ART facilities, urban bias.
- Home-based testing: challenge or opportunity?
- Good fit required for legal and regulatory environment.
**Possible Ways Forward**

1. Private Public partnerships and sourcing alternative funding mechanisms-NAC to take leadership
2. Ensure that Mobile telephone companies to send out adherence message
3. Ministry of Health to cost the roll-out and cost-effectiveness of TasP
4. Develop a plan on how to proceed with TasP
5. All ministries to be engaged
6. To investigate options into SADC production facility for drugs; promotion of production in the region
7. Adherence week! Need opinion leaders, champions & ambassadors to promote adherence and retention of patients in care- estimate the costs

**Group C: Legal and Regulatory Issues, Ethics and Human Rights**

Testing is an entry point needing thought and deliberations

- Higher numbers will result in higher uptake of treatment
- Strong push for compulsory testing by many in the group
- The challenge is clarity in terms of understanding the current policy and terminologies around testing e.g. compulsory, mandatory, universal, routine, PITC

In the context of increase uptake, there is a need to clarify the terms, examine current testing options what has worked well, and build on that. The challenge will be the tendency to compel people to test with the threat of sanctions for defaulters.

The other domain that needs to be addressed is Intellectual property- as Zambia has not been able to manufacture generic drugs largely because very few funds have been allocated. PEPFAR, Global Fund prefers to donate products, which are externally sourced.

The current hurdles include:

- The criminalization of sex work, IDU and MSM. There is need for political will address this issue
- Addressing willful transmission – current legal framework provides for this but needs to be strengthened
- Better understanding of the current legal provision to protect children whose guardians prevent their access to services
- Lack of information among HCWs and the communities about available services and legal provisions
- Clarity around partner notification – policy/practice
- Protection of PLHIV who participate in research around TasP

**Group D: Access to Testing and Linkage to Care in Zambia**
Access to Testing in Zambia

- Counseling & testing is gateway to care and treatment services
- HIV TC offer HIV prevention benefits through reduction of sexual risk behaviours.
- UNGASS 2011 report: only 22.8% of individuals between 15 – 49 years counseled and tested for HIV in Zambia
- 33% sub Sahara region
- About 25.1% increase from 2010 to 2011 (from 1.3 million to 1.8 million)
- Facility based, mobile CT and home based approaches used
- Integrated in FP, PMTCT, MC, TB services, wards, OPD (PITC) and DCT
- Encourage work place testing. In some organisations like Zambia military it is mandatory for new entrance, annual examinations

Opportunities

- Door to door sensitization
- Moonlight testing – start in the evening testing
- Work place testing
- Self testing
- Market places testing and bus stations
- Faster testing reagents e.g. institutions

Challenges

- Health care system – specific times and days for service delivery
- Access, space, confidentiality
- Poor Linkage – difficult to determine who get into care
- Stigma – staff and self
- Low sensitization among small and medium business work places
- Inadequate human resource
- Provider attitude
- Inadequate of funding

Implications for Scale up

- Inadequate human resource
  - Training
  - Task shifting
- Infrastructure improvement
- Commodity management
- Storage facilities
- Increased funding

Next Steps
• Improve coordination between testing teams and clinical team
• Need testing kits which differentiates types of HIV
• Increase sensitization on public health messages and guideline
  o Well packaged messages
• Encourage task shifting at facility level using CHW who have undergone standardized training
• Community testing should be National policy
• Using multidisciplinary mobile teams which will test, link and treat

GROUP E: TasP: Implementation: Yes, but How?

Background

• Overwhelming evidence for TasP
  o Quinn et al. (2000) viral load as predictor of heterosexual transmission
  o HPTN 2011
  o Granich et al. mathematical modeling on incidence
  o Gardner et al Treatment cascade from 80% to 18% Too many still unaware of their status
• Theory to practice challenges
  o Low pediatric coverage (<30% of those needing treatment vs >80% for adults)
  o Urban coverage > rural
• Attrition (Fox & Sheare CROI 2013) less attrition if initiated on ART vs. pre-ART care or VCT only (11.8%, 23.5%, 70.2% BUT still big issue

Opportunities for Implementation

• Focus on “low hanging fruit”
  o Those that keep coming back for CD4 but have not yet been eligible
  o Pastors and religious groups
• Full implementation of TasP for discordant couples (strengthen M&E to track this) and capture lessons learned
• Re-strengthen and reorientation of counselors, they need to know and be able to education and advise on new policies
• Phased approach (pregnant women/WCA, TB patients, etc)
• Strong communication strategy
  o Promote “test and treat” not TasP (too confusing)
• Learn from existing TasP policies (e.g Discordant couples, TB patients)
• Get a better sense of the numbers, e.g how many are in pre ART already that could be started with as a phased approach. (e.g. pregnant women 60% above 350, 40% below)
• Go to scale with cell phone technology
• Focus on those that are already in our programs but not getting treatment
CIDRZ have 200,000 patients who would qualify today—these are the low hanging fruit.

