PREPARING FOR MICROBICIDE ACCESS
ZAMBIA COUNTRY PROFILE

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COMPANION VOLUME TO *MICROBICIDE COUNTRY PREPAREDNESS ASSESSMENT – ZAMBIA*

JO HESLOP

PREFACE

With partial funding from the European Community, the International Partnership for Microbicides (IPM) commissioned a series of country profiles that compile information on demography, HIV and health systems in countries hosting or planning to host microbicide trials. These are intended to provide basic overviews that can inform the development of more detailed policy research agendas and support future planning for the introduction of microbicides. They do not set out detailed microbicide introduction strategies or address product-specific challenges.

Constella Futures was commissioned to prepare profiles for India, Nigeria, Rwanda and Tanzania. Studies were also conducted separately in South Africa and Zambia. All reports in the series are available at www.ipm-microbicides.org.

While IPM commissioned these reports, the recommendations they contain are those of the authors and do not necessarily reflect IPM's views, positions or plans.

ACKNOWLEDGEMENTS

The author would like to thank Carol Bradford and Constella Futures on their supportive guidance on other country reports in this series, which helped inform the contents of this report. The author would also like to thank IPM personnel, in particular Saul Walker, for support in the preparation of this profile.

REPORTS IN THIS SERIES

Prepared by Constella Futures:

- India Country Profile
- Nigeria Country Profile
- Rwanda Country Profile
- Tanzania Country Profile
- Preparing for Microbicides Access: A Synthesis Report

Prepared by Jo Heslop (data are comparable to Constella Futures reports):

- South Africa Country Profile
- Zambia Country Profile

Prepared by Health and Development Africa:

- A Country Preparedness Assessment of Microbicide Access and Use in South Africa

Prepared by JHPIEGO/ Zambia:

Microbicide Country Preparedness Assessment – Zambia

CONTENTS

ACRONYMS

ART	Antiretroviral therapy
CBOH	Central board of health
CDC	Centers for Disease Control and Prevention
CHAZ	Church Health Association of Zambia
DFID	UK Department for International Development
DHMB	District health management board
DHMT	District health management team
DHS	Demographic and health survey
DOH	Department of Health
EDL	Essential Drugs List
EU/EC	European Union/European Commission
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GFCCM	The Global Fund Country Coordinating Mechanism
GIDD	Gender in Development Division
HCC	Health centre committee
HIV/AIDS	Human immunodeficiency virus/ Acquired immunodeficiency syndrome
IEC	Information, education and communication
IMAI	Integrated management of adult and adolescent illness
IPM	International Partnership for Microbicides
MAP	Multisectoral AIDS Programme
MCDSS	Ministry of Community Development and Social Sciences
MOH	Ministry of Health
MOU	Memorandum of understanding
MSL	Medical Stores Ltd.
MWRA	Married women of reproductive age
NAC	National HIV/AIDS/STI/TB Council
NGO	Non-governmental organisation
NHC	Neighbourhood health committee
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PHO	Provincial health office
PMTCT	Prevention of mother-to-child transmission of HIV
PRB	Population Reference Bureau
SRH	Sexual and reproductive health
STI	Sexually transmitted infection(s)
SWAp	Sector-wide approach(es)
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing of HIV
WHO	World Health Organization

EXECUTIVE SUMMARY

Zambia is a large country with a low population density and a population of almost 12 million. It is a low-income country, with 94 percent of the population living on under US$2 a day. Much of the wealth, industry and urbanisation are concentrated in Lusaka, the capital, and the Copperbelt area, and wealth inequality is high. Zambia is linguistically diverse and is predominantly Christian, with a significant Muslim population.

Use of modern contraceptives is fairly low and fertility is high, at 5.7. The life expectancy is one of the lowest in the world and has dropped significantly since the 1990s, largely because of HIV/AIDS. Literacy levels are fairly high for women, but women are much less economically active then men. There are high levels of physical and sexual violence against women by husbands and partners, and more women are more likely than men to agree that men have the right to beat their wives in certain circumstances. Women also have low decision-making powers – almost half are not involved in decisions concerning their health care.

Zambia is facing a mature, generalised HIV epidemic, with an estimated prevalence of 17 percent that has been steadily increasing since the 1980s but shows signs of stabilising. Women are more at risk than men, and the high prevalence of intergenerational sex puts women at risk at a younger age. There are strong regional variations, and urban areas have more than twice the HIV prevalence of rural areas. Zambia has a high HIV/AIDS burden, with an estimated one million people infected and 710,000 children orphaned by AIDS.

Median age at first sex is 16.8 for women and 18 for men. There are signs that age of sexual debut is increasing, especially for men. Multiple sexual partnerships are almost twice as common in men as women. Figures for intergenerational and transactional sex are high – 38 percent of 15-19-year-old females had recently exchanged sex for money or gifts. The average age gap in relationships is four years, and women with partners more than four years older have a significantly higher risk of contracting HIV.

Zambia's health system has undergone major reforms, moving towards a system of decentralisation to the district level, with a basic package of health services available to meet primary needs of patients. This process has involved setting up an implementing body separate from the Ministry of Health, but there are plans to re-merge the two again. The government spends over 10 percent of its budget on health, showing a strong commitment. However, this is insufficient to meet the health needs of the country and the health system is highly dependent on donor funding. The health system is highly fragmented, with many parallel systems in place, and the government is attempting to improve coordination. A basket funding mechanism is in place, which allocates government and donor money to the district level on a population-based formula. Staff shortages and weak procurement and distribution systems are major challenges to the health system.

The private sector is prominent in the delivery of Zambia's health services. Most significant is the faith-based sector, which falls under an umbrella organisation called the Churches Health Association of Zambia and which provides up to 30 percent of health services in the country. These bodies collaborate closely with the state and are often considered part of the public health system. Almost two-thirds of women who practise family panning source their contraceptives from public health facilities.

Use of modern contraceptives has increased in recent years, due in particular to an increase in use of oral and injectable contraceptives. Knowledge of family planning methods is high and higher for modern rather than traditional methods. Over one in 10 women practise traditional methods.

Overall, the level of political commitment to addressing HIV/AIDS in Zambia is lower than the average for the region; the same goes for policy and planning. However, organisational structure is strong, as measured by the AIDS Programme Effort Index. Zambia was one of the first countries to set up a national HIV/AIDS programme and coordinating body and to introduce home-based care. The National HIV/AIDS/STI/TB Council coordinates the multisectoral response, including the health sector response. The government relies heavily on donors to fund its HIV/AIDS programme, particularly the Global Fund and PEPFAR.

