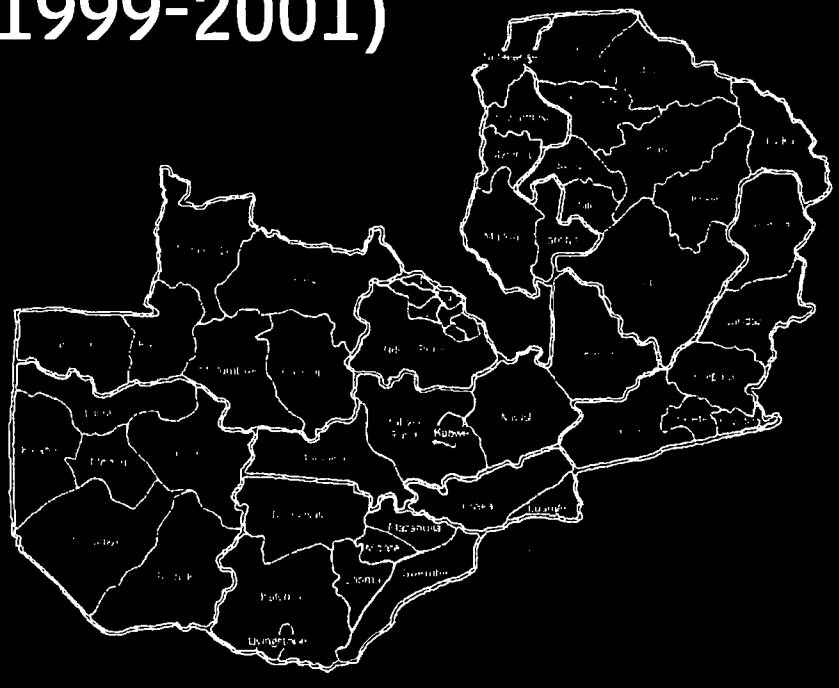
HIV Prevention & Orphans Support in Zambia

(1999-2001)



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HIV Prevention and Orphans Support in Zambia

Project Proposal (1999-2001)

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HIV Prevention and Orphans Support in Zambia: Responding to the Orphan Generation

Requesting Agency:	UNICEF Lusaka, Zambia
Geographic Location:	Eastern and Southern Africa: Zambia
Proposed Duration:	1999-2001
Budget:	US $ 1,476,000
Collaborating Ministry:	Ministry of Sport, Youth and Child Development
Potential Partners:	UNAIDS, UNFPA, UNICEF National Committees and USAID. Cooperating Ministries will include Sport, Youth and Child Development; Legal Affairs; Health; Education; Community Development and Social Services. Key NGOs will include CHIN, Chikankata, the Copperbelt Health Education Project, Zambia Community Schools Secretariat, Family Health Trust, Kanyama Peer Education Project, Kara Counseling Training Trust and other community based and religious institutions.
Geographic Coverage:	National.

Description of the Proposal

Problem:

There are an estimated 1.5 million orphans in Zambia in 1998. The HIV/AIDS epidemic in Zambia is among the most serious in the world, and the proportion of children under 15 who are orphans (32%) is also among the highest in the region. The proportion of children orphaned by AIDS will continue to increase through 2010 at the earliest, bringing the total to over 2 million. Assumptions by the National AIDS, STD and Leprosy Programme that HIV prevalence rates peaked at 20% of adults in 1997 lead to the conclusion that the proportion of children who are orphans will remain unusually high for the next three decades if not longer.

The vast majority of orphans in Zambia are still being absorbed by the extended family. Almost three-quarters of all Zambian households contain at least one orphan. Their caretakers are predominantly women. The burden of poverty already places strains on these families thereby limited the level of care provided to these children; it is estimated that 70 % of all households are poor and 53% extremely poor – disproportionately so in rural areas and among female headed households. Patterns of income poverty are matched by nutrition and health status, limited access to services and educational status. Severe and moderate malnutrition (stunting) affects 42% of all under-5s; the under-5 mortality rate is high at 197/1000 live births; only 23% of rural households have access to safe water; the net primary school enrolment rates [illegible]. Access to regular primary and secondary education is lower for orphaned children. There is also

some evidence that they are discriminated against in terms of labour and responsibility in the household. A study of physical and sexual abuse in (urban) homes and schools is now being completed, and suggests that abuse is high and common among step children. In all these respects the situation of girls is worse than that of boys

Among orphans not absorbed by the extended family system, the number of street children is estimated at 90,000 and growing, of which 50% are orphans. At most, only 9,000 children are accommodated in registered orphanages (i.e. 0.05% of the total orphan population). Formal adoption is virtually non-existent in Zambia.

