



REPUBLIC OF ZAMBIA

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADC) 2015 ANNUAL PROGRESS REPORT ON HIV AND AIDS

July 2016

1.0 BACKGROUND

Since the first case of HIV in Zambia was reported in 1984, the epidemic has presented major health challenges in a country that reports one of the highest HIV prevalence in the world. With an estimated prevalence rate of 13.3%¹ among adults aged 15-49 years in 2014. It is estimated that about 1.2 million² people were living with HIV in Zambia by the end of 2015. Unprotected heterosexual activity is the main driver of new HIV infections accounting for over 90% of new adult infections³.

In Zambia, HIV is most prevalent in the two urban provinces of Lusaka and Copperbelt. The HIV epidemic varies considerably within and across provinces, with Copperbelt reporting the highest prevalence at 18.2%, Lusaka at 16.3% while Muchinga and North Western reported the least prevalence at 6.4% and 7.2% respectively in 2015. Copperbelt province also has the highest estimated HIV incidence at 1.24% among adults with Muchinga at 0.36%. Trends in HIV incidence show a steady decline in the last decade. HIV prevalence is highest among women estimated at 15% compared to men at 11%. In young women aged 15-24, HIV prevalence is more than twice that of young men⁴.

Figure 1: HIV Prevalence by Age, 2015

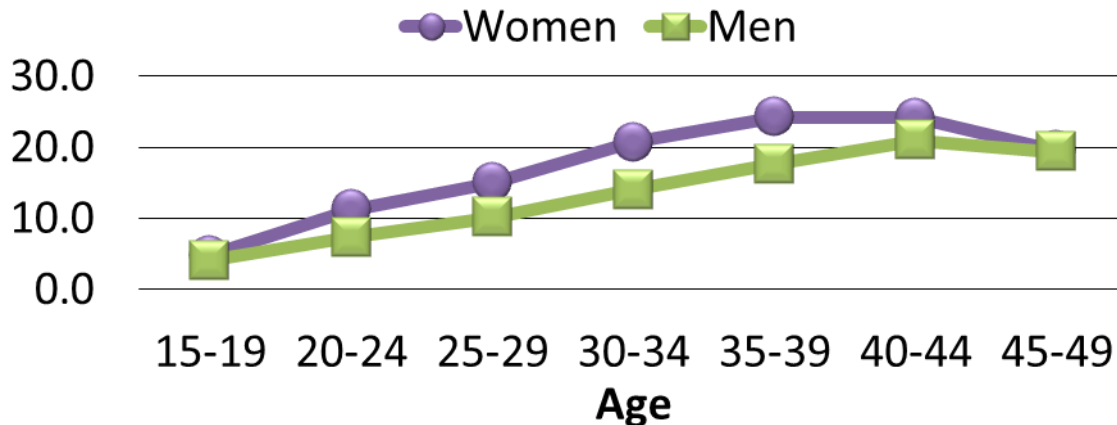


Figure 1 above shows that among women, HIV prevalence is highest at age 35-39 (24.2%) and lowest at age 15-19 (4.8%). Among men, HIV prevalence is highest at age 40-44 (21%) and lowest at age 15-19 (4.1%). Adolescent girls and young women are particularly affected, with 4.5% of all those aged 15-25 years living with HIV (compared to 3.4% of young men).