Zambia has demonstrated a strong commitment to prevention programming. A national school-based HIV/AIDS education programme is in place. Leadership has driven an emphasis towards abstinence-focused prevention programming, and there is high stigma regarding condoms and HIV in general. Possibly as a result of this, levels of abstinence and faithfulness have risen while condom use has fallen. Voluntary counselling and testing have been expanding rapidly in recent years. However, the large proportion of the population that would like to be tested but hasn't suggests high levels of stigma and other factors. PMTCT has also been expanding rapidly, and now coverage is fairly high, with one-quarter of women needing PMTCT receiving it.

Political commitment to care and treatment is high. ART scale-up has been rapid and coverage is fairly high, with one-quarter of those who need it receiving ART. However, Zambia is only halfway to reaching its "3–by-5" target. Almost half of chronically ill people receive some form of external support, but more comprehensive home-based care support is rare. The government is implementing programmes to financially support orphans and vulnerable children through their foster families.

There are high levels of donor and civil society activity. The institutional mapping section (Annex) summarises some key players in the HIV/SRH sector.

Some recommendations arising from the information gathered in this profile are:

- The fact that almost half of Zambian women do not take part in decision-making about their own health care must be taken into consideration when planning microbicide introduction – social marketing aimed at men will be particularly important in this context.
- The weaknesses in state drug supply mechanisms mean that government-managed microbicide procurement and distribution would require significant support.

1 INTRODUCTION

This country profile for Zambia is one of a series of six country profiles commissioned by the International Partnership for Microbicides to look at issues of microbicides access at a country level. The project is funded by the EC.

The primary aim of the project is "to accelerate access to microbicides for women in less-developed countries as soon as possible after clinical trials have demonstrated their effectiveness in preventing HIV infection." Broadly, the objectives of the project are to identify mechanisms, critical pathways and key procedures to accelerate the availability of microbicides in developing countries.

This country profile for Zambia is meant to be a resource for the microbicides community as access to microbicides becomes a reality over the next few years. The profile includes summary demographic and health information as well as an overview of HIV/AIDS programming in Zambia. Recommendations for microbicide planning and research in Zambia conclude this report. Finally, the profile includes institutional mapping of Zambia, outlining the key players in HIV/AIDS and sexual and reproductive health (SRH) in the Annex.

This country profile uses standardised data, where possible, and a standardised format, so that the six country profiles are comparable. This profile does not contain information on regulatory, manufacturing and procurement issues, but these are covered in depth in "Microbicide Country Preparedness Assessment – Zambia," prepared by JHPIEGO for IPM. It is useful to read these two reports alongside each other as the two are designed to be complementary.

2 METHODOLOGY

The author built the country profile around the outline suggested by IPM. The researchers discussed the best sources for each item and, in some cases, multiple sources were used. Public sources such as UNAIDS, WHO and PRB were used, with every effort to ensure comparability between country profiles.

The author collected the data and "grey literature" and presented this in a standardised format. The profile was reviewed by IPM staff.

3 Demographic Information

3.1 Basic Demographic and Socio-economic Context

Table 3.1 Demographic Data

Total population *(PRB, 2006).*	11, 861,000
Population density per square mile *(PRB, 2006).*	41
Percentage of population living in urban areas *(PRB, 2006).*	35%
GDP per capita *(WHO, 2005).*	US$346
Human Development Index *(WHO, 2005).*	0.394 (ranked 166th/177)
Percentage of population on under $2 a day *(PRB, 2006).*	94%

Zambia is a large, landlocked country in southern Africa, bordering Angola, the Democratic Republic of Congo, Tanzania, Malawi, Mozambique, Zimbabwe and Namibia. Zambia has a population of nearly 12 million. It is largely rural, with a low population density of 41 people per square mile and just over one-third of the population living in urban areas, most of these being concentrated around Lusaka and the Copperbelt. Zambia is a low-income country with a GDP per capita of US$346 and a Human Development Index of 0.394 (the 12th lowest ranking in the world). Zambia has high income inequality, with a Gini Coefficient of 0.51.[1] Ninety-four percent of the populations live on under $2 a day.

The territory of Northern Rhodesia was administered by the (British) South Africa Company from 1891 until it was taken over by the UK in 1923. During the 1920s and 1930s, advances in mining spurred development and immigration. The country's name was changed to Zambia upon independence in 1964. In the 1980s and 1990s, declining copper prices and a prolonged drought hurt the economy. The first multi-party democratic election took place in 1991. The country is divided into nine provinces and 72 districts. English is the official language and major vernaculars are: Bemba, Kaonda, Lozi, Lunda, Luvale, Njaya, Tonga and approximately 70 other indigenous languages. The population is 50-75 percent Christian, 24-49 percent Muslim and Hindu and one percent indigenous beliefs. Main exports are copper/cobalt (64 percent), electricity, tobacco, flowers and cotton.[2]

3.2 Health and Fertility

Table 3.2 Health and Fertility Data

Crude birth rate	41
Crude death rate	23
Projected population increase 2006-2050	92%
Life expectancy at birth	37 years
Life expectancy at birth (male)	38 years
Life expectancy at birth (female)	37 years
Total fertility rate	5.7

[1] DFID, 2000.
[2] CIA, 2006.

Ideal family size – women *(ZDHS, 2001-2).*	4.7
Ideal family size – men *(ZDHS, 2001-2).*	5.3
Percentage of married/in union women of reproductive age using contraception	34%
Percentage of MWRA using modern contraception	23%
Unmet need for family planning	27%
Age at first marriage *(DHS, 2006).*	17.8 years
Age at first sex *(DHS, 2006).*	16.8 years
Age at first birth *(ZDHS, 2001-2).*	18.7 years

Source: PRB, 2006, unless otherwise stated.

The birth and death rates are high (the birth rate is average, but death rate much higher than the average for the region). Life expectancy, at 37 years old, is one of the lowest in the world, after three other countries in southern Africa, and has been greatly reduced in recent years. Due to the impact of HIV/AIDS, life expectancy has dropped by almost 11 years during the 1990s and has continued to fall.[3] Fertility is high, at 5.7 (and high for southern Africa, but on a par with East Africa), but it has been gradually declining since 1980. Ideal family size is also high, with men wanting larger families than women. Ideal and actual family sizes vary enormously with socio-economic variables; people who are younger, urban and more educated want and have smaller families. One woman in three practises family planning and fewer than one in four use modern methods. There is a significant unmet need for family planning, as over one-quarter of the women who want to delay or end childbearing are not using contraception.

3.3 GENDER

TABLE 3.3 GENDER DATA

Percentage of women aged 15-24 who are literate (can write a simple sentence)	86%
Literate women as a percentage of literate men	94%
Percentage of women aged 15+ who are economically active	66%
Percentage of men aged 15+ who are economically active	86%
Percentage of women with access to newspaper, TV and radio *(DHS, 2005)*	7.1%

Source: PRB, 2005, unless otherwise stated.