In response to the orphan generation, Government and community responses are currently very limited. Government safety nets (principally the Public Welfare Assistance Scheme, PWAS), which might contribute to support for orphans and guarantee access to education and health services, reach only 2% of the needy. The Health Cost Care Scheme exempts under-5s, pregnant women and the elderly from user fees but is not effective at exempting the needy as identified by PWAS. Instead, external support for the families assisting orphans comes primarily from civil society, which includes an array of NGOs, church groups and community-based organizations – even here coverage is limited to perhaps 10%. In the education sector, the community school movement in Zambia has widened school access for many children and accommodates a large number of orphans. A number of NGOs are supporting peer education through Anti-AIDS clubs, both within schools and in community.

In the field of AIDS prevention, GRZ/UNICEF cooperation through the Advocacy and Education programmes is to support formal, community and peer education interventions. HIV infection rates are lowest among the 5-15 age group, which provides a "Window of Hope". The highest infection rates are among 20-29 year olds (especially among girls) which highlights the urgency of addressing the needs of the current AIDS free youth.

Objectives:

Overall, the objective of the GRZ/UNICEF programme on Advocacy, Planning and Action for Women and Children (1997-2001) is to *create an environment which places the highest priority on the needs of children and women and recognises and strives to fulfil their rights.*

Within this, the component projects have the following objectives (1997-2001):

- *To strengthen Zambian society's will and institutional capacities to fulfil women's and children's rights.*
- *To promote and develop the effective use of communications, participatory methods and con munity based approaches to mobilise action towards the achievement of women's and children's rights.*
- *To develop and support approaches which strengthen family and community capacities to protect and care for children in need.*
- *To strengthen capacities to develop policies and programmes which contribute to improvements in the wellbeing of the poor, and address the rights and needs of women and children.*

In the Education For All programme the overall objective set out in the GRZ/UNICEF Programme of Cooperation (1997-2001) is to *ensure access to quality education for all children of primary school age (7-13 years); and provide learning opportunities to empower individuals with the skills, knowledge, confidence and capacities required to enable them to manage life challenges and fully participate in Zambia's challenges.*

Within this, the objective of the Learning Opportunities project is:

- *To develop and expand learning opportunities and life skills education for out-of-school children and adolescents.*

In this broader programming context, this project proposal is intended to secure support through UNICEF to strengthen government and community mechanisms which most effectively assist households to provide improved protection and care for orphans. In particular, to:

- raise awareness of magnitude and urgency of the problem;
- increase coverage of response by government, NGOs and community-based organization; and,
- help young people (7-18) to develop positive psycho-social skills (life skills)

Summary of Proposed Support (1999-2001)		
Objectives (1999-2001)	**Strategies**	**Major Lines of Actions**
▪ Raise awareness of magnitude and urgency of the problem	▪ Advocacy/ Information	▪ Data collection/ dissemination, including research and mapping existing provision of services (geographic and programmatic) ▪ Monitoring the violation of child rights through CBOs and NGOs. ▪ Support and promote effective government safety net mechanisms
▪ Increase coverage of response	▪ Innovation/ demonstration of effective community-based interventions ▪ Partnership building and coordination of orphan support between Governments, donors and NGOs	▪ Assess existing coping capacity within community. ▪ Provide technical/ financial assistance to community-based orphan support ▪ Support networking between government, community-based organizations, and NGOs ▪ Evaluation of innovative approaches ▪ Development and promotion of best practices (models of care)
▪ To help young people (7-18) to develop positive psycho-social skills (life skills) which will enable them to make informed decisions and take charge of their own lives	▪ Prevention of HIV/AIDS through formal, community and peer education channels	▪ Needs assessment ▪ Development, production, pre-testing of lifeskills materials for teachers, youth leaders and pupils ▪ Training of teachers ▪ Support Sara communication initiative to complement life-skills approach in Zambia

Proposed Actions for Implementation

National-level Advocacy

Although existing data and research in Zambia have created some awareness of the increasing numbers of orphans, there is still little understanding at national level of the gravity and enormity of the challenge. There is no sense of urgency that this is a problem demanding immediate attention. In collaboration with partners UNICEF will support a programme of advocacy with the view of gaining political and social leadership commitment to an immediate national initiative, and to gain resources to formulate and implement it.