¹ ZDHS 2013/2014

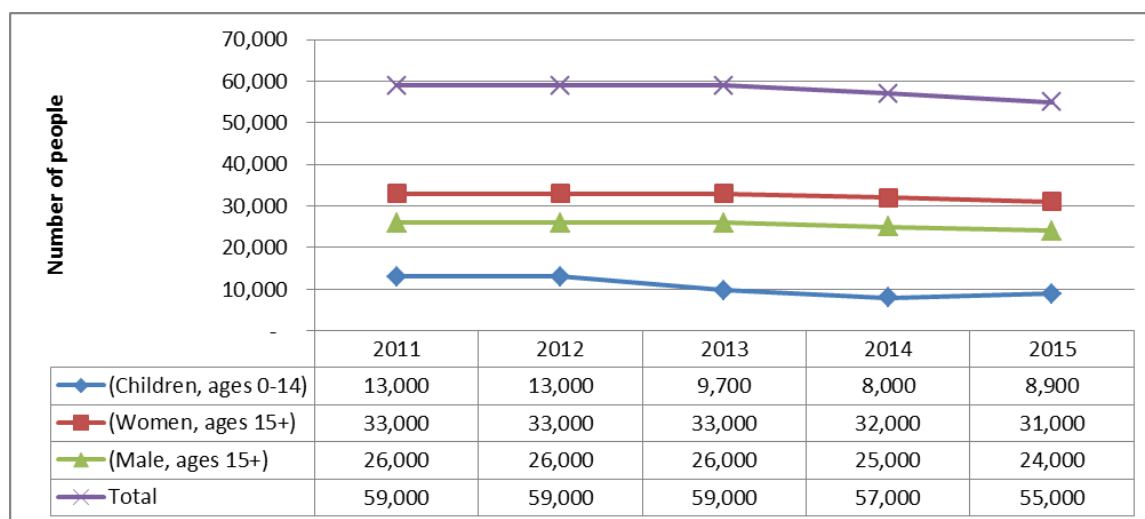
² UNAIDS, 2014

³ Modes of Transmission Study, 2009

⁴ ZDHS 2013/2014

Zambia has made important progress in its AIDS response, achieving more than 41% decrease in new infections between 2005 and 2015. Overall, Zambia experienced a decline of about 20% of HIV incidence between 2005 and 2014. The trend is projected to be declining in the near future⁵.

Figure 2: Estimated number of new infections by age and sex



Source: Spectrum, 2015

Annual new infections decreased from an estimated 59,000 in 2011 to 55,000 in 2015. The decrease was highest among children aged 0-14 years, where the reduction was about 31.5%.

2.0 PROGRESS IN IMPLEMENTATION OF COMMITMENTS

2.1 HIV Prevention and Social Mobilization

In prevention, the most dramatic success between 2011 and 2015 has been in the Prevention of Mother-to-Child Transmission. Approximately, 75,576 Women living with HIV delivered in 2015 and out of which 72,441 received efficacious ARVs for PMTCT. As such, HIV transmission rate from mother to child, including during breast feeding declined from 24 per cent in 2009 to less than 5 per cent in 2015. Additionally, there was an increase in uptake demonstrated in HIV Counselling and Testing (HCT) with 3,270,070 tested and received results in 2015 against the NASF 2014/2016 target of 3,630,688 (90.1%). The number of HCT sites increased from 56 in 2001 to 1,800 in 2015.

Additionally, Zambia managed to circumcise a total of 1,005,424 men out of a target of 1,864,396 by 2015, thus achieving a national Voluntary Male Medical

⁵ Spectrum Estimates, 2015

Circumcision (VMMC) coverage of 54%. The number of sites providing VMMC services increased from 135 in 2010 to more than 500 by December 2015.

The reported condom distribution has continued to increase from 42,095,104 in 2009 to 66,429,400 in 2015⁶. However, female condom uptake has continued to be low compared to male condoms due to many cultural and social factors surrounding its use by women.

Over 19, 000 female and 16, 000 male youths were reached with messages on risk reduction, condom use and HIV/STI pregnancy prevention in 2015 through the Condomize! Campaign supported by UNFPA⁷. The **Condomize!** teams carried out sensitization campaigns in various districts across the country. In order to attract more young people who are the most victims of HIV and AIDS, the Condomize campaign teams involved the use of popular Zambian music artists.

The table below reflects some of the achievements under this intervention area.