- Build up what we already have, implementing B+, now focus on children
- Greater use of CHW’s to follow up and send data via cell phone
- Decentralize medical stores with provincial hubs
- Development of model sites for SmartCare
- Use this time to change model of care (try new things, safely)
  - Model we have now should not be replicated (too centralized)
- Prospective study to monitor response in people started at higher CD4 counts
- Change model of care and implement more community based approaches which are shown to be more responsive to patient needs, moving some aspects of care outside the facility
  - Refills
  - Psychosocial care
  - Nutrition support

**Challenges**

- Need robust system for tracking patients, functional EHR (SmartCare)
- TasP requires tracking through cascade
- Patients need education on knowing their patient number (Health ID number)
- Need better understanding of retention challenges
- Need “buy in” from population for uptake of TasP
  - Need to sell it, package the messaging
  - Needs to be focused on personal benefits to own health
  - Risk of misunderstanding prevention message
- Need better national data- eligible, loss to follow up
- Supply chain concerns- easier to reach ART sites equipped with skilled staff
  - But to reach 1800 sites, need 1.) more skilled staff for supply chain management, 2.) better supply chain --EMLIP not working well.
  - Storage is a big issue
- Quality of care
  - Waiting time
  - Health worker attitude, workload
  - Follow up
- Human resources
  - Use of community health assistants
  - Pre service and in service training
  - Task shifting and legal support
  - Nurses as ART providers- very small numbers trained, CHA’s
- More use of mobile clinics (increase frequency)
- Sites which are cut off seasonally
- Donor funding dependent
Implications for scaling up implementation and improving retention over time

- Ensure opportunity costs are reduced for those who are already eligible and accessing treatment
- Address bottlenecks, e.g. care for children
- Dramatic switch in messaging because a lot of prior messaging focused on waiting for treatment
- Need to decentralize a system that is currently centralized
- Phased implementation- focus on clients “already committed to the service”
- Financial implications- donor dependent
- PopART study will provide comparison, risk benefit data and feasibility
- Review model of care at both clinic and community level, needs to be as attractive as other care (e.g. faith based healers)

Next Steps: Plan, Do, Study, Act

1. Develop operations research protocols before implement
2. Get baseline of where we are currently?
   - Data challenges
   - Retention levels
   - SmartCare model sites, Smartcards,
3. Short term pilot TasP while await mid-term of PopART interim analysis which is expected in second half of 2015
4. Strengthen current M&E system to ensure have data – use Option B+ as a proxy for test and treat which we can learn from
5. Look at retrospective data from private clinics
   - Patient outcomes (retention, mortality, toxicity, CD4 response, viral load suppression)
6. Don’t go out proactively creating demand until ready. Start with patient demand for test and treat (look at Tete, Moz model of care)
7. Possibly start with cluster groups (e.g. pregnant women, TB patients)
8. Aggressive public messaging (like male circumcision), emphasize community “buy in”

GROUP F: Behavioural Issues

Benefits and Risks for the Individual

Benefits

- Improved quality of life
- Improved physical status
- Improved Health Seeking Behavior
- Increased productivity
- Improved self esteem
- Demand for access to treatment
• Improved sexual behavior
• Increased hope and value for life
• Improved social interaction/reduced stigma and discrimination

Risks

• Risky sexual behavior may increase
• Poor adherence
  o Immediate
  o Long term
• Discouragement to take up treatment upon observing side effects in others
• Self medication
• Complacency

Benefits and Risks for the Community

Benefits

• Improved quality of life
• Improved relationships, arising from CCT.
• Improved Community Health Seeking Behavior
• Increased productivity at community level
• Demand for access to treatment
• Improved sexual behavior
• Increased hope and value for life > better performance
• Improved social interaction/reduced stigma and discrimination.

Risks

• Relationship breaking
• Poor adherence
  o Immediate
  o Long term > higher viral load
• Risky community sexual behavior
• Discouragement to take up treatment upon observing side effects in others
• Self medication
• Complacency
• Increased pressure may worsen the attitudes of HCWs

Opportunities

• CCT, Ante-natal care (PMTCT)
• Sexual and Reproductive Health and Rights
• Use of existing structures
• Goodwill from government and partners
• PIT
• Change of legal framework for HIV and protection of minors

Challenges

• Capacity
• Minority Groups
• Negative attitude of HCWs
• Stigma and Discrimination
• Current behavior change interventions are left to two line ministries
• Comprehensive understanding of human sexuality

Solutions

• Legislative change/ de-criminalization
• Improve attitudes
• Inclusion
• Increasing the number of qualified behavioral scientists.
• Need an inter-disciplinary approach to our response so as to have a careful balance of specialized skill sets
• Meaningful community involvement

Next Steps

• An all inclusive meeting for all stakeholders
• Create an agenda for the meeting
• Increased community sensitization
• Need for Policy Guidelines on TasP through the stakeholders meeting
Concept Note – Use of antiretroviral drugs to prevent transmission of HIV

The co-organisers of this consultation are committed to working towards universal access for all who require anti-retroviral drugs. They also advocate for the scaling up of treatment and comprehensive HIV services and promoting greater political, scientific, programmatic and fiscal commitment from across all sectors of society to address the issue of HIV in a holistic and consistent manner.

