



# HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
<b>Total Population*</b>	13.5 million (2010)
<b>Estimated Population Living with HIV/AIDS**</b>	1,100,000 [1,000,000–1,200,000] (end 2007)
<b>Adult HIV Prevalence***</b>	14.3% (2007)
<b>HIV Prevalence in Most-at-Risk Populations****</b>	FSWs: 65.4% (urban) (2004)
<b>Percentage of HIV-Infected People Receiving Antiretroviral Therapy*****</b>	85% (2009)

\*U.S. Census Bureau \*\*UNAIDS \*\*\*ZDHS 2007 \*\*\*\*UNGASS \*\*\*\*\*WHO/UNAIDS/UNICEF *Towards Universal Access*, 2008

With an HIV prevalence of 14.3 percent among adults 15 to 49 years old, Zambia is one of the worst-affected countries in all of sub-Saharan Africa. Zambia's first case of HIV was reported in 1984 and was followed by a rapid rise in prevalence through the mid-1990s. Since 2004, there has been a steady decrease in mortality from HIV/AIDS due to an increased availability of treatment, and in 2007, an estimated 56,000 people died as a result of HIV, down from a peak of more than 66,000 deaths in 2003. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimated Zambia had 1.1 million people living with HIV/AIDS (PLWHA) in 2007. As of 2010, Zambia's HIV hyper-epidemic is considered to be mature and generalized.

The primary mode of transmission in Zambia is heterosexual, accounting for about 90 percent of new HIV infections. High prevalence rates are fueled by early initiation of sex, unprotected sex with nonregular partners, concurrent sexual partnerships, low incidence of condom use among high-risk groups and by individuals, sexual violence against women, and poverty that forces women and girls to sell sex for food, good grades, small gifts, or money. Nonconsensual sex is particularly risky in the context of the HIV/AIDS epidemic and is one cause of the high prevalence in women. In many circumstances, there is no opportunity for negotiating safer sex, and attempting to negotiate increases the likelihood of additional injuries that could add to the risk of HIV transmission.

Unlike many other countries in Africa, the epidemic in Zambia primarily affects urban, educated, and wealthier populations. Women are disproportionately affected, particularly young women ages 15 to 24. According to the 2007 Zambia Demographic and Health Survey (ZDHS), HIV prevalence among young women 20 to 24 years old (11.8 percent) was more than double that of young men in the same age group (5.2 percent).

According to the 2008 *Towards Universal Access* report, Zambia has one of the highest rates of antenatal care (ANC) coverage in the region (93 percent, according to the ZDHS), though trained assistance at delivery is far lower (47 percent), and Zambia has a high proportion (65 percent) of pregnant women tested for HIV compared with other southern African countries. With the majority of pregnant women accessing at least one ANC visit, there is great potential to provide HIV counseling and testing, and, as appropriate, antiretroviral drugs (ARVs) for the prevention of mother-to-child transmission of HIV (PMTCT) to all pregnant women. According to United Nations Children's Fund (UNICEF) estimates and the U.S. Government (USG) 2009 Country Operational Plan, PMTCT coverage was 45 percent in 2006 and had increased to 68 percent of pregnant women by 2008. Testing of infants born to HIV-positive mothers has scaled up as well, with the number of infants tested doubling from 2007 (11,000) to 2008 (approximately 22,000).

Zambia does not systematically monitor HIV prevalence in commonly known most-at-risk populations (MARPs), such as female sex workers (FSWs), men who have sex with men (MSM), prisoners, men in uniform (military and police), and transport workers. Available data confirm that FSWs, sexually transmitted infection and tuberculosis (TB) patients, MSM, and prisoners are disproportionately infected. In 2004, a study of FSWs found a prevalence of 65.4 percent. There have been increased outreach services among sex workers in the past few years; according to the 2009 Behavioral Surveillance Survey, the percentage of FSWs who received an HIV test in the last 12 months and knew their results increased from 19.8 percent in 2005 to 74.5 percent in 2009. Data on HIV prevalence rates among MSM are sparse, generated from surveys with very limited sample sizes. However, the potential



impact of HIV/AIDS transmission by MSM to or from their partners may be significant, as approximately 50 percent also have sex with female partners, including sex workers.

Zambia's urban and rural HIV epidemics show significant differences in scale and trend. Urban residents are more likely to be HIV positive, with a prevalence rate in the 2007 ZDHS of 19.7 percent, compared with 10.3 percent in rural populations. While the urban epidemic has been shrinking, especially among men, the rural epidemic only showed a minor decrease in prevalence between the 2001–2002 ZDHS and 2007 ZDHS. In 2007, HIV prevalence was significantly higher in urban women (26.3 percent) than in urban men (19.2 percent); in rural areas, 12.4 percent of women were HIV positive compared with 8.9 percent of men. The AIDS epidemic has also had an impact on many children. In Zambia, there are an estimated 1.2 million orphans and vulnerable children, most (800,000) of whom are orphaned due to HIV/AIDS, according to the 2007

ZDHS. With one or both parents dying due to HIV/AIDS, grandparents or other relatives often assume the burden of caring for surviving children.

TB is a major public health problem that has an intricate relationship with HIV. With an incidence of 470 cases per 100,000 population in 2008, TB is endemic in Zambia. According to the World Health Organization (WHO), 68 percent of new cases are reported to be HIV positive. The TB burden is greatest in the provinces with the highest HIV prevalence, such as Lusaka and the Copperbelt, where as many as 800 individuals per 100,000 population have been diagnosed with TB. HIV-TB co-infection complicates the care and treatment of both diseases.