Table 1: HIV Prevention and Social Mobilization

1. HIV Prevention and Social Mobilization			
(1) Indicator	(2)⁸ National Figure	(3)⁹ Source and Year	(4)¹⁰ Earlier National Figure, Source and Year
1.1 Percentage of young people aged 15-24 years who are HIV infected	6.6%	ZDHS 2013/2014	M: 4.2% F: 8.4%, EPP 2013
1.2 Percentage of men and women aged 15-49 years who had sex with more than one partner in the last 12 months	1.7%	ZDHS 2013/2014	M(15-49): 19.7% F(15-49): 1.6%, ZSBS, 2009
1.3 Proportion of young people aged 10-24 years who cite a member of the family as a source of HIV and AIDS related information	* (No data)	* (No data)	* (No data)
1.4 Percentage of schools that	* (No data)	* (No data)	* (No data)

⁶ NACMISONLINE, 2015

⁷ NAC Annual Report, 2014

⁸ The value of each of the indicators to be provided should be a national value

⁹ It is important to include all the sources of the data that have been used to derive each indicator. Note that a single data source can be source of many indicators

¹⁰ This is the level of an indicator that was established earlier than the one contained in column (2)

provided life skills-based HIV education in the last academic year			
1.5 Percentage of women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmissions	46.7%	ZDHS, 2013/2016	35.33%, ZDHS, 2007
1.6 Percentage of HIV-positive pregnant women who received Antiretrovirals to reduce the risk of mother-to-child transmission	63%	HMIS, 2015	96.7%, HMIS, 2013
1.7 Percent of donated blood units screened for HIV in a quality-assured manner	100%	HMIS, 2015	100%, HMIS, 2013
1.8 Number of female and male condoms distributed	M: 53,233,560 F: 1,036,846	UNFPA, 2015	M: 22,516,124 F: 1,282,337, UNFPA, 2010
1.9 Percentage of men and women aged 15-49 years who used a condom the last time they had sex with a casual partners with in the last 12 months	M: 29% F: 29.7%	ZDHS, 2013/2014	M: 19.2% F: 20% ZDHS, 2007
1.10 Percentage of infants born to HIV-infected mothers who are infected	3.7%	Spectrum, 2015	12%, HMIS, 2013

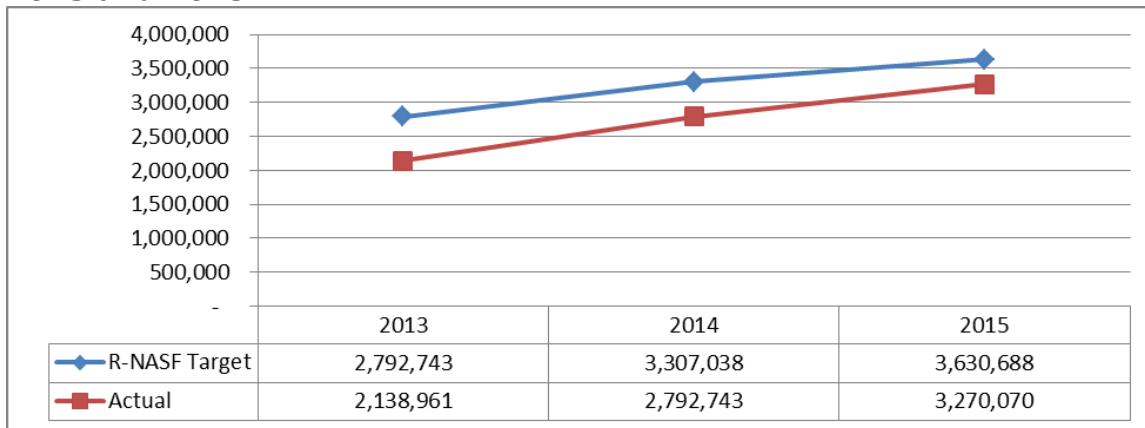
2.2 Improving Care, Access to Counseling and Testing Services, Treatment and Support

2.2.1 Improving Care, Access to Counseling and Testing Services

HIV testing has continued to improve since 2007 when only 19% of women and 12% of men had been tested and received their results within 12 months. According to the ZDHS 2013/2015, HIV testing rates for men were lower than those for women generally and that only 41.5% of the population knows their HIV status.