Research and Data Collection on Orphans

National policy and programme development must be guided by credible data and information. Systems that regularly collect and disseminate information on the impact of HIV/AIDS on families and children are particularly important. When community members and local-level officials participate in collecting and analysing such data, they become more familiar with the scale and nature of the problem and are usually motivated to take charge and find local solutions to problems.

In collaboration with partners UNICEF will support the mapping of existing geographic and programmatic coverage of services for vulnerable children, families and communities. An inventory and assessment of agencies providing such services will be made. At local and community level systems for data collection will be developed that can be managed and acted upon at those levels. UNICEF will support the regular updating of data to reflect changes and the impact of interventions.

In partnership with USAID and others, mechanisms and indicators would be developed to monitor community-based processes, outputs and impacts on families and children affected by HIV/AIDS.

Reviewing protection mechanisms for children 0-18, especially orphans

Based on the mapping exercise and assessment of existing mechanisms, support would be given to strengthen protection mechanisms/ safety nets (such as the Public Welfare Assistance Scheme) – paying particular attention to the needs of orphans and the criteria for providing support to them.

Promotion of Community Based Orphan Support

Considerable numbers of community based organizations exist in Zambia that have already accumulated valuable experiences in identification, assessment, support and assistance to children and families affected by HIV/AIDS. Assistance has generally focused on the provision of health and education services and food, clothing and shelter. However, 'burnout' is reported among some care-givers. There is some indication that traditional practices, particularly regarding the role of women and inheritance, may be changing.

In collaboration with partners, UNICEF will identify appropriate community-based responses, evaluate their effectiveness and share lessons learnt. Communities will be supported to narrate their own experiences to others. Support in the form of technical assistance will also be given to innovative community approaches which address a wider range of psycho-social needs of vulnerable women and children - including early childhood development and grief counselling. Approaches which offer more support to care-givers and to cooperative arrangements for work-load sharing will be pursued. In all cases monitoring and lessons learnt will be a key issue.

Develop Life Skills Programme for in-school and out-of-school children

Building on the initiative in 1998 to develop the life-skills approach in Zambia to help young people (7-18) develop positive psycho-social skills which will enable them to make informed decisions and take charge of their own lives (especially in the context of HIV/AIDS), support will be provided to develop the approach through formal, community and peer education approaches. Government has acknowledged the validity of the approach, but more will need to be done to advocate and develop the approach. This will include materials development and testing of teaching and learning materials (including radio) and training of teachers.

Social mobilization and programme communication strategies, such as the Sara Communication Initiative, would be used within the overall framework of lifeskills training. This programme aims to promote community participation in debates on issues such as girls' education, HIV/AIDS and orphans, child rights and child labour, and career development, thereby enhancing positive knowledge, attitude and behaviour formation and change

Strengthening Early Childhood Development interventions

The potential for expanding community schools and peer education initiatives to cover children 0-7 would be assessed and communities enabled to respond to these needs on a sustainable basis.

Coordination of interventions

Collaboration among governments, donors, international organisations, NGOs and other partners is essential to ensure that resources are mobilised and directed to the most cost-effective interventions. Government efforts must be directed to protect the most vulnerable children and provide essential services for those who are not served through community programmes. Integrated between existing services, whether government or non-government, must be achieved.

UNICEF, together with other partners, will support Government to formulate national policy and programmes that are effective, with a low cost per beneficiary and sustainable over the long term. Support will be given to strengthen national social welfare services including the Public Welfare Assistance Scheme (PWAS) and to prevent abuse. Cooperation between NGOs and community-based organisations will be fostered. Support will be given to identify and mobilise resources. Government will be assisted to ensure that policies and infrastructure are in place to support community interventions and innovations.

National Coverage

Community commitment to assisting children and families affected by HIV/AIDS has already been shown to be strong in Zambia. The growth of NGOs, the rapid expansion of the community school movement, the growth of voluntary home-base care programmes all point to awareness and commitment. However, responses to children, families and communities affected by HIV/AIDS have been far too limited in scope. For this reason successful interventions will be taken to scale and advocacy will be undertaken to promote replication by partners.