There is a broad range of situations where antiretroviral drugs can be used to prevent transmission of HIV, including:

• Treatment of HIV-infected persons who stand to benefit themselves from having the treatment, as their ability to transmit to others will be then be markedly reduced. Treatment as prevention (TasP) - a term used to describe use of antiretroviral drugs to treat all HIV-positive persons, regardless of their CD4 count, where the application of this strategy at population level will reduce spread of HIV in that population.
• Treatment of pregnant HIV-positive women irrespective of their CD4 count and their new-borns in order to prevent mother-to-child transmission (MTCT) of HIV.
• Use of ART for uninfected persons at high risk of acquiring HIV either before or after they are exposed to HIV in order to reduce their risk of acquiring the infection: known as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), respectively.

There is a large body of evidence that supports that use of antiretroviral drugs either in the infected or uninfected person reduces HIV transmission. The strong evidence from observational and randomized controlled trials of treating pregnant HIV-positive women to prevent MTCT and HIV-positive person in a heterosexual sero-discordant relationship to prevent transmission to their uninfected partner support the efficacy of ART in preventing HIV transmission. Conversely, whereas the proof-of-concept that PrEP is effective has been demonstrated and implemented in a few countries, there remain significant challenges in more widespread utilization of this prevention strategy. As such, use of antiretroviral therapy for persons already HIV-positive is the current focus area, and among the various applications outlined above, IAS has chosen to focus on TasP as a priority area for further elaboration. As TasP has already been partly adopted in the global strategy to start HIV-positive persons with already impaired immune function on antiretroviral therapy (which will lower these persons infectiousness), the focus is to further explore the possibilities for using this strategy as a population-wide intervention.

The four key aspects of TASP implementation for the country consultation:

1. Economic issues: Examination of the potential benefits of expanding treatment from an individual, health sector and societal perspective. Specifically, what conclusions can we draw from the modeling and analyses undertaken regarding the potential savings on individual, health sector and societal costs associated with the implementation of TasP,
or some of its components? What is known about the operational and financial feasibility of these strategies given our current and potential resources?

2. Policy, legal, legislative and regulatory issues: What legislation or regulations need to be in place if a country decides to implement TasP? What impact, positive or negative, could national strategies for the implementation of TasP have on the laws and regulations that negatively impact PLHIV? What impact would there be in countries where the transmission of HIV is criminalized? What effects would TasP have on the notion of shared responsibility?

3. The impact on health care systems, health care providers, health care systems delivery and additional challenges or benefits that entail from the implementation of TasP.

4. Individual and social issues: What do PLHIV, key affected populations and caregivers know and think about expanding treatment to attain TasP benefits as a strategy? What interaction is taking place with scientists involved in this topic? How are individual and social issues integrated and reflected in TasP strategies, processes and the decisions about them?

The Zambian consultation lifts up economic, legal and regulatory, systemic and social and individual issues regarding TasP that are relevant to the context of the nation, bringing the experiences, opportunities, challenges and complexities of potential TasP implementation strategies. It is designed to illustrate the diversity of local issues on these four key aspects. In addition, efforts will also be made to bring greater awareness and understanding regarding TasP and different approaches to treatment. Participants represent scientists, health care providers, civil society, PLHIV, and policy makers, so that all opinions can be expressed and captured. The information and data compiled during these consultations will be collated and disseminated at suitable forums, such as the International Treatment as Prevention Workshop in Vancouver or as part of the international conferences organized and co-organized by the International AIDS Society.
**Agenda**

**DAY 1: Wednesday 13 March 2013**

08:30 – 09:00  Registration

**PART I**

09:00 – 09:30  OFFICIAL OPENING: Welcome Remarks, Rationale & General Overview

H.E. Mark C. Storella, US Ambassador

Anna Zakowicz, International Co-Chair TasP Steering Group, IAS/AHF

Helen Frary, Country Co-ordinator, UNAIDS

Bishop Joshua Banda - Board Chair, NAC

Hon Dr. Joseph Kasonde, M.P Minister of Health

*Opening ceremony concludes*

09:30 – 09:45  Setting the Scene – TasP and the Zambian Situation

Dr. Mwango – Country Coordinator ART Programme. MOH

09:45 – 10.00  Setting the Scene: A Regional Perspective

Pride Chigwedere, Coordinator, Universal Access, UNAIDS (RST-ESA)

10:00 – 10:15  Enhancing Prevention Benefits Current WHO Guidelines and Next steps

Dr. Susan Tembo, HIV Officer, WHO and Charles Holmes, Executive Director, CIDRZ

10:15 – 10:35  The Economic Vision: Opportunities and Challenges

Els Sweeney-Bindels, Health Finance Programme Manager, Clinton Health Access Initiative and Dr. Charles Holmes

10:35 – 11:00  Tea Break

11:00 – 11:15  Questions and Answers

**PART II**

11:15 – 11:30  Access to Care, Retention and Support

Dr. Dhally Menda, Director of Programmes, CHAZ
11:30 – 11:45 TasP, Ethics, Stigma and Discrimination
Malala Mwondela Executive Director, ZARAN