## National Response

Zambia's National HIV/AIDS Strategic Framework for 2006–2010 is currently being updated for another five-year period, along with other national strategies and frameworks. A number of sectors contribute to the strategy, including health, education, labor, transportation, defense, gender, and youth. Given the size and scope of the epidemic, most programs aim to cover the general population; however, some special target populations do stand out, including pregnant women, commercial sex workers, PLWHA and their caregivers, youth, migrant/mobile populations, health care providers, and, more recently, prisoners.

While Zambia does not have many laws and regulations specifically protecting PLWHA against discrimination, there are general nondiscrimination provisions in other laws that can be applied to the protection of PLWHA. A Government policy prohibits employers from requiring new employees to undergo an HIV test, and the Government supported awareness campaigns on the policy throughout 2007. There have also been few key human rights achievements related to HIV in recent years, though in 2005, the Government amended the penal code to prohibit "widow cleansing," a practice whereby women whose husbands have died submit to sex with a village leader in order to be re-accepted into the community. Challenges remain in these areas, as knowledge of human rights and discrimination laws remains very low, especially in rural areas, and there is thus a need for more awareness. The rights of some MARPs, such as MSM, injecting drug users, sex workers, and prisoners, are not safeguarded, creating challenges in designing programs to address these groups. Antisodomy laws and the general lack of acceptance of MSM make it difficult to implement targeted interventions for this population, just one example of the issues in providing prevention, testing, and treatment services for MARPs.

State provision of antiretroviral therapy (ART) began in Zambia in late 2002, though initially very few people could afford the monthly payments for ARVs. In 2004, the Government committed to providing ART free of charge in the public sector and rolled out a free ART package in public facilities within a year. This was made possible largely by an unprecedented amount of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria; the U.S. President's Emergency Plan for AIDS Relief (PEPFAR); and other sources. The delivery of the program is spearheaded by a strong public sector response, complemented by the work of nongovernmental organizations (NGOs), churches, and communities. Both WHO and UNICEF have been working with partners to develop operational guidance on provider-initiated testing and counseling for children, which has helped to substantially increase the number of HIV-infected infants and children who are detected and can be treated.

In 2009, WHO made notable changes to its recommendations on when to initiate ART. WHO 2006 guidelines recommended PLWHA begin treatment when the client's CD4 (a form of white blood cell) count reached or dropped below 200/mm<sup>3</sup>. The new recommendations raised this threshold to 350 cells/mm<sup>3</sup>, greatly increasing the number of PLWHA eligible for treatment. In 2007, WHO estimated 46 percent of PLWHA in need of ART were receiving treatment according to the 2006 standard; by 2009, it was estimated 85 percent of those in need were on treatment.

According to the 2010 report of the United Nations General Assembly Special Session (UNGASS), by the end of 2009, one-third of all health facilities in the country were able to offer treatment. Ultimately, Zambia aspires to make ART equally available to everyone who is clinically eligible.

Numerous faith-based organizations play a role in expanding treatment access, providing as much as 40 percent of all HIV-related health services in Zambia. With financial assistance from bodies such as the Global Fund, the Churches Health Association of Zambia had provided ARVs to 17,000 individuals by the end of 2008; in addition, it is providing the resources for more than 100 church health facilities to implement DOTS (directly observed treatment, short-course) for TB.

Most HIV/AIDS programs in Zambia are supported by donor funding, including support from WHO, the Global Fund, United Nations agencies, and bilateral organizations. As of 2010, the Global Fund has approved \$456 million in grants for HIV/AIDS since 2003. The latest grant of \$13.8 million was approved to start in January 2010 for the Scaling-Up Prevention and Impact Mitigation and Strengthening Health Systems program. The USG provides nearly 30 percent of the Global Fund's total contributions.

## **USAID Support**

Through the U.S. Agency for International Development (USAID), Zambia received \$148 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Zambia are implemented as part of PEPFAR. Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

Zambia is one of PEPFAR's 15 original focus countries, which together represent approximately 50 percent of HIV infections worldwide. In Zambia, PEPFAR programs are implemented under the leadership of the U.S. ambassador through a joint agency team that includes USAID, the U.S. Centers for Disease Control and Prevention, the Peace Corps, and the State and Defense Departments. Programs are also implemented with the support of many partners, including the Zambian Government, local and international NGOs, and U.S.-based organizations.

USAID activities focus on reducing Zambia's high HIV prevalence rate through combination prevention activities; improving the capacity of the Ministry of Health to administer, monitor, and evaluate programs; and working with religious and community organizations in prevention, care, and treatment. Scale-up of the Zambia PMTCT program has been particularly successful: In 2009 alone, 398,000 pregnant women received HIV counseling and testing services, and 57,000 HIV-positive pregnant women received ARV prophylaxis for PMTCT. Other remarkable achievements in 2009 for USG HIV/AIDS programs in Zambia included:

- ART for 229,200 individuals
- care and support for 387,400 HIV-positive individuals, including TB/HIV services
- counseling and testing 861,400 individuals outside of PMTCT settings
- reaching 1.2 million individuals with community outreach HIV/AIDS prevention activities that promote correct and consistent use of condoms and related interventions

## **Important Links and Contacts**

USAID/Zambia

Tel.: +260-211-254-303

Fax: +260-211-254-532

Web site: <http://zambia.usaid.gov/>

USAID's HIV/AIDS Web site for Zambia:

[http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/zambia.html](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/zambia.html).

For more information, see USAID's HIV/AIDS Web site: [http://www.usaid.gov/our\\_work/global\\_health/aids](http://www.usaid.gov/our_work/global_health/aids).