Programme support

Programme support for monitoring and evaluating project implementation and operational costs-including a National Project Officer (Info/Comms). – 20% of total budget

Estimated Budget: in US$ 1,476

Items	1999	2000	2001
Situation Analysis of Orphans	50,000	25,000	25,000
Training NGOs/CBOs for monitoring child rights	50,000	100,000	25,000
Support to Govt, NGOs, CBOs to establish home-based orphan care	150,000	200,000	200,000
Networking/Information sharing systems	50,000	25,000	50,000
Peer Education/Non-formal schools support	100,000	50,000	50,000
Evaluation of Orphan support	0	0	50,000
Subtotal	***400,000***	***400,000***	***400,000***
3% local, 5%NYHQ technical support costs	32,000	32,000	32,000
15% Overhead	60,000	60,000	60,000
Total	**492,000**	**492,000**	**492,000**

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Zambia

UNICEF/GRZ Programme of Cooperation for Women and Children, 1997-2001

THE SITUATION OF CHILDREN AND WOMEN

Since the late 1970s Zambia has faced increasing economic difficulty. As employment and incomes have declined, and as the economic reforms have proceeded, over 50 percent of households have been pushed to the brink and are unable to afford a nutritionally adequate diet. Morbidity and mortality rates have risen and one child in two is malnourished.

As the economic decline continued during the 1980s and early 1990s, social sector budgets were cut, resulting in a deterioration in both the coverage and quality of health, education, water supply and other essential services. Despite continuing high levels of population growth, and urbanisation, there have been few new investments in the social infrastructure. Consequently, compared to a decade earlier, more children have less access to quality health care; school places have become harder to find and drop out rates have increased; an increasing proportion of children are being forced to live in poor and congested housing in unsanitary surroundings with limited access to safe water supplies; and the coping capacities of many households have been stretched beyond their limits, thereby forcing increasing numbers of children out of school and on to the streets to eke out a living. Girls and women, most often, are those who have suffered first and most.

The growth in poverty, increasing disease burdens (malaria, TB and diarrhoea) HIV/AIDS and the collapse of household coping capacities is taking a heavy human toll. Child mortality reduction trends of the 1970s have been reversed. Infant mortality rates have grown from 80 to 113 per 1,000 live births between 1980 and 1992 and under five mortality rates have risen from 150 to 202. With rising HIV infection rates, these figures are expected to increase by as much as 20 and 45 per cent respectively by the year 2000. These rates, combined with increased adult deaths due to AIDS related illnesses, have resulted in a decline in adult life expectancy from 54 years in the mid 1980s to an estimated 45.5 years in 1992.

Child Mortality

The first year of life is a high risk period for the new child. Forty two per cent of infant deaths occur within the first month of life, largely associated with prematurity and from one month onwards Zambian infants suffer from very high rates of respiratory infections, diarrhoeal diseases and malaria: which together

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Zambia

Epidemiological Fact Sheet

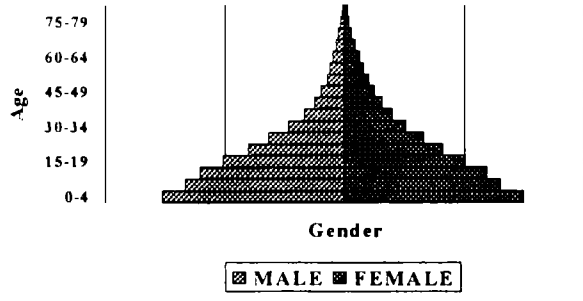
on HIV/AIDS and sexually transmitted diseases

UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

World Health Organization

Country information

Population pyramid, 1997



Indicators	Year	Estimate	Source
Total Population (thousands)	*1997*	8,478	UNPOP
Population Aged 15-49 (thousands)	*1997*	3,832	UNPOP
Annual Population Growth	*1980-1995*	3 3	UNPOP
% of Population Urbanized	*1996*	43	UNPOP
Average Annual Growth Rate of Urban Population	*1980-1996*	3	UNPOP
Net Migration Rate			
GNP Per Capita (US$)	*1995*	400	World Bank
GNP Per Capita Average Annual Growth Rate	*1985-1995*	-1	World Bank
Human Development Index Rank (HDI)		143	UNDP
Real GDP Per Capita Rank - HDI Rank		15	UNDP
Gender Related Development Index Rank		112	UNDP
Gender Empowerment Measure Rank		71	UNDP
Human Poverty Index Value (HPI)		35 1	UNDP
% Population Economic Active		41	ILO
Unemployment Rate			
Total Adult Literacy Rate	*1995*	78 5	UNESCO
Adult Male Literacy Rate	*1995*	86	UNESCO
Adult Female Literacy Rate	*1995*	71	UNESCO
Male Secondary School Enrollment Ratio	*1990-1995*	31	UNESCO
Female Secondary School Enrollment Ratio	*1990-1995*	19	UNESCO
Crude Birth Rate (births per 1,000 pop.)	*1996*	43	UNPOP
Crude Death Rate (deaths per 1,000 pop)	*1996*	10	UNPOP
Maternal Mortality Rate (per 100,000 live births)	*1990*	940	WHO/UNICEF
Life Expectancy at Birth	*1996*	43	UNPOP
Total Fertility Rate	*1995*	5.7	UNPOP
Infant Mortality Rate (per 1,000 live births)	*1996*	112	UNICEF/UNPOP
Under Five Mortality Rate (per 1,000 live births)	*1996*	202	UNICEF/UNPOP
% Population Access to Safe Water	*1990-1996*	27	UNICEF
% Population Access to Adequate Sanitation	*1990-1996*	64	UNICEF

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http://www.unaids.org

UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support -- will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. Epimodel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

Adults and children	**770000**		
Adults (15-49)	**730000**	**Adult rate (%)**	**19.07**
Women (15-49)	**370000**		
Children (0-15)	**41000**		

Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occured since the beginning of the epidemic:

Cumulative no. of AIDS cases	**630000**

Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

Cumulative deaths	**590000**

Estimated number of adults and children who died of AIDS during 1997:

Deaths in 1997	**97000**

Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

Cumulative orphans	**470000**

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

Current living orphans	**360000**

HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

HIV prevalence in selected populations in percent

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Major Urban Areas	N_Sites		2		1			1		3	4	4			
		Minimum		2		11.6			24.5		22.6	22	21.7			
		Median		5		11.6			24.5		27	25.15	26.55			
		Maximum		8		11.6			24.5		29.7	27.1	35.3			
Pregnant women	Outside Major Urban Areas	N_Sites							4	2	6	8	22			
		Minimum							9	7.5	5.9	4.9	1.6			
		Median							16.5	18	9.95	12.5	13.8			
		Maximum							30	28.5	23.3	19.2	31.9			

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Prisoners	Major Urban Areas	N_Sites					1				1					
		Minimum					16.1				28					
		Median					16.1				28					
		Maximum					16.1				28					

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Major Urban Areas	N_Sites		1						1						
		Minimum		26.9						59.7						
		Median		26.9						59.7						
		Maximum		26.9						59.7						
STD patients	Outside Major Urban Areas	N_Sites								6						
		Minimum								33.3						
		Median								37.65						
		Maximum								49.3						

Assessment of epidemiological situation

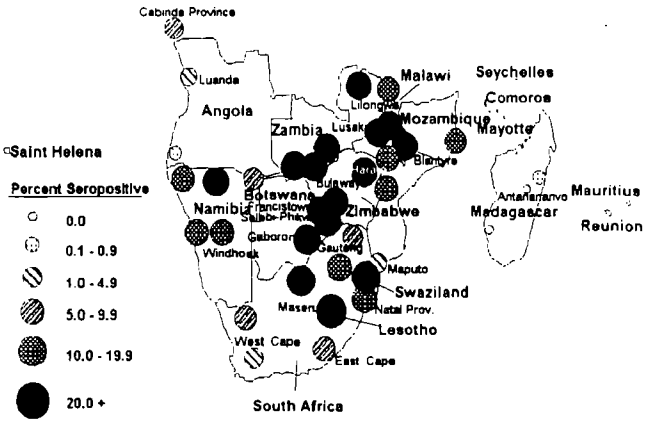
Assessment of country epidemiological situation

HIV seroprevalence information among antenatal clinic attenders is available since the mid-1980s from Zambia. In Zambia, Lusaka and Ndola are the major urban areas. HIV prevalence among antenatal women tested in the major urban areas increased from 5 percent in 1985 to 27 percent in 1994. In 1993, 27 percent of antenatal clinic women less than 20 years of age tested were HIV positive. In 1994, 22 sites outside of the major urban areas reported HIV sentinel surveillance information. HIV prevalence ranged from 2 percent to 32 percent of women tested. In 1993, 11 percent of antenatal clinic women less than 20 years of age who were tested outside of the major urban areas were HIV positive.