In 2015, reports from health facilities across the country show that more than 3,270,070 people accessed HIV Testing and Counseling (HTC) against the NASF 2014-2016 annual target of 3,630,688. Figure 3 below shows HTC performance against NASF 2014-2016 targets between 2013 and 2015.

Figure 3: HTC performance against NASF 2014-2016 targets between 2013 and 2015.



Source: R-NASF, HMIS 2015

By the end of 2015, there were 1,800 health facilities countrywide providing HIV Testing and Counseling (HTC) services¹¹.

2.2.2 Treatment and Support

Significant progress has been made in increasing and improving access to and the use of HIV treatment services over the past five years.

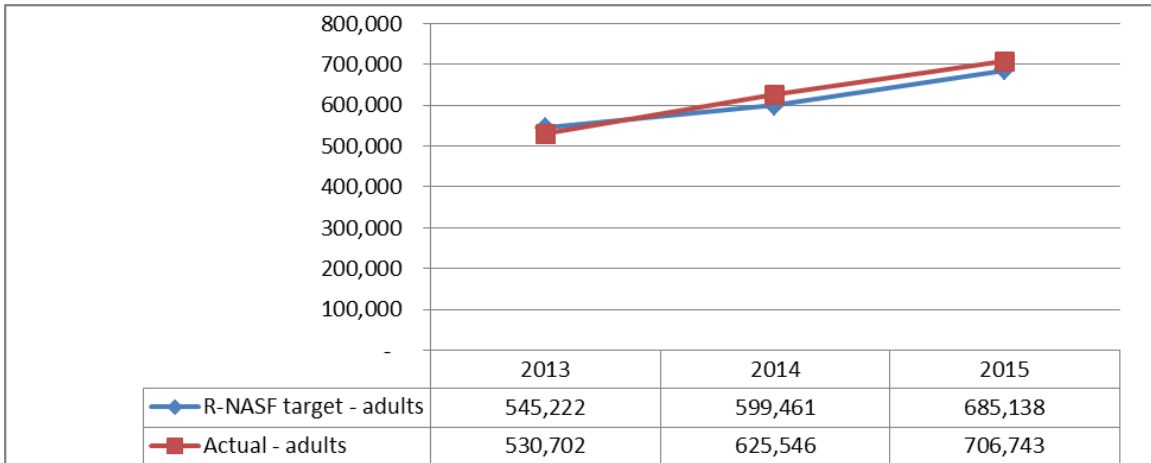
In February 2014, Zambia started implementing the 2013 Zambia Consolidated Guidelines for Treatment and Prevention, which were based on the 2013 World Health Organization (WHO) treatment guidelines and increased many patients' eligibility for treatment, and expanded the use of antiretroviral drugs for HIV treatment and prevention.

The ART programme continues to show impressive performance. In 2015, a total of 706,743 adults and 51,903 children were receiving antiretroviral. This represented an estimated coverage of 63.2% for adults. Of these, 87,580 were newly initiated during the year.

However, pediatric ART coverage was low at 48.4%. The low coverage for pediatric ART is due to poor identification of children needing Early Infant Diagnosis (EID) due to inadequate integration with other child survival interventions like immunization and nutrition services. For the children identified and diagnosed with HIV, initiation is delayed as most Adult ART and PMTCT sites do not offer ART services for children.