11.45 – 12:00 Community Perspectives Kunyima Banda, NZP+

12:05 – 12:30 Questions and Answers

12:30 – 13:45 Lunch Break

PART III

13.45 - 14.00 NGO Experience (Health Care Foundation Experience in TasP Implementation)
Dr. Lydia Buzaalirwa, Director Quality Management AHF Africa Bureau

14:00- 16:00 Break-out Groups (short presentation followed by group discussion)
2. Group B- Economic Questions: Haimbe, CHAI Moderator

16:15 – 17:45 Report back from rapporteurs for Groups D, E and F

DAY 2: Thursday 14 March 2013

09:00 – 09:30 Summary of Day 1 (Plenary)
Dr. Manoj Kurian, Senior Manager, Policy & Advocacy, IAS and Elizabeth Hendry, Project Coordinator, IAS

PART IV- Implications in Zambia (continued)

09:30 – 12:00 Break-out group (short presentations followed by group discussion)

Group D – Access to Testing and Linkage to Care in Zambia – Status, Challenges and New Approaches- Dr. Prisca Kasonde, ZPCT2 Moderator

Group E – TasP: Implementation? Yes, but how? Treatment and Care, Supply Chain Management, M&E: Dr. Sikazwe Moderator

Group F – Behavioural Issues: Dr. Biemba, Moderator
12:30 – 13:30 Lunch Break

13:30 – 15:00 Report back - Rapporteurs for Groups D, E and F

15:00 -16:00 Conclusions and next Steps - Dr. C. Chela, Dr. A. Mwango and Dr. Carol Phiri
### Attendance List