Literacy levels are relatively high in Zambia – both the promotion of literate women and women's literacy as a percentage of men's literacy are higher than the world average, much higher than East Africa but lower than southern Africa. However, women are much less economically active than men. Just seven percent of women have full access to the media.

The 2001-2002 DHS sought to measure levels of sexual violence against women and of women's empowerment. There is a high level of violence against women in Zambia. Over half of women have experienced beatings or physical mistreatment and one-quarter of women have in the past year. Levels of violence are higher for women who have never been married.

[3] World Bank, 2006.

For those who had experienced physical violence, half of perpetrators were current husbands or partners, 20 percent were parents, 16 percent were former husbands or partners, and the remaining 14 percent were a variety of other people, including teachers and friends.

One in six women has experienced sexual violence and one in 12 has in the past year. Reported sexual violence is slightly lower for married women. For those who reported experiencing sexual violence, 26 percent said the perpetrator was a current husband or partner, while 22 percent pointed to a current boyfriend, 20 percent to friends, 14 percent to strangers and the remaining 18 percent to a variety of other people, including male relatives and former boyfriends.

Women were asked about attitudes to a wife refusing sex with her husband. Men's and women's answers were quite different. Men were more likely than women to agree that women have the right to refuse sex if the husband has sex with other women or if the woman is tired, but less likely than women to agree she can refuse sex in the case of the man having an STI or the woman having recently given birth (see Table 3.4). Overall, more men than women agreed that women have the right to refuse sex in any of the above situations. Women were also asked about their attitudes towards wife-beating. Over 85 percent of women, compared to 69 percent of men, find wife-beating justified in certain circumstances, the most common being infidelity.

TABLE 3.4 MEN'S AND WOMEN'S ATTITUDES TOWARDS WIFE REFUSING SEX WITH HER HUSBAND
(Percentage agreeing with the statements below)

Wife is justified in refusing sex with her husband if she:	*Women*	*Men*
Knows her husband has an STI	86%	72%
Knows her husband has sex with other women	73%	91%
Has recently given birth	88%	82%
Is tired or not in the mood	67%	93%
All of the above	53%	60%

Source: ZDHS, 2001-2

Evidence suggests that women have low levels of decision-making power in the household in Zambia. Forty-three percent of married women participate in decision-making about their healthcare (alone or jointly with their partner or someone else), 37 percent participate in decision-making on large household purchases, 43 percent on visits to family and friends, and 46 percent on how many children to have and when. The vast majority of decisions were made by husbands and a small proportion by someone else. Decisions about the healthcare of 47 percent of women are made by their husbands alone. Unmarried women had more decision-making power, but decisions were still largely made by another person (usually parents). Decision-making power increases with age, number of children and level of education.[4]

[4] ZDHS, 2001-2002

4 HIV Levels and Trends and Sexual Behaviour

4.1 HIV/AIDS Epidemiology

Table 4 HIV Data

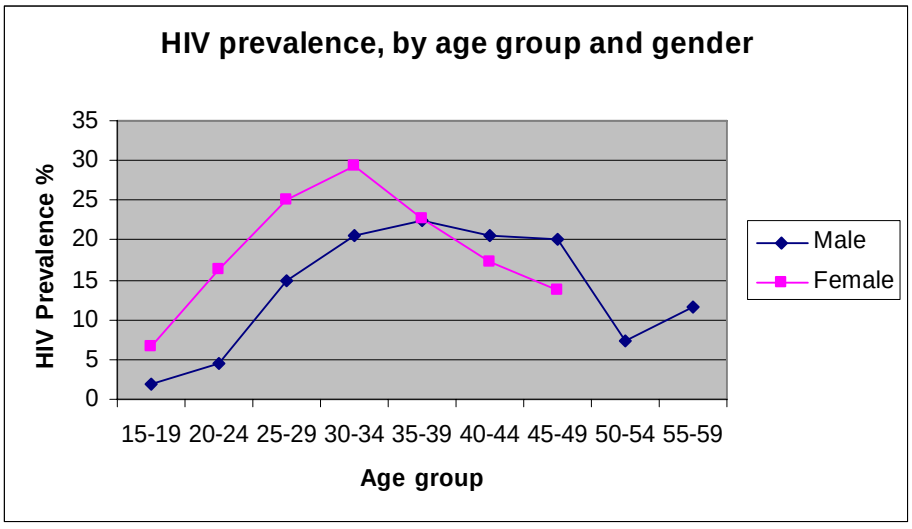
HIV prevalence	17.0%
# of people living with HIV (adults and children)	1,100,000
# of children (0-14) living with HIV	130,000
# of adults (15-49) living with HIV	1,000,000
# of adult women living with HIV	570,000 (57%)
# of children (aged 0-17) orphaned by AIDS	710,000

Source: UNAIDS, 2006.

Zambia is facing a mature, generalised epidemic, with an estimated prevalence rate of 17 percent. There is evidence that the epidemic, which has been increasing in intensity since the 1980s, is beginning to stabilise. It is estimated that 1.1 million people are infected with HIV. Women are more vulnerable than men, accounting for 57 percent of infections. In fact, the 2001-2002 DHS found women to have an HIV prevalence of 18 percent compared to 13 percent for men.

Figure 4.1.1, as well as illustrating the higher vulnerability of women, shows that women are more likely to be infected at a younger age than men, whose risk level increases more slowly and peaks later. This is an indication of intergenerational sex (see Section 4.2). Interestingly, HIV prevalence in men increases again in the 55-59 age group. HIV infection is highly urbanised in Zambia – prevalence is 26 percent in urban areas compared to 12 percent in rural areas. It varies by province from 25 percent in Lusaka and 22 percent in Copperbelt provinces (more urban) to 8.8 percent in North-Western (highly rural).[5]

Figure 4.1.1



Source: ZDHS, 2001-2. (Note: no data for women aged 50-59)

[5] ZDHS, 2001-2002.