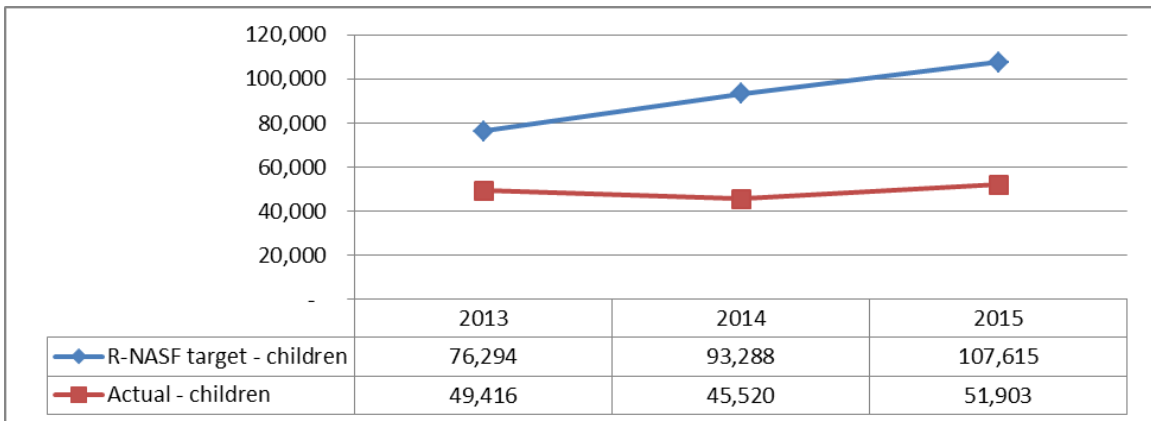
¹¹ Zambia HMIS, 2015

Figure 4: Number of adults receiving ART 2013 – 2015, target vs actual



Source: R-NASF, ART Register

Figure 5: Number of children receiving ART 2013 – 2015, target vs actual

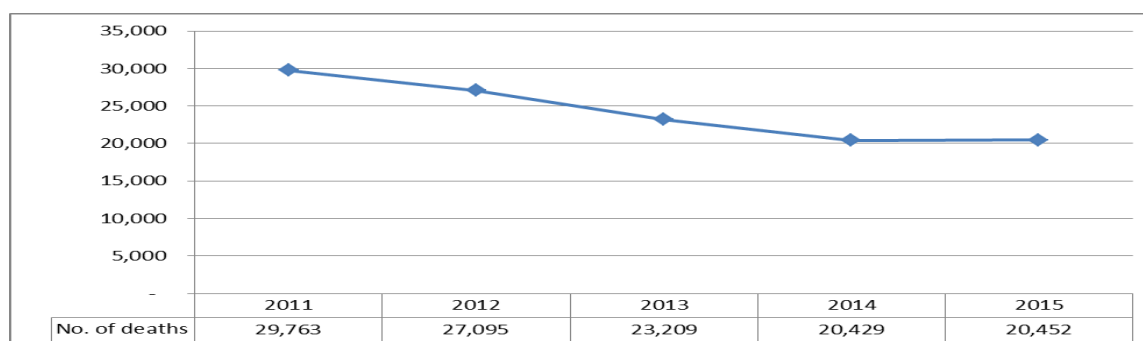


Source: R-NASF, ART Register

The number of ART sites increased from 592 in 2014 to 879 sites 2015 and there were improvements in compliance with the revised treatment guidelines.

Further, there has been remarkable decline in AIDS related deaths from about 69,000 in 2003 to less than 24,000 by the end of 2015 representing a 66% decline.

Figure 6: Estimated annual AIDS deaths in Zambia, 2015



Source: Spectrum, 2015

The rapid expansion of access to antiretroviral therapy is primarily responsible for these reductions in AIDS-related mortality.