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<tr>
<th>NO</th>
<th>NAME</th>
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<th>ORGANISATION</th>
<th>CONTACT NUMBER</th>
<th>EMAIL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ROY MWILU</td>
<td>EXECUTIVE DIRECTOR</td>
<td>CHEP</td>
<td>0977779622</td>
<td><a href="mailto:Mroy00@yahoo.com">Mroy00@yahoo.com</a></td>
</tr>
<tr>
<td>2.</td>
<td>DR. FELIX MICHELO</td>
<td>MEDICAL SUPERINTENDENT</td>
<td>CHIKANKATA</td>
<td>0977346820</td>
<td><a href="mailto:Michelofelix@gmail.com">Michelofelix@gmail.com</a></td>
</tr>
<tr>
<td>3.</td>
<td>REV. GOODSON SILAVE</td>
<td>CO-ORDINATOR</td>
<td>NZP+ SOLWEZI</td>
<td>0977988003</td>
<td><a href="mailto:goodsonsilavwe@yahoo.com">goodsonsilavwe@yahoo.com</a></td>
</tr>
<tr>
<td>4.</td>
<td>REV. DANIEL SATELA</td>
<td>PALIATIVE CARE MANAGER</td>
<td>NAZARENE COMPASSIONATE MINISTRIES</td>
<td>0977848142</td>
<td><a href="mailto:bakasag@yahoo.com">bakasag@yahoo.com</a></td>
</tr>
<tr>
<td>5.</td>
<td>BELEN KINFEGBIEL</td>
<td>PROGRAMME ANALYST</td>
<td>UNAIDS</td>
<td>0979106060</td>
<td><a href="mailto:Kinfegebrielb@unaids.org">Kinfegebrielb@unaids.org</a></td>
</tr>
<tr>
<td>6.</td>
<td>ZIKHALO PHIRI</td>
<td>PROGRAMME DIRECTOR</td>
<td>YOUNG HAPPY, HELATHY &amp; SAFE/ZPI</td>
<td>0977485861</td>
<td><a href="mailto:Happysafe2006@gmail.com">Happysafe2006@gmail.com</a></td>
</tr>
<tr>
<td>7.</td>
<td>SCOTT ROBERTSON</td>
<td>CMASKPA</td>
<td>ZPI</td>
<td>0966888091</td>
<td><a href="mailto:srobertson@fhi360.org">srobertson@fhi360.org</a></td>
</tr>
<tr>
<td>8.</td>
<td>ROBIN RIDLEY</td>
<td>INVESTMENT ADVISOR</td>
<td>UNAIDS</td>
<td>0972459874</td>
<td><a href="mailto:ridley@unaids.org">ridley@unaids.org</a></td>
</tr>
<tr>
<td>9.</td>
<td>DR. CHANDWA NG’AMBI</td>
<td>PHO</td>
<td>MOH PHO CBP</td>
<td>0977806754</td>
<td><a href="mailto:chandwang@yahoo.com">chandwang@yahoo.com</a></td>
</tr>
<tr>
<td>10.</td>
<td>DR. THIERRY MALEBE</td>
<td>SENIOR ADV. PMTCT</td>
<td>FHI360/2PCT II</td>
<td>0977670934</td>
<td><a href="mailto:tmalebe@fhi360.org">tmalebe@fhi360.org</a></td>
</tr>
<tr>
<td>11.</td>
<td>JOYCE MWALE</td>
<td>CT/PMTCT TECH. OFF.</td>
<td>FHI360/ZPCTII</td>
<td>0977820858</td>
<td><a href="mailto:jmwale@fhi360.org">jmwale@fhi360.org</a></td>
</tr>
<tr>
<td>12.</td>
<td>EUNICE MASI</td>
<td>PAGA – LUSAKA</td>
<td>NAC</td>
<td>0977123920</td>
<td><a href="mailto:eunicemasi@yahoo.com">eunicemasi@yahoo.com</a></td>
</tr>
<tr>
<td>13.</td>
<td>KUNYIMA BANDA</td>
<td>NZP+ PROGRAMME MANAGER</td>
<td>NZP+</td>
<td>0977775880</td>
<td><a href="mailto:kunymabanda@yahoo.com">kunymabanda@yahoo.com</a></td>
</tr>
<tr>
<td>14.</td>
<td>SICHULA MIKE</td>
<td>REPORTER</td>
<td>5FM RADIO</td>
<td>0977719061</td>
<td><a href="mailto:mikeishmeal@gmail.com">mikeishmeal@gmail.com</a></td>
</tr>
<tr>
<td>15.</td>
<td>PRUDENCE MICHELO-HAIMBE</td>
<td>HEALTH FINANCING ANALYST</td>
<td>CHAI</td>
<td>0976446473</td>
<td><a href="mailto:phaimbe@clintonhealthaccess.org">phaimbe@clintonhealthaccess.org</a></td>
</tr>
<tr>
<td>16.</td>
<td>DR. CHELA FOSTINA CHIBOLELA</td>
<td>E. M. O</td>
<td>ZAMBIA SUGAR PLC</td>
<td>0969759732</td>
<td><a href="mailto:fchela@zamsugar.zm">fchela@zamsugar.zm</a></td>
</tr>
<tr>
<td>17.</td>
<td>CHALES HOLMES</td>
<td>DIRECTOR</td>
<td>CIDRZ</td>
<td>0977870666</td>
<td><a href="mailto:Charles.holmes@cidrz.org">Charles.holmes@cidrz.org</a></td>
</tr>
<tr>
<td>18.</td>
<td>FATIMA A. SOUD</td>
<td>ACTING CDC DIRECTOR</td>
<td>CDC</td>
<td>0977640525</td>
<td><a href="mailto:soudf@zm.cdc.gov">soudf@zm.cdc.gov</a></td>
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<td>DR. ALBERT MWANGO</td>
<td>N. A. P.C.</td>
<td>MOH</td>
<td>0950230522</td>
<td><a href="mailto:mwangoj@yahoo.co.uk">mwangoj@yahoo.co.uk</a></td>
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<td>20.</td>
<td>IZUKANI SIKAZWE</td>
<td>TA ART</td>
<td>MOH/UMB</td>
<td>0977233829</td>
<td><a href="mailto:isikazwe@gmail.com">isikazwe@gmail.com</a></td>
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<td>Dr. Sitali Maswenye Lo</td>
<td>PMTCT Specialist</td>
<td>UNICEF</td>
<td>0977749854</td>
<td><a href="mailto:smaswenyelo@unicef.org">smaswenyelo@unicef.org</a></td>
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<tr>
<td>22</td>
<td>Dr. Tina Chisenga</td>
<td>AG. Medical Superintendent</td>
<td>MOH/Monze Mission Hospital</td>
<td>0965033369</td>
<td><a href="mailto:tinachisenga@gmail.com">tinachisenga@gmail.com</a></td>
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<tr>