Over 700,000 children are reported to be orphaned by AIDS (over one in five children). Stigma is strong in Zambia and there has been a recent increase in the number of children living on the streets because they have been excluded from their families or communities, putting them further at risk.[6] The economic impact has been severe. According to the Zambia Business Coalition, 82 percent of known causes of employee deaths are HIV-related, stripping the workforce of valuable skills and experiences and increasing costs of production while consumer spending falls.[7] As Zambia's Poverty Reduction Strategy Paper acknowledges, "the epidemic is as much likely to affect the economic growth as it is (to be) affected by it."[8]

4.2 SEXUAL BEHAVIOUR

Age at first sex

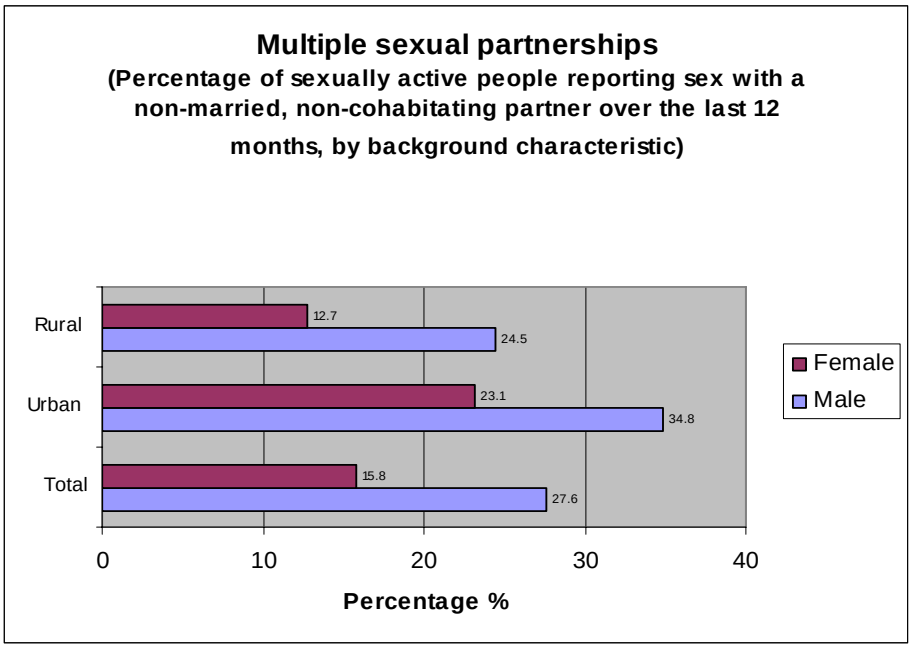
Understanding sexual behaviour can help us understand the cultural, behavioural and gender dynamics that affect risk-taking behaviour. Median age at first sex is reported to be 16.8 years for women aged 25-49 (see table 4.2) and 18 years for men aged 25-59. Women and men who are more educated and more urban delay their sexual debut. There are also signs that age of sexual debut has increased in recent years, especially for men.[9] Age at first sex is on average one year before age at first marriage.

Sexual partnerships

Multiple sexual partnerships are almost twice as common among men as among women (see Figure 4.2). The pattern follows for urban and rural men and women, with multiple partnerships being higher in urban areas, although the rural-urban difference is more pronounced for women. There has been little difference in prevalence of multiple partnerships since 2000.

[6] Avert, 2006.
[7] Avert, 2006.
[8] PRSP, 2002.
[9] ZSBS, 2005.

FIGURE 4.2



Source: ZSBS, 2005.

Frequency of sexual intercourse

A 2005 survey found that 85 percent of married Zambians have had sex with their spouse in the past month, which is no significant change from studies in previous years. This was slightly higher among urban dwellers than their rural counterparts, but there was no gender difference. The numbers reporting sex the previous day has increased significantly in the past five years, but the reasons for this are unclear.[10]

Prevalence of intergenerational sex

There is a high level of intergenerational sex in Zambia, with a tendency for girls and women to have relationships with older men. Women begin sexual activity at an earlier age. Transactional sex is common, and this is closely linked with intergenerational sex as older men are able to provide more for material needs of women and girls. In fact, 38 percent of unmarried adolescent females aged 15-19 had recently exchanged sex for money or gifts. A study carried out in the urban area of Ndola in 2001 found that:

- 21 percent of 15-19-year-old females had had at least one partner aged 25 or over in the last year;
- 34 percent of men aged 25-49 had had at least one non-marital partner below the age of 20 years;
- Men aged 15-49 reported that their non-marital partners were on average four years younger than themselves;

[10] ZSBS, 2005.

- No women aged 15-19 whose partners were less than four years older than themselves were infected with HIV. However, 34 percent of women whose partners were four years older or more were infected.[11]

This illustrates the effect that mixed-age sex has on HIV risk, and helps to explain the earlier peak in HIV prevalence in women compared to men (see Figure 4.1.1).

STI prevalence

In the 2005 national population-based survey, 5.2 percent of sexually active respondents reported STI symptoms (discharge or ulcers) in the previous 12 months. STI prevalence was higher in males than females and higher in rural than urban areas. It was also higher than in 2000 and 2003.[12] The 2002 DHS carried out syphilis screening tests and found that seven percent of women and eight percent of men aged 15-49 had syphilis. The syphilis rate rises rapidly with age, peaking in the 25-to-29 age group, then decreases and peaks again in the 45-to-49 age group. This is the same for men and women. Syphilis rates are higher in men and women who are urban and have less education.[13]

5 HEALTH SYSTEM PROFILE

5.1 DESCRIPTION

The Zambian government has made a concerted effort to reform the health service, moving towards a system decentralised to the district level, with a basic package of health services available to meet the primary care needs of patients. This decentralisation of financial and administrative powers required a major restructuring of the Ministry of Health, which included the creation of the Central Board of Health (CBOH), with distinct responsibilities from the MOH. However, the cabinet and Parliament are planning to dismantle the CBOH and merge it back in with the MOH to form one governing body again.[14]

There has been little donor confidence in the health system, particularly in procurement and distribution of commodities, and this had contributed to a fragmented sector, with many parallel and vertical systems in place. This is despite a sector-wide approach having been in place since 2000.[15] The Zambian government has attempted to address this through a collaborative planning process with partners resulting in a memorandum of understanding, which will act as a coordinating framework for collaboration to support the new Health Sector Strategic Plan 2006-2010.[16] Since 1993, districts have been receiving direct funding through the “basket” mechanism, which allocates government and untied donor money through a

[11] Luke N. and Kurz K., 2002.
[12] ZSBS, 2005.
[13] ZDHS, 2001-2002.
[14] JHPIEGO, 2005.
[15] DFID, 2006.
[16] GRZ, 2006.

crude population-based formula. This funding has been used to support the implementation of annual district health plans developed in collaboration with health facilities and communities.[17]

Government health management structures
The health reforms and decentralisation plan aims to implement a bottom-up approach to managing the health system, with each level informing the decision-making and planning of the level above.

Community level
Each health centre should have its own health centre committee, which supervises and works closely with neighbourhood health committees. The NHCs represent local communities.

District level
Each district has a district health management board and a district health management team. Districts receive funds from the central government (including donor funds put in the "district basket") and are responsible for planning and implementing health services within the district.

Provincial level
Nine provincial health offices have been established to support district level activities, as an extension of the Central Board of Health. The PHOs provide technical assistance, such as quality assurance and assistance in planning and management processes.