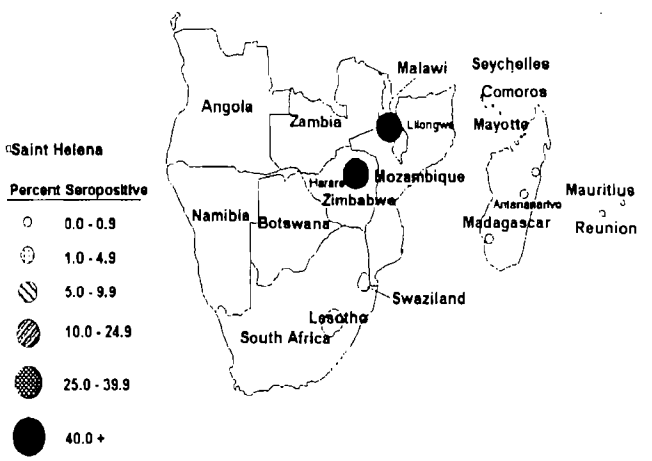
In 1991, 60 percent of male STD patients tested in Lusaka were HIV positive. Outside of Lusaka, 38 percent of male STD patients tested were HIV positive.

Regional maps

Seroprevalence of HIV-1 for Pregnant Women Southern Africa



Seroprevalence of HIV-1 for Sex Workers Southern Africa



Reported AIDS cases

AIDS cases by year of reporting

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total	Unknown
0	0	0	0	0	1	3	1584	3862	4477	4638	4702	5264	3376	2894	1963	5950	4552	1676		44942	

Date of last report: 31-Jul-1997

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

AIDS cases by mode of transmission

Hetero: Heterosexual contacts.
Homo/Bi: Homosexual contacts between men.
IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.
Blood: Blood and blood products.
Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.
NS: Not specified/unknown.

Sex	Trans. group	<94	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All									
	Hetero									
	Homo/Bi									
	IDU									
	Blood									
	Perinatal									
	Other known									
	Unknown									
Male	All									
	Hetero									
	IDU									
	Blood									
	Other known									
	Unknown									
Female	All									
	Hetero									
	IDU									
	Blood									
	Other known									
	Unknown									
NS	All									
	Hetero									
	IDU									
	Blood									
	Perinatal									
	Other known									
	Unknown									

AIDS cases by age and sex

Sex	Age	<1994	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All									
	0-4									
	5-14									
	15-19									
	20-29									
	30-39									
	40-49									
	50-59									
	60+									
	NS									
Male	All									
	0-4									
	5-14									
	15-19									
	20-29									
	30-39									
	40-49									
	50-59									
	60+									
	NS									
Female	All									
	0-4									
	5-14									
	15-19									
	20-29									
	30-39									
	40-49									
	50-59									
	60+									
	NS									
NS	All									
	0-4									
	5-14									
	15-19									
	20-29									
	30-39									
	40-49									
	50-59									
	60+									
	NS									

Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

Estimated incidence and prevalence of curable STDs

	Incidence				Prevalence			
STDs	Year	Male	Female	All	Year	Male	Female	All
Chlamydia trach.								
Gonorrhoea								
Syphilis								
Trichomonas								
Comments								
Source								

STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

Health service indicators

HIV-prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. These efforts may range from reaching out to vulnerable communities through large-scale educational campaigns or interpersonal communication; provision of treatment for STDs; distribution of condoms and needles; creating an enabling environment to reduce risky behaviour; voluntary testing and counselling; home or institutional care for persons with symptomatic HIV infection; and preventing perinatal transmission and transmission through infected needles or blood in health care settings. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators -- such as the percentage of a population with access to health care services; the percentage of women covered by antenatal care; or the percentage of immunized children -- may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS-related issues.