<td>23</td>
<td>Mutale Kani</td>
<td>Journalist</td>
<td>Radio Phoenix</td>
<td>0979301007</td>
<td><a href="mailto:kanimutale@yahoo.co.uk">kanimutale@yahoo.co.uk</a></td>
</tr>
<tr>
<td>24</td>
<td>Dennis Chibuye</td>
<td>Programme Officer</td>
<td>TALC</td>
<td>0971999740</td>
<td><a href="mailto:dennischibuye@yahoo.com">dennischibuye@yahoo.com</a></td>
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<tr>
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<td>Alemach T. Kalusa</td>
<td>HIV/AIDS Specialist</td>
<td>UNICEF</td>
<td>0974775530</td>
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<td>26</td>
<td>Kenly Sikwese</td>
<td>Activist</td>
<td></td>
<td>0966261218</td>
<td><a href="mailto:ksikwese@gmail.com">ksikwese@gmail.com</a></td>
</tr>
<tr>
<td>27</td>
<td>Dr. Kalamatila</td>
<td>IEC Officer</td>
<td>NAC</td>
<td>255044</td>
<td><a href="mailto:rkalamatila@nacsec.org.zm">rkalamatila@nacsec.org.zm</a></td>
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<tr>
<td>28</td>
<td>Dr. Dhalley Menda</td>
<td>Director of Health Programme</td>
<td>CHAZ</td>
<td>0977794101</td>
<td><a href="mailto:Dhall.menda@chaz.org.zm">Dhall.menda@chaz.org.zm</a></td>
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<tr>
<td>29</td>
<td>Francis Banda</td>
<td>Office Assistant</td>
<td>NAC</td>
<td>0977488197</td>
<td><a href="mailto:fbanda@nacsec.org.am">fbanda@nacsec.org.am</a></td>
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<tr>
<td>30</td>
<td>Dr. Mwiya M.</td>
<td>Consultant Paediatrician</td>
<td>UTH</td>
<td>0977757501</td>
<td><a href="mailto:Mwiya2002@yahoo.com">Mwiya2002@yahoo.com</a></td>
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<tr>
<td>31</td>
<td>Nscendo Hamunke</td>
<td>Member</td>
<td>NZP+</td>
<td>0966942222</td>
<td><a href="mailto:nsom@yahoo.co.uk">nsom@yahoo.co.uk</a></td>
</tr>
<tr>
<td>32</td>
<td>Olivert Simusokwe</td>
<td>Driver</td>
<td>NAC</td>
<td>0962271107</td>
<td><a href="mailto:osimusokwe@nacsec.org.zm">osimusokwe@nacsec.org.zm</a></td>
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<td>Fridah Kamanga</td>
<td>Receptionist</td>
<td>NAC</td>
<td>0977665997</td>
<td><a href="mailto:fkmamgana@nacsec.org.zm">fkmamgana@nacsec.org.zm</a></td>
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<td>Mildred Mulenga</td>
<td>Pharmacist</td>
<td>MOH</td>
<td>0977306442</td>
<td><a href="mailto:Milie52000@yahoo.com">Milie52000@yahoo.com</a></td>
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<tr>
<td>35</td>
<td>Natasha Sakala</td>
<td>Reporter</td>
<td>Conet Radio</td>
<td>0977999553</td>
<td><a href="mailto:Stasha2011@gmail.com">Stasha2011@gmail.com</a></td>
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<td>Enock Ngoma</td>
<td>Journalist</td>
<td>Times of Zambia</td>
<td>097783129</td>
<td><a href="mailto:Enoxngoma@gmail.com">Enoxngoma@gmail.com</a></td>
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<td>Rose L. Musumali</td>
<td>PLHIV Manager</td>
<td>SHARE II</td>
<td>0979638730</td>
<td><a href="mailto:rosemulungu@yahoo.com">rosemulungu@yahoo.com</a></td>
</tr>
<tr>
<td>38</td>
<td>Dr. T. Kaila</td>
<td>HOH. COM</td>
<td>UNZA</td>
<td>0977985772</td>
<td><a href="mailto:t.kaila@unza.zm">t.kaila@unza.zm</a></td>
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<td>39</td>
<td>Ndangwa Mwittah</td>
<td>Journalist</td>
<td>Zambia Daily Mail</td>
<td>0966480140</td>
<td><a href="mailto:Nmwwittah@yahoo.com">Nmwwittah@yahoo.com</a></td>
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<td>40</td>
<td>Dr. Landry Tague</td>
<td>HIV/AIDS Specialist</td>
<td>UNICEF</td>
<td>0908121776</td>
<td><a href="mailto:ltsague@unicef.org">ltsague@unicef.org</a></td>
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<tr>
<td>41</td>
<td>Nachilima Musukuma</td>
<td>AG. Admin. Manager</td>
<td>NAC</td>
<td>255044</td>
<td><a href="mailto:nmusukuma@nacsec.org.zm">nmusukuma@nacsec.org.zm</a></td>
</tr>
<tr>
<td>42</td>
<td>Dorcas S. Phiri</td>
<td>SNR. Nurse &amp; CBTS Technical Advisor</td>
<td>Maryland Global Initiative Co-Operation</td>
<td>0977855078</td>
<td><a href="mailto:dorasphiri@yahoo.com">dorasphiri@yahoo.com</a></td>
</tr>
<tr>
<td>43</td>
<td>Hambweka Mankombwe</td>
<td>Field Operations Coordinator</td>
<td>AIDS Health Care Foundation</td>
<td>0977443197</td>
<td><a href="mailto:Hambweka.munkkombwe@aidshealth.org">Hambweka.munkkombwe@aidshealth.org</a></td>
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<tr>
<td>44</td>
<td>Helen Ayles</td>