National level
While the MOH at central level is responsible for policy formulation, guidance and strategic planning, the CBOH is responsible for implementation of health policies.
Source: JHPIEGO, 2005.

GOVERNMENT HEALTH SERVICE DELIVERY STRUCTURES

Primary healthcare facilities
Health centres serve a population of 30,000-50,000 in urban areas and 10,000 in rural areas. They are generally the first point of contact in the health delivery system, although there are a small number of health posts catering for rural populations of fewer than 500 people. These are intended to provide primary and curative services 24 hours a day and be staffed by nurses, midwives, clinical officers and environmental health technicians. However, many centres are not able to provide these services due to staffing and equipment shortages.

District hospitals (first-referral institutions)
District hospitals are found in almost all districts and are intended to serve 80,000 -200,000 people. They aim to provide medical, obstetric, surgical and diagnostic services as well as clinical services to support health centre referrals. Many provide more primary level services due to a lack of supplies.

General hospitals/provincial hospitals (second-referral institutions)

[17] DFID, 2000.

General hospitals are found at the provincial level and serve a population of 200,000-800,000, with services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology, dentistry, psychiatry and intensive care. They also take referrals from district hospitals and provide them with technical assistance.

General specialised hospitals (third-referral institutions)
The three hospitals in Zambia that fall under this category cover catchment populations of 800,000 people and more and have sub-specialisations in areas such as psychiatry and surgery.
Source: JHPIEGO, 2005.

There are staff shortages, particularly in the rural areas. Key health-worker–to-population ratios are low, but not lower than surrounding countries.

TABLE 5.1 HEALTH-WORKER-TO-POPULATION RATIO

Number of physicians per 100,000 people	7
Number of midwives and nurses per 100,000 people	113

Source: PSP-One, 2005.

5.2 ANNUAL EXPENDITURE

TABLE 5.2 HEALTH EXPENDITURE DATA

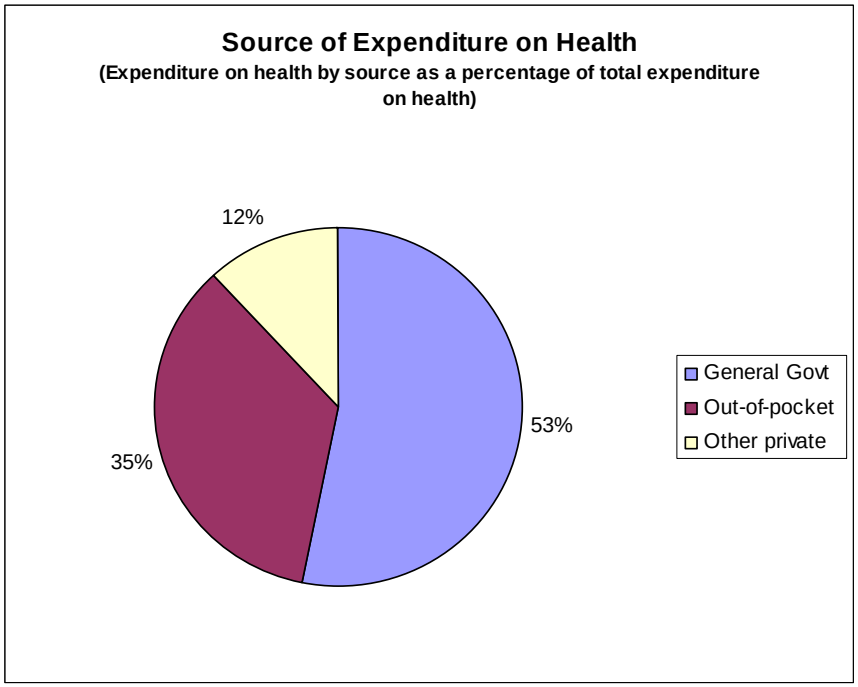
Total annual expenditure on health	US$237 million
Per capita expenditure on health	US$20
Percentage of government budget spent on healthcare	11.3%
Total expenditure on health as a percentage of GDP *(PSP-One).*	6%

Source: WHO, 2005, unless otherwise stated.

The government spends 11.3 percent of its budget on health, showing a strong commitment to health. This equates to US$20 per capita, which is higher than most countries in Africa. Over half of health spending is borne by the government, and the majority of the rest is borne by the public in out-of-pocket expenditure (see Figure 5.2). Zambia operates a cost-sharing system. User fees, which vary between districts, are the most common payment method. However, there is a generous exemption package, including young children, the elderly, the vulnerable and those unable to pay. In addition, specific services are free to everyone. These include treatment of chronic illnesses, such as TB and HIV/AIDS; STI treatment; treatment of epidemics such as cholera, antenatal, delivery and postnatal care; family planning; and emergency cases. Other payment methods are prepaid insurance schemes, pre-purchased discount cards and payment in kind (particularly in the rural areas).[18]

[18] JHPIEGO, 2005.

FIGURE 5.2



Source: PSP-One, 2005.

5.3 PROPORTION OF DONOR FUNDING

TABLE 5.3 ESTIMATED HEALTH FUNDING SOURCES IN 2003

Funding source	Amount in US$	Percentage
External (donors)	106m	44.7
Domestic	131m	55.3
TOTAL	**237m**	**100**

Source: WHO, 2006.

Donors provide almost half of all funding for health in Zambia, a very high proportion. Domestic health funding, in proportion to overall government budget, has declined since the late 1990s.[19]

5.4 PUBLIC/NOT-FOR-PROFIT/PRIVATE MIX

The public and private sectors are less distinct in Zambia than many countries. The private sector is dominated by the Churches Health Association of Zambia (CHAZ), the umbrella organisation that supports a network of mission hospitals and healthcare facilities operated by 16 churches. CHAZ institutions manage approximately 30 percent of health facilities in Zambia through 92 health facilities, and provide up to 50 percent of health services in the rural areas. CHAZ and the state have a very close relationship – the Zambian government contracts CHAZ to provide health services, pays salaries and posts staff at many CHAZ

[19] DFID, 2000.