Table 2: HIV and AIDS Care, Access to Counseling and Testing Services and Support

2. Improving Care, Access to Counseling and Testing Services and Support			
(1) Indicator	(2)¹² National Figure	(3) Source and Year	(4) Earlier National Figure, Source and Year
2.1 Percentage of health care facilities providing ART	32%	HMIS, 2015	30%, HMIS, 2013
2.2 Percentage of health care facilities with referrals for HIV and AIDS care and support services	90%	HMIS, 2015	83%, HMIS, 2013
2.3 Percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child			58.8%, JMTR, 2013
2.4 Current school attendance among orphans and non-orphans aged 10-14 years	87.8%	MoE Annual School	Orphans:14.9% Non Orphans: 19.2%, JMTR,

¹² . In cases where the country does not have data for certain indicators, instead of leaving the space blank, the country should enter “na” for not applicable

Note: Meaning of columns as in Table 1 above

		Census, 2015	2013
2.5 Percentage of children aged less than 18 years who are orphans (single, double orphans)	* (No data)	* (No data)	* (No data)
2.5 Percentage of large enterprises/companies which have HIV and AIDS workplace policies and programmes	71%	NACMIS, 2015	* (No data)
2.7 Percentage of chronically ill people that are receiving home-based care from trained care providers	65%	NACMIS, 2015	50%, HMIS, 2014
2.8 Number of providers trained in home-based care	* (No data)	* (No data)	* (No data)
2.9 Percentage who took an HIV test in the last 12 months and who know the results	41.6%	ZDHS, 2013/2014	41%, HMIS, 2013
2.10 Percentage of facilities providing HIV testing services	90%	HMIS, 2015	85%, HMIS, 2014
2.11 Percentage of population expressing accepting attitudes towards PLWHA	M: 27.2% F: 18.7	ZDHS, 2013/2014	38% ZDHS, 2007
2.12 Percentage of people with advanced HIV infections receiving ART	63.2%	HMIS, 2015	82%, HMIS, 2013
2.14 Percentage of districts or local administration units with at least one health facility providing ART	100%	Health Facility Survey, 2012	100%, Health Facility Survey, 2012

Additional Indicators

(1) Indicator*	(2) National Figure	(3) Source and Year	(4) Earlier National Figure, Source and Year
4.1 Percentage still alive after initiating ART (1 st and 2 nd line)	Adults: 63.2%	HMIS, 2015	Adults: 81%

after 36 months,	Children: 48.4%		Children: 90%, HMIS, 2013
4.2 Percentage of people with advanced HIV infections receiving ART (disaggregated by age: 0-14, 15+years)	* No data	* No data	0 – 14: 52% 15 – 48: 86%, HMIS, 2013
4.3 Percentage of most-at-risk populations (IDU, MSM, CSW)** who received an HIV test in the last 12 months who know the result	IDU: * (No data) MSM: * (No data) Prisoners: 27.4%) CSW: (56.4%)	Zambia Prisons Survey, 2011 & IBBSS, 2015	IDU: * (No data) MSM: 27.4% (Prisoners) CSW:*(No data)
4.4 Percentage of most-at-risk populations (IDU, MSM, CSW) who are HIV-infected	IDU: * (No data) MSM: * (No data) CSW: 56.4%	IBBSS, 2015	* (No data)
4.5 Number of males circumcised	222,481	HMIS, 2015	199,057, HMIS, 2014
4.6 Percentage of males circumcised (disaggregated by age)	* No data	* No data	0–11mths: 1.5% 1–14ys: 38.7% 15–49ys: 59.5% 50 + ys: 0.3%, HMIS, 2013

* Where possible all indicators must be disaggregated by age and sex

** IDU=Injecting Drug Users; MSM=Men who have sex with men; CSW=Commercial sex workers

Integrated TB/HIV activities have been implemented in line with the WHO Policy on TB/HIV collaborative activities since 2005 with the establishment of the National TB/HIV Coordinating Committee that included all major stakeholders in both TB and HIV. Following the development of the National Guidelines for the Implementation of TB/HIV activities, the national level coordinating committee was replicated at Provincial and District levels in all 9 Provinces at the time. The main emphasis in the integrated approach in the initial phase of the response was on two of the three thrusts of collaborative TB/HIV activities; namely reducing the burden of TB among the HIV patients and reducing the burden of HIV among the TB patients.