<td>Director</td>
<td>Zambart</td>
<td>0966746796</td>
<td><a href="mailto:Helen@zambart.org.zm">Helen@zambart.org.zm</a></td>
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<td>45</td>
<td>PRIDE CHIGWEDERE</td>
<td>COORDINATOR</td>
<td>UNAIDS REGIONAL OFFICE</td>
<td><a href="mailto:chigwederep@unaids.org">chigwederep@unaids.org</a></td>
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<tr>
<td>46</td>
<td>DR. GEORGE M. PHIRI</td>
<td>DIRECTOR</td>
<td>ZAMBIA POLICE SERVICE</td>
<td><a href="mailto:gmsipu@gmail.com">gmsipu@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>DR. PANGANANI D. NJOvu</td>
<td>COMMANDANT</td>
<td>MSMH.DFMS</td>
<td><a href="mailto:panganani@zamtel.zm">panganani@zamtel.zm</a></td>
<td></td>
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<tr>
<td>48</td>
<td>DR. HUMPHREY CHANDA</td>
<td>PHYSICIAN</td>
<td>CHIPATA GENERAL HOSPITAL</td>
<td><a href="mailto:Humphreychanda@gmail.com">Humphreychanda@gmail.com</a></td>
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<tr>
<td>49</td>
<td>VICTORIA KALOTA</td>
<td>COUNTRY PROG. MANAGER</td>
<td>AIDS HEALTHCARE FOUNDATION</td>
<td><a href="mailto:Victoria.kalota@aidshelath.org">Victoria.kalota@aidshelath.org</a></td>
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<tr>
<td>50</td>
<td>DR. ERNEST MWILA</td>
<td>DCOP (CHAZ)</td>
<td>CHAZ</td>
<td><a href="mailto:Ernest.mwila@chaz.org.zm">Ernest.mwila@chaz.org.zm</a></td>
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<tr>
<td>51</td>
<td>JACOB CHATWA</td>
<td>PHLC</td>
<td>JSI</td>
<td><a href="mailto:jchata@jsi.co.zm">jchata@jsi.co.zm</a></td>
<td></td>
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<tr>
<td>52</td>
<td>DENNIS CHALI</td>
<td>PUBLIC HEALTH LOGISTICS ADVISOR</td>
<td>JSI</td>
<td><a href="mailto:dchali@jsi.co.zm">dchali@jsi.co.zm</a></td>
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<td>GEORGE SINYANGWE</td>
<td>SENIOR HEALTH ADVISOR</td>
<td>USAIDS</td>
<td><a href="mailto:gsinyangwe@usaid.gov">gsinyangwe@usaid.gov</a></td>
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<td>54</td>
<td>PHILLIMON NDBUNI</td>
<td>PRENTION TEAM LEAD</td>
<td>CDC</td>
<td><a href="mailto:pandulamp@zm.cdc.gov">pandulamp@zm.cdc.gov</a></td>
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<td>MUKA CHIKUBA</td>
<td>CHIEF OF PARTY</td>
<td>SHARelI</td>
<td><a href="mailto:Muka.chikuba@shareii.org">Muka.chikuba@shareii.org</a></td>
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<td>56</td>
<td>HAGGAI NYAMBE</td>
<td>PROVINCIAL COORDINATOR</td>
<td>TALC-NWP</td>
<td><a href="mailto:haggainyambe@yahoo.com">haggainyambe@yahoo.com</a></td>
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<td>57</td>
<td>ELIZABETH HENDRY</td>
<td>PROJECT COORDINATOR</td>
<td>INTERNATIONAL AIDS SOCIETY</td>
<td><a href="mailto:Elizabeth.hendry@iasociety.org">Elizabeth.hendry@iasociety.org</a></td>
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<td>LYDIA BUZALIRWA</td>
<td>DIRECTOR OR QUALITY MANAGEM T (AFRICA)</td>
<td>AHF</td>
<td><a href="mailto:Lydia.buzaalirwa@aidshealth.org">Lydia.buzaalirwa@aidshealth.org</a></td>
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<td>59</td>
<td>ELS SWEENEY-BINDELS</td>
<td>AG. HIV FINANCE MANAGER</td>
<td>CHAI</td>
<td><a href="mailto:ebindels@clintonhealthaccess.org">ebindels@clintonhealthaccess.org</a></td>
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<td>DR. SUZZAN ZIMBA TEMBO</td>
<td>NPO/HIV</td>
<td>WHO</td>
<td><a href="mailto:tembos@zm.afro.who.int">tembos@zm.afro.who.int</a></td>
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<td>FALES MWAMBA</td>
<td>CPS</td>
<td>MOH</td>
<td><a href="mailto:falesz@yahoo.co.uk">falesz@yahoo.co.uk</a></td>
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<td>CLEMENTINE MUMBA</td>
<td>CHAIRPERSON</td>
<td>INTERNATIONAL COMMUNITY HIV/AIDS ZAMBIA CHAPTER</td>
<td><a href="mailto:bombekikaluba@gmail.com">bombekikaluba@gmail.com</a></td>
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<td>63</td>
<td>CHILAMBE KATUTA</td>
<td>DIRECTOR</td>
<td>YOUTH VISION</td>
<td><a href="mailto:chilambe@gmail.com">chilambe@gmail.com</a></td>
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<tr>
<td>64</td>
<td>DR. OKUKU JACKSON</td>
<td>TECH ADVISOR</td>
<td>JHPIEGO</td>
<td><a href="mailto:jokuku@jhpiego.net">jokuku@jhpiego.net</a></td>
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<td>ORMOND MUSONDA</td>
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<td>ZNBC 0977855267</td>