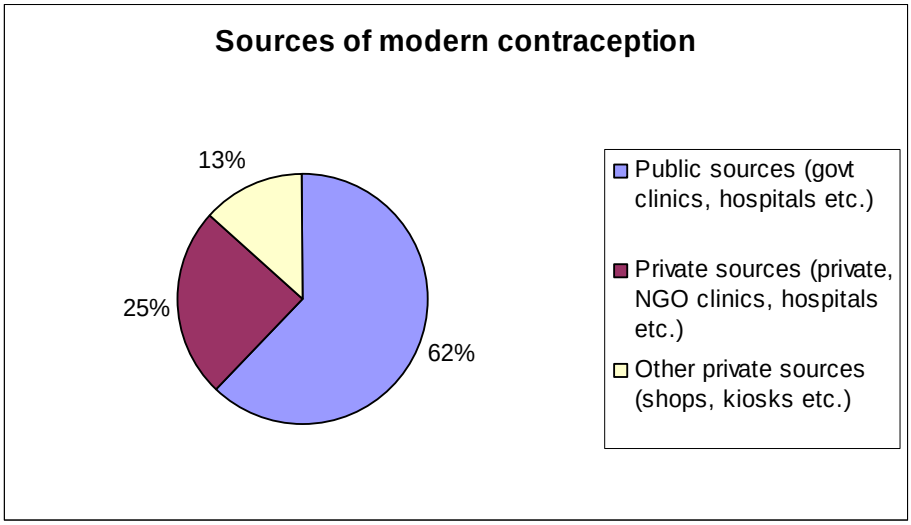
institutions, while CHAZ obtains commodities from government stores and receives training from the government. They are generally regarded as part of the public health system.[20, 21]

The mining industry also is a substantial provider of higher-cost health services to mine employees and their families in the Copperbelt area.[22]

Public/private mix for family planning

The government provides almost two-thirds of women with contraceptives, while the private and non-profit sectors provide one-quarter (see Figure 5.4). These percentages are close to the average for the region.

FIGURE 5.4



Source: PRB, 2002.

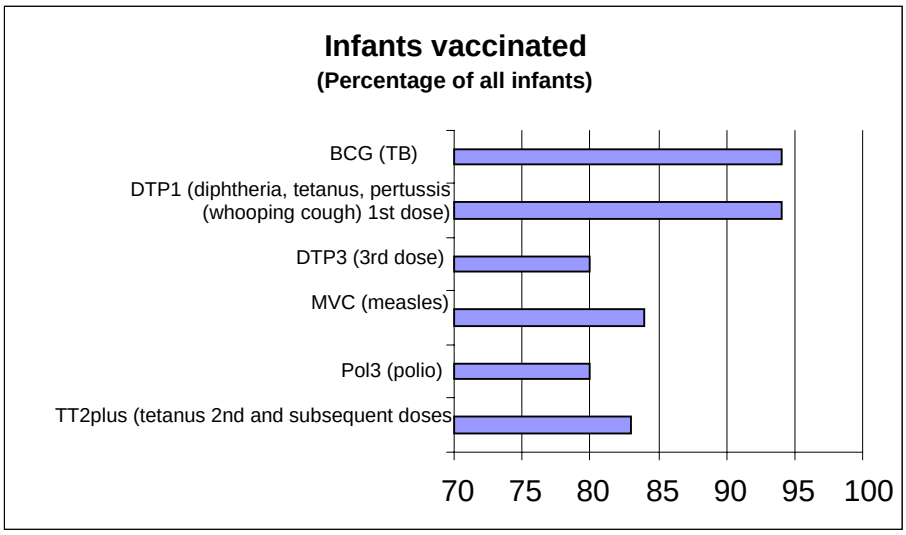
5.5 KEY HEALTH INTERVENTIONS

5.5.1 KEY VACCINES

The Government of Zambia has adopted the WHO guidelines for immunising children. Overall 70 percent of children are fully immunised and only three percent have received no vaccinations. Immunisation coverage rates are 80 percent or more for each of the main vaccinations (see Figure 5.5.1). Immunisation coverage increased from 1992 to 1996 and slightly decreased again in 2002 for all vaccinations.[23]

[20] DFID, 2006.
[21] JHPIEGO, 2005.
[22] DFID, 2000.
[23] ZDHS, 2110-2002.

FIGURE 5.5.1



Source: UNICEF, 2006.

5.5.2 CONTRACEPTIVE COVERAGE

Standardised PRB data show that modern contraceptive use is fairly low in Zambia, compared to neighbouring countries, with one in seven women using modern family planning methods (see Table 5.5.2). The oral contraceptive pill is the most common method, although condom use for family planning purposes is also popular and is higher than for surrounding countries. A high proportion of women use traditional methods. However, latest data show overall modern contraceptive use to have risen by half, to 22.6 percent, this being particularly due to an increase in use of the pill and injectable contraceptives. Use of traditional methods remains unchanged. Contraceptive use increases with age up to 30-34, and then starts to decline. Contraceptive use is higher for women who are urban, have a higher level of education and live in the central provinces (contraceptive prevalence is six times higher in Lusaka than in Luapula province).[24]

Knowledge of contraceptive methods of some sort is almost universal in Zambia, with 98 percent of all women and men knowing at least one method. Modern methods are better known than traditional methods. The male condom is the best known (94 percent) followed by the pill (93 percent).[25]

[24] ZDHS, 2001-2002.
[25] Ibid.

TABLE 5.5.2 CONTRACEPTIVE METHOD MIX
(Selected methods, married/in union women of reproductive age, 15-49)

		Data from comparable source (PRB, 2002)	Most recent data (ZDHS, 2001-2)
Modern methods	Pill	7.2%	11.9%
	Injection	1.0%	4.5%
	Condom	3.5%	3.8%
	Female sterilisation	2.0%	2.0%
	Male sterilisation	0%	-
	Other modern methods	0.7%	0.4%
	Total	**14.4%**	**22.6%**
Traditional methods	**Total**	**11.5%**	**11.6%**
No method	**Total**	**74.1%**	**65.8%**

Source: PRB, 2002; ZDHS, 2001-2002.

5.5.3 ESSENTIAL MEDICINES

There is an absence of national data on the availability of essential medicines. A DFID assessment found that magnesium sulphate (a key safe drug for prevention and treatment of pre-eclampsia or eclampsia) was neither widely available nor widely used, despite being on the Essential Drug List. Cost is also a major barrier to essential medicines access. Although government services for reproductive and maternal health are free according to health policy, the health service registration fee and high collateral costs prevent many people from accessing services.[26] In fact, 77 percent of women say they have major problems accessing healthcare when they are sick, citing cost and availability of transport as well as distance to health facilities being the biggest barriers.[27] A drug kit system is in operation, which is further explained in the following box.

[26] DFID, 2006.
[27] ZDHS, 2001-2002.

Drug Distribution in Zambia: Pushing and Pulling

Drug kits were initiated in 1987 by the Swedish International Development Agency to counteract the persistent problems of frequent shortages of drugs and supplies that were experienced in most health facilities. Before the kits were introduced, hospitals were meant to order drugs and distribute them to health centres in their referral network. In practice, clinics often did not get adequate supplies, for a variety of reasons to do with the capacity to order and distribute, as well as the availability of items. Although it was acknowledged that needs would vary across the country and facilities, the kit system was assumed to offer greater security than relying on health centres and hospitals to order correctly. There are now two drug kits, one for health centres to meet the basic needs of 1,000 new clients per month, and the other for hospitals. These are 'pushed' to the districts and hospitals. The content is periodically revised to take account of changes in need and drug availability. A number of different donors have funded the provision of the kits, specifically the Royal Netherlands Embassy, Japanese International Cooperation Agency, and UNICEF over the last three years.