Notable success has been recorded in reducing the burden of HIV among TB patients since 2006 with more than 90% of the notified TB patients knowing their HIV status, more than 93% coverage of Cotrimoxazole, and more than 66% of HIV positive TB patients on ART by the end December, 2015. The prevalence of HIV in TB patients was 6.8%¹³ in 2015.

Table 3: Collaborative Indicators for HIV/TB, 2015

(1) Indicator*	(2) National Figure	(3) Source and Year	(4) Earlier National Figure, Source and Year
5.1 Percentage of HIV-positive people who are screened for TB on their first visit to an HIV clinic	* No data	* No data	99.98%, NTP, 2014-2016
5.2 Percentage of HIV-positive TB patients who are on ART	* No data	* No data	65%, NTP, 2014-2016
5.3 Percentage of HIV-positive people who are TB-positive (co-infection rate)	* No data	* No data	63%, NTP, 2014-2016

3.0 Accelerating Development and mitigating the impact of HIV and AIDS

The interventions under Impact Mitigation focused on strengthening the capacity of vulnerable households and individuals to cope with the socio-economic impacts of HIV and AIDS. The array of interventions envisaged included micro-credit schemes, backyard and community gardens, small livestock and poultry initiatives, training in various business aspects (marketing, project and financial management). The interventions were executed within the context of a broader **Social Protection** framework (implementation of sustainable livelihoods, improving household food security, strengthening systems that provide social security, and reducing household risks and vulnerability). People living with HIV (PLHIV), orphans and vulnerable children, people with disabilities, and care givers were recognized as the key vulnerable groups.

Mitigating the needs of the orphans and vulnerable children was of high priority for the Government and mitigating the outcome of the growing OVC population of Zambia through provision of Social cash transfers. The Zambian Government, in collaboration with development partners, put in place policies and strategic measures to address the OVC situation. These included the National Child Policy 2006, a National Plan of Action for OVC 2011 - 2015, a draft minimum standards

¹³ TB Survey, 2015

of care package. Furthermore, the Government put in place a legislative framework to protect the welfare and promote the rights of OVCs such as the Juveniles Act Cap 53, Adoptions Act Cap 64, Affiliation and Maintenance Act Cap 313.

By 2015, there were over 300 organisations were identified as providing OVC support and care the most common been Community Based Organizations (CBOs), faith-based, local NGOs and international NGOs that have shown continued commitment to provide education support for OVC who were working alongside with the Government sectors, demonstrating the invaluable response to OVC education support in the country. The coverage of education support was expanding for few prominent NGOs in the country. The main success was through their contribution for the provision of bursaries to orphans in schools. However, challenges in the increase of orphans in some provinces to meet their basic needs remained problematic in districts, even though there was evidence that numbers of orphans declined.

The role played by Government sectors in the provision of education support to orphans was another achievement of maintaining sustainable measure of commitment and ownership of OVC support. The Social Welfare Department of the Ministry of Community Development and Social Services (MCDSS) and the Ministry of General Education (MoGE) were the key Government bodies involved in the provision of education support among the OVCs.

4.0 Intensifying Resource Mobilization

HIV and AIDS have long term implications for treatment and prevention costs due to the chronic nature of the conditions. Many low- and middle-income countries where HIV prevalence is high have traditionally relied heavily on external donor assistance, and Zambia falls in this category. Donor assistance has declined steadily over the past several years, and this situation is expected to continue, calling upon the Government to take increasing responsibility for financing the HIV Response.

Historically, contributions from Government for the health sector in general, and the national response in particular, has been low but there are efforts, to increase Government funding for the health sector. The US Government and Global Fund are the major source of funding for the national response contributing to the positive health outcomes achieved in 2015.