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<td>JUSTINE KAWISHA</td>
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<td>WILLIAM NGULUWE</td>
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<td>DR. MICHAEL CHANDA MULIMANSENGA</td>
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<td>JO MUSONDA</td>
<td>HIV/AIDS PROGRAM MANAGER</td>
<td>PEACE CORPS 0977815614</td>
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<td>DR. JOSHUA H.K. BANDA</td>
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<td>DR. PATRICK CHIKUSU</td>
<td>DEPUTY MINISTER</td>
<td>MOH 251373</td>
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<td>MOH 0977405230</td>
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<td>PATRICIA ULLAYA</td>
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<td>MICHAEL GWABA</td>
<td>PROG. MANAGER</td>
<td>CITAM+ 0977354793</td>
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<td>NATHAN NHLANI</td>
<td>NATIONAL COORDINATOR</td>
<td>ZNARVS 0977776090</td>
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<td>MAUREEN CHILILA</td>
<td>PMTCT TECH, ADVISOR</td>
<td>JHPIGO 0966250007</td>
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<td>ANNA ZAKOWIZ</td>
<td>CO-CHAIR TASP AG IAS</td>
<td>IAS-AHF 9666250007</td>
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<td>83.</td>
<td>ROB SHENEBERG</td>
<td>COUNTRY MEDICAL DIRECTOR</td>
<td>UNIVERSITY OF MARYLAND-MGIC ZAMBIA 0977302770</td>
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<td>DR. PRISCILLA MULENGA</td>
<td>HEAD QAQC</td>
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<td>DR. NM ZYONGWE</td>
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**Treatment as Prevention (TasP) Consultation. 13 -14 March 2013, Lusaka, Zambia**
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<td>86</td>
<td>LUNDU MAZOKA</td>
<td>FOR-MCED FORMC</td>
<td></td>
<td><a href="mailto:lundumazoka@gmail.com">lundumazoka@gmail.com</a></td>
</tr>
<tr>
<td>87</td>
<td>MALALA MWONDELA</td>
<td>EXECUTIVE DIRECTOR</td>
<td>ZARAN</td>
<td><a href="mailto:malalamwondela@gmail.com">malalamwondela@gmail.com</a></td>
</tr>
<tr>
<td>88</td>
<td>JUSTINE MWIINGA</td>
<td>DONOR COORDINATOR R/PR MANAGER</td>
<td>National AIDS Council (NAC)</td>
<td><a href="mailto:jmwiinga@nacsec.org.zm">jmwiinga@nacsec.org.zm</a></td>
</tr>
<tr>
<td>89</td>
<td>CATHERINE MUYAWALA</td>
<td>IEC COORDINATOR</td>
<td>NAC</td>
<td><a href="mailto:cmuyawala@nacsec.org.zm">cmuyawala@nacsec.org.zm</a></td>
</tr>
<tr>
<td>90</td>
<td>MIRRIAM M. KATONGO</td>
<td>ADMINISTRATIVE ASSISTANT</td>
<td>NAC</td>
<td><a href="mailto:mmoba@nacsec.org.zm">mmoba@nacsec.org.zm</a></td>
</tr>
<tr>
<td>91</td>
<td>DR. MANOJ KURIAN</td>
<td>SNR. MANAGER-POLICY &amp; ADVOCARY</td>
<td>International AIDS Society (IAS)</td>
<td><a href="mailto:manoj.kurian@iasociety.org">manoj.kurian@iasociety.org</a></td>
</tr>
<tr>
<td>92</td>
<td>CAROLYN BOWIMORE</td>
<td>CMO</td>
<td>CIDRZ</td>
<td><a href="mailto:Caslyr-both@cidrz.org">Caslyr-both@cidrz.org</a></td>
</tr>
<tr>
<td>93</td>
<td>SUSAN STRASSER</td>
<td>COUNTRY DIRECTOR</td>
<td>EGPAF</td>
<td><a href="mailto:sstrasser@pedaids.org">sstrasser@pedaids.org</a></td>
</tr>
<tr>
<td>94</td>
<td>DR. MAX BWEUPE</td>
<td>MOH</td>
<td></td>
<td><a href="mailto:membei@state.gov">membei@state.gov</a></td>
</tr>
<tr>
<td>95</td>
<td>IAN MEEMBE</td>
<td>SENIOR M&amp;E SPECIALIST</td>
<td>SG/PEPFAR</td>
<td><a href="mailto:membei@state.gov">membei@state.gov</a></td>
</tr>
<tr>
<td>96</td>
<td>FELLY NKWETO SIMMONDS</td>
<td>SNR GENDER &amp; BC ADVISOR</td>
<td>Z-LED PREVENTION INITIATIVE-ZPI</td>
<td><a href="mailto:fsimmonds@fhi360.org">fsimmonds@fhi360.org</a></td>
</tr>
<tr>
<td>97</td>
<td>K SHANAUBE</td>
<td>POPART STUDY MANAGER</td>
<td>ZAMBART</td>
<td><a href="mailto:kshanaube@zambart.org">kshanaube@zambart.org</a></td>
</tr>
<tr>
<td>98</td>
<td>EDDIE LOELIGER</td>
<td>MD</td>
<td>ZAMBART</td>
<td><a href="mailto:Edde.loeliger@gmail.com">Edde.loeliger@gmail.com</a></td>
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<td>ZAMBART</td>
<td><a href="mailto:Musonda@zambart.org.zm">Musonda@zambart.org.zm</a></td>
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<td>ZAMBIA DAILY MAIL</td>
<td><a href="mailto:nmwitah@yahoo.com">nmwitah@yahoo.com</a></td>
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<td>DR. CLEMENT CHELA</td>
<td>DIRECTOR GENERAL</td>
<td>NAC</td>
<td><a href="mailto:cchela@nacsec.org.zm">cchela@nacsec.org.zm</a></td>
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