Individual 'bulk' drugs may be ordered to supplement what is in the kits. These are obtained through a 'pulling' system, whereby districts are meant to order what they need from MSL. The kits are meant to provide the basic necessities for clinics and hospitals but the availability of the bulk items gives them the flexibility to meet the particular needs of their patient workload.

Contraceptives are available to order only as 'bulk' items, with the exception of male condoms which are also included in limited quantities in the kits.

Source: DFID, 2006b.

6 HIV PROGRAMMING

6.1 LEVEL OF POLITICAL COMMITMENT

WHO describes political commitment to fight the HIV/AIDS epidemic as "high."[28] Robust frameworks are in place, including the following:

- As early as 1986, Zambia created a national AIDS surveillance committee and its National AIDS Prevention and Control Programme.
- In December 2002, the National HIV/AIDS/STI/TB Council (NAC) was established to coordinate the national multisectoral response, one component of which is the health sector response. The NAC includes representation from government, NGOs, religious and traditional leaders, mass media, youth and the private sector and integrates participation of multilateral and bilateral agencies.
- The National HIV/AIDS/STI/TB Intervention Strategic Plan 2002-2005 was developed with the following priority interventions: promoting behaviour change,

[28] WHO, 2005.

reducing mother-to-child transmission, ensuring safe blood transfusion, providing care, treatment and support to people living with and affected by HIV/AIDS, improving care and support for orphans and vulnerable children and strengthening multisectoral coordination of interventions.

- A high-level cabinet committee on HIV/AIDS has been established to provide policy direction and regularly report to the cabinet on HIV/AIDS issues.
- Zambia has developed various policies, planning frameworks, guidelines and protocols to guide the national response.
- A national implementation plan to scale up ART for 2004-2005 was established, with the aim of expanding access to treatment across the country. This has now been superseded by the 2006-2008 plan.
- Zambia has been scaling up the health sector response through several initiatives, including the Poverty Reduction Strategy Programme, the Highly Indebted Poor Country Initiative, the Zambia Social Investment Fund, the Zambia National Response to HIV/AIDS Project (funded through the World Bank MAP) and grants from the Global Fund.
- The government is addressing human resource issues in the health sector by introducing retention schemes based on incentives for doctors and rural health workers and conducting training for health workers using the WHO Integrated Management of Adult and Adolescent Illness (IMAI) approach.[29]

6.2 FUNDING FOR HIV/AIDS

There is an absence of authoritative data on the breakdown of funding sources for HIV/AIDS in Zambia. The National HIV/AIDS Interventions Strategic Plan 2002-2005 has a budget of US$559 million, an average of US$140 million each year.[30] It is estimated that US$32 million was disbursed in 2005, which is 1.53 percent of the national budget. However, this only includes funds disbursed through the NAC and not the whole HIV/AIDS response (for example, funds disbursed directly to districts and funds provided by other agencies that do not go through the NAC are not included).[31] Table 6.2 shows the major donors to the national HIV/AIDS response. Although the picture is incomplete and funding information is not comparable, it is clear that external donors fund the majority of the HIV/AIDS response.

TABLE 6.2 MAJOR EXTERNAL FUNDING SOURCES, 2002-2005

Donor	Timescale	Funding
Global Fund	Disbursed 2002 2004-2009	$92 million $254 million
PEPFAR	2005	$85 million
World Bank (MAP)	Disbursed 2002	$42 million

Source: Avert, 2006.

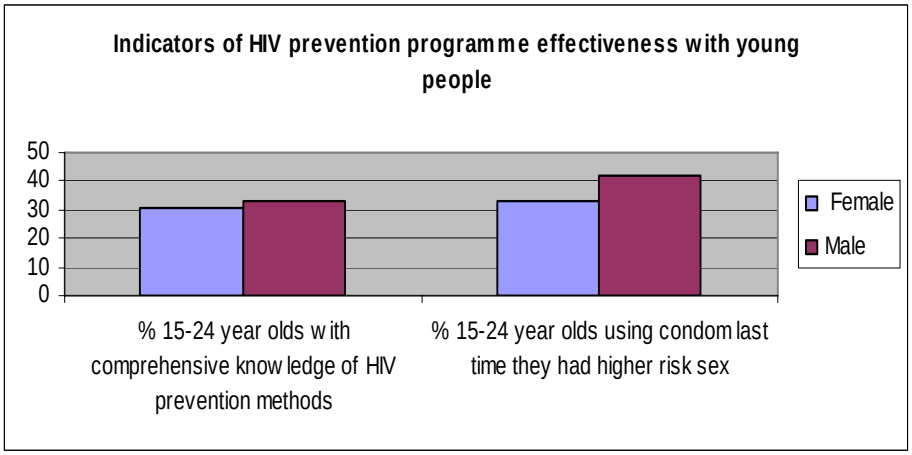
[29] Ibid.
[30] UNAIDS, 2004.
[31] NAC, 2005.

6.3 COVERAGE OF HIV/AIDS INTERVENTIONS

PREVENTION COVERAGE

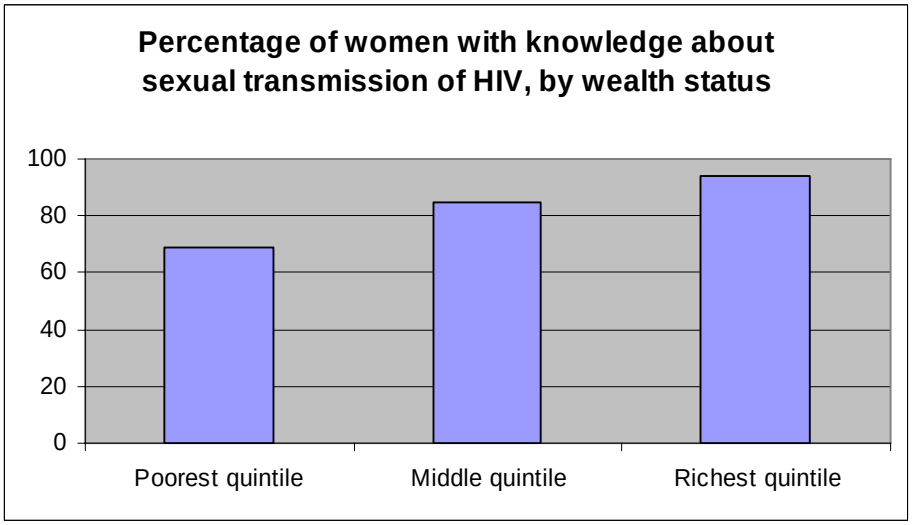
Knowledge of HIV prevention methods (ability to correctly identify condom use and limiting sex to one uninfected partner as major ways of preventing the sexual transmission of HIV, ability to correct two of the most common misconceptions about HIV and knowing that a healthy-looking person can transmit HIV) is 31 percent for young women and 33 percent for men (see Figure 6.3.1). This is about average in relation to other countries in the region. Condom use among young people (33 percent for female and 42 percent for males) is also in line with other countries in southern and eastern Africa. Meanwhile, Figure 6.3.2 illustrates how poverty is a barrier to HIV prevention knowledge, and indicates further need to focus HIV awareness and prevention efforts among the poorest Zambians.