The Government of Zambia has been exploring options for increasing domestic financing. In April 2011, a report on "Sustainable Financing for AIDS in Zambia" was done. The report explored how the Government could approach long term financing for AIDS up to 2020. Alternative financing options presented in the report included private sector contributions, public sector mainstreaming, general taxation, borrowing and social health insurance. Over the last several years,

much work went into a feasibility study and subsequent design of a National HIV Trust Fund. However, current discussions are leaning towards the establishment of a Social Health Insurance Scheme that would cover broader health issues and integrate HIV into a general National Health Fund. The modalities for the Health Fund are yet to be defined.

Although the HIV and AIDS response in Zambia is known to be heavily dependent on external aid, the public sector contribution is under-estimated due to hidden costs. In fact, Government is a major contributor to the national response. This includes financing for infrastructure such as hospitals, training schools, health centers, roads, supply of health commodities, equipment, utilities, transport, salaries for staff and other recurrent expenditure. Although it is difficult to apportion how much of such spending can be attributed to the HIV and AIDS response, it is undeniable that without these basic necessities that government provides, no health programmes would run effectively.

The Government also provides varying budgetary allocations to ministries for public sector HIV and AIDS mainstreaming activities. A non-fixed percentage of between 1% - 5% of project funds for all road and large capital projects is provided towards environmental impact assessments and mitigation for HIV and gender mainstreaming, using the Environmental Impact Assessment (EIA) process regulations. Examples of these projects include: the Link Zambia 8000 Roads Development Project, the Pave Zambia 2000, and township roads built through the Local Government and the Constituency Development Funds. The rural electrification projects under the Rural Electrification Authority (REA), and the Mines and other businesses in the private sector also provide similar funds for HIV and AIDS services for their workers and the surrounding communities in their project areas. Some of these funds go towards providing services for contract workers on these projects (internal mainstreaming), and some of the funds go towards financing the overall HIV and AIDS response in communities in the surrounding areas of the project vicinity.

However, Zambia will still require international assistance with a focus on support that contributes to sustainable programmes and systems.

Table 4: Indicator to measure resource mobilization in SADC Member States, 2015

3. Intensifying Resource Mobilisation			
(1) Indicator	(2) National Figure	(3) Source and Year	(4) Earlier National Figure, Source and Year
3.1 Percentage of the national budget committed to the health sector	9.6%	2015 National Budget	12%, National Budget, 2013
3.2 Amount of public funds for research and development	* (No data)	* (No data)	* (No data)

of a preventive HIV vaccine and microbicide			
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Note: *Meaning of columns as in Table 1a above.*

5.0 Strengthening Institutional Monitoring and Evaluation Mechanisms

In accordance with the "Three Ones Principle", Zambia developed a National Monitoring and Evaluation Plan which was a comprehensive narrative document that clearly articulates all monitoring and evaluation activities for the national HIV Response. The plan is being used to measure progress in achieving the results set out in the RNASF 2014-2016 based on defined indicators at various levels and its implementation is supported by a number of partners including UNDP, UNICEF, UNFPA, UNAIDS, CDC, PEPFAR, etc. However, despite the existence of this plan, there have been notable challenges with regards to monitoring and evaluation.

These challenges include:

- Data quantity and quality arising from complexities in the formulation of some of the indicators in the NASF which is making it difficult to determine progress in the National HIV Response. However, this is being addressed in the process of developing the NASF 2017-2021. Indicators will be minimized and strategically formulated.
- Inadequate human resources and financial capacities for effective monitoring of the national response. A number of studies to inform the response were not conducted during the period under review on account of limited funding.
- Gaps mainly at district and community levels such as inadequate M&E capacity, inadequate data harmonization, and weak feedback loops and poor data use culture.

6.0 Conclusion

Despite the significant achievements in the response, Zambia still remains one of the top 10 countries in the world with the highest number of people living with HIV. A considerable number of PLHIV (about 500,000) are not accessing treatment and an estimated 80,000¹⁴ are adolescents many of whom do not know their HIV status.

The Zambian government working together with various stakeholders is committed to national, regional and global efforts to end the AIDS epidemic by 2030.