Access to health care

Indicators	Year	Estimate	Source
% of Pop. with access to health services - total:			
% of Pop. with access to health services - urban:			
% of Pop. with access to health services - rural:			
Contraceptive prevalence rate (%):	*1990-1996*	15	UNPOP
% of births attended by trained health personnel:	*1990-1996*	51	UNICEF
% of pregnant women immunized against tetanus:	*1995-1996*	48	UNICEF
% fully immunized - Tuberculosis:	*1995-1996*	100	UNICEF
% fully immunized - DPT:	*1995-1996*	83	UNICEF
% fully immunized - Polio:	*1995-1996*	81	UNICEF
% fully immunized - Measles:	*1995-1996*	93	UNICEF
Proportion of blood donations tested:			
% of ANC clinics where HIV testing is available:			
HIV/AIDS Hospital Occupancy Rate (Days):			

Latex condoms are the only technology available that can prevent sexual transmission of HIV/STD. Persons needing protection in situations that carry risk should have consistent access to high quality condoms. National AIDS Programmes implement activities to increase both availability of and access to condoms. The two condom availability indicators below are intended to highlight areas of strength and weakness at the beginning and at the end of the distribution system so that programmatic resources can be directed appropriately to problem areas.

Condom availability (central level)

Prevention Indicator 2: Availability of condoms per capita in the country over the last 12 months (central level).

Year	Area	N	Rate
n/a			

Comments:
Sources:

Condom availability (peripheral level)

Prevention Indicator 3: Proportion of people who can acquire a condom (peripheral level).

Year	Area	N	Rate
n/a			

Comments:
Sources:

Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

Year	Area	Age group	Male	Female	All
n/a		15-19			
n/a		20-24			
n/a		25-49			
n/a		15-49			

Comments:

Sources:

Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

Year	Area	Age group	Male	Female	All
1990	Lusaka	15-19	26	13	
1990	Lusaka	20-24	54	11	
1990	Lusaka	25-39	36	6	
1990	Lusaka	40-49	21	4	
1990	Lusaka	15-49	33	8	
1995	Lusaka	15-19	24	8	
1995	Lusaka	20-24	36	7	
1995	Lusaka	25-39	30	3	
1995	Lusaka	40-49	17	2	
1995	Lusaka	15-49	27	5	

Comments:

Sources: KABP/Behavioural Studies - GPA, 1993. Dynamics and determinants of the HIV epidemic: A review of Zambian epidemiological, demographic and behavioural observations. K. Fylkesnes, Rsemary Mubanga Musonda, Kelvin Kasumba, Zacchaeus Ndhlovu. +998, 1997.

Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

Year	Area	Age group	Male	Female	All
1996	Rural		21	7	
1996	Urban		46	23	

Comments: Sample size for Urban/peri-Urban/Rural Men and Women combined: 4784.

Sources: Dynamics and determinants of the HIV epidemic: A review of Zambian epidemiological, demographic and behavioural observations. K. Fylkesnes, Rsemary Mubanga Musonda, Kelvin Kasumba, Zacchaeus Ndhlovu +998, 1997

Knowledge and behaviour

Ever use of condom

Percentage of people who ever used a condom.

Year	Area	Age group	Male	Female	All
1992	All	15-19		5.6	
1992	All	20-24		15.1	
1992	All	25-29		13.7	
1992	All	30-34		9.8	
1992	All	35-39		6.1	
1992	All	40-44		2.9	
1992	All	45-49		1.6	
1992	All	Total		9.1	
1996	All	15-19	23.9	11.7	
1996	All	20-24	51.5	24.9	
1996	All	25-29	57.3	25.9	
1996	All	30-34	45.4	17.2	
1996	All	35-39	42.9	12.8	
1996	All	40-44	29.5	7.1	
1996	All	45-49	18.9	3.7	
1996	All	Total	38.3	17	

Comments: All women

Sources: Demographic and Health Survey

Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

Year	Area	Age group	Male	Female	All
1992	All	20-24		16.9	
1992	All	45-49		16.6	

Comments: Median is for women aged 25-29; median for 20-24 was not calculated since less than 50% had had sex.