FIGURE 6.3.1



Source: WHO, 2005.

FIGURE 6.3.2



Source: PRB, 2004.

The teaching of HIV/AIDS is a compulsory and integral component of the curriculum at all educational levels. Sixty percent of schools have teachers who have been trained in life-skills-based HIV/AIDS education and who have taught it during the last academic year. Attitudes around condoms have had an impact on HIV programming. Near the end of his presidency, Frederick Chiluba said: "I don't believe in condoms myself because it is a sign of weak morals on the part of the user. The only answer is abstinence." The next government, backed by the NAC, banned the distribution of condoms in schools. In 2001, television advertisements promoting condom use were taken off the air after generating protest letters.[32]

Evidence of the emphasis on abstinence can be seen in national impact data. For example:

- Abstinence among 15-19-year-olds has increased from 60 percent in 2000 to 66 percent in 2005
- Median age at first sex has increased from 16.5 in 1998 to 18.5 in 2005
- The proportion of sexually active 15-19-year-olds who have had sex with more than one partner has declined from 12 percent in 2000 to three percent in 2005
- Condom use amongst 15-24-year-olds decreased slightly between 2000 and 2005.[33]
- The proportion of men engaging in highest-risk sex, that is, unprotected sex with a non-cohabiting partner, fell from 25 percent in 1996 to 12 percent in 2003. However, condom use remained the same and the reduction was due to men having less sex overall, an increased proportion of those who are not abstaining remaining faithful to one partner, and a later age of first sex.

It appears that abstinence and fidelity messages are having a greater impact on behaviour than those advocating condom use, but could have also resulted in reduced condom use.

Eighty percent of large companies have HIV/AIDS workplace policies and programmes in operation.[34]

Voluntary counselling and testing services in Zambia are provided through two major models, private stand-alone sites that attract significant proportion of males, and sites integrated into public health facilities that tend to attract more females than males.[35] VCT has been expanding rapidly in recent years and there were 420 centres in operation by September 2005 (see Table 6.3.2). The percentage of people who have gone for VCT and know their results now stands at 13 percent. However, 73 percent desire to be tested, or tested again, and fear of results is the most common reason that stops people getting

[32] Avert, 2006.
[33] DHS, 2006.
[34] NAC, 2005.
[35] Ibid.

tested.[36] There has been some controversy in recent years as the government and industry have attempted to introduce compulsory HIV testing in certain populations (military and mine workers). Since then, the National AIDS Council has proposed routine opt-out testing for all people using health services, an option that continues to be considered.[37]

PMTCT has also been expanding rapidly, almost doubling to 256 sites by the end of 2005 (see Table 6.3.2). This provides for 25 percent of women in need, a higher coverage than most countries in Africa. In Zambia, the government has been strategic in using PMTCT programming, supported by the Global Fund, to improve some aspects of reproductive health.[38]

TABLE 6.3.2 USE OF HEALTH SERVICES FOR HIV PREVENTION

# of VCT sites	420
# of VCT sites per 1,000,000 people	19.6
# of people tested at VCT sites (cumulative)	
# of sites providing PMTCT services *(NAC, 2005).*	256
Percentage of HIV+ pregnant women receiving treatment for PMTCT *(NAC, 2005).*	25%

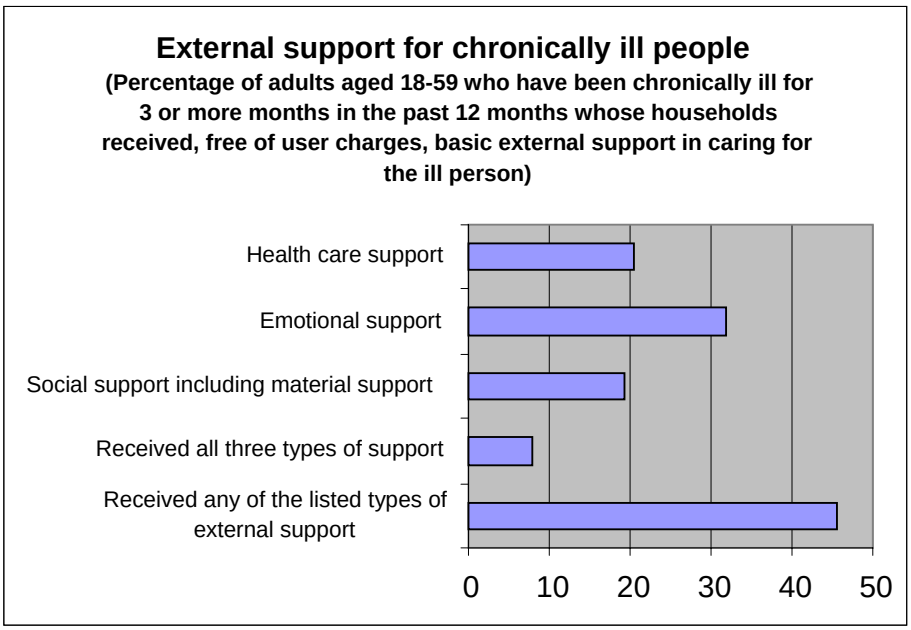
Source: WHO, 2005, unless otherwise stated.

Care coverage

Care is difficult to measure as most care in Africa takes place in the home. Zambia was among the first countries in Africa to implement home-based care. Faith-based organisations provide leadership in implementing these programmes.[39] The Sexual Behaviour Survey 2005 attempted to find out the prevalence of care and support. Almost half of chronically ill people had received some form of external support, but only one in 12 had received a combination of health care, emotional and social/material support (see Figure 6.3.3).

FIGURE 6.3.3

[36] ZSBS, 2005.
[37] Avert, 2006.
[38] DFID, 2006.
[39] WHO, 2005.



Source: ZSBS, 2005. (Please note: The small sample size of 88 that was used to compile this information means that results should be interpreted with caution).