Sources: DHS/1992

Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

Year	Area	Age group	Rate	N
1992	All	15	5.3	384
1992	All	16	14.7	427
1992	All	17	29.9	392
1992	All	18	54.3	380
1992	All	19	65.6	401
1996	All	15	4.5	398
1996	All	16	15.3	419
1996	All	17	28.3	379
1996	All	18	46.1	406
1996	All	19	59.4	401

Comments:

Sources: DHS/1992

Sources

Fleming, A. F., J. Schneider, I. Wendler, et al., 1987, AIDS in Africa, In: AIDS The Safety of Blood and Blood Products, John Wiley and Sons, pp. 241 248

Fylkesnes, K., R. Mubanga Musonda, N. P. Luo, et al., 1993, HIV Infection in Pregnant Women in Zambia 1990 93: HIV among Women in Zambia, The Epidemiology and Research Unit, National AIDS/STS/TB and Leprosy Programme, Lusaka, unpublished report, pp. 1 22

Fylkesnes, K., R. M. Musonda, K. Kasumba, et al., The HIV Epidemic in Zambia: Socio-demographic Prevalence Patterns and Indications of Trends Among Childbearing Women, AIDS, No. 3, Vol. 11, pp. 339-345 (1997).

Hira, S., G. Bhat, J. Kamanga, et al., 1989, Perinatal Transmission of HIV 1 in Lusaka, Zambia, British Medical Journal, vol. 299, no. 6718, pp. 1250 1252.

Hira, S., J. Kamanga, G. Tembo, et al., 1991, Control Strategies in STD/HIV Clinic in Zambia: a Demonstration Project, VII International Conference on AIDS, Florence, Italy, 6/16 21, Poster W.C.3082.

Johns Hopkins University, 1986, AIDS A Public Health Crisis, Population Information Program, Population Reports, Issues in World Health, July Aug., Series L, no. 6, pp. 194 228.

Kanyama, I. D. A., 1991, Sentinel Surveillance of HIV Infection in Northern Zambia, VII International Conference on AIDS, Florence, Italy, 6/16 21, Abstract M.C.3301.

Melbye, M., E. K. Njelesani, A. Bayley, et al., 1986, Evidence for Heterosexual Transmission and Clinical Manifestations of Human Immunodeficiency Virus Infection and Related..., Lancet, Nov. 15, vol. 2, no. 8516, pp.1113 1115.

Simooya, O. O., M. N. Maboshe, S. K. Hira, et al., 1992, A Strategy for the Control of HIV Infection in African Prison Establishments, VIII International Conference on AIDS, Amsterdam, 7/19 24, Abstract MoD 0041.

Simooya, O. O., 1994, Controlling HIV/AIDS in African Prisons, Tenth International Conference on AIDS, Yokohama, Japan, 8/7 12, Abstract P.C.0347.

Annex: HIV Surveillance data by site

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Outside Major Urban Areas	Chikankata								23.3	19.2				
		Chilonga										16.8			
		Chipata										30.3			
		Chitokoloki										7.1			
		Ibenga										11.4			
		Isoka										11.4			
		Kabompo						20				1.6			
		Kabwe										29.5			
		Kalabo								5.9	4.9	10.2			
		Kamuchanga										23.1			
		Kapiri Mposhi										13			
		Kasaba										12			
		Kasama										22			
		Kashikishi										14.6			
		Livingstone										31.9			
		Macha								7.9	10	9.1			
		Mansa										23.6			
		Minga								12.9	17.7	9.6			
		Mongu										28.4			
		Mporo Kosso										12.9			
		Mukinge						13	7.5		9.7	9.8			
		Mwinilunga						9			9.5				
		Nchelenge								11.4	15.1				
		Samfya										20			
		Solwezi						30	28.5	8.5	15	24.2			
	Major Urban Areas	Lusaka	8		11.6			24.5							
		Lusaka - Chelstone								22.6	26.8	24.7			
		Lusaka - Chilenje								27	22	35.3			
		Lusaka - Kalingalinga									23.5	21.7			
		Lusaka - Matero								29.7	27.1	28.4			
		Ndola	2												

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas														

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas														

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Prisoners	Major Urban Areas	Lusaka				16.1									
		Ndola								28					

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Outside Major Urban Areas	Central Province							33.3						
		Eastern Province							40						
		Luapula							35.3						
		Northern Province							49.3						
		Southern Province							40.8						
		Western Province							35.1						
	Major Urban Areas	Lusaka							59.7						
		Lusaka Province	26.9												

Notes:

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HIV/AIDS in ZAMBIA

Background
Projections
Impacts
Interventions

December
1997

Ministry of Health
Central Board of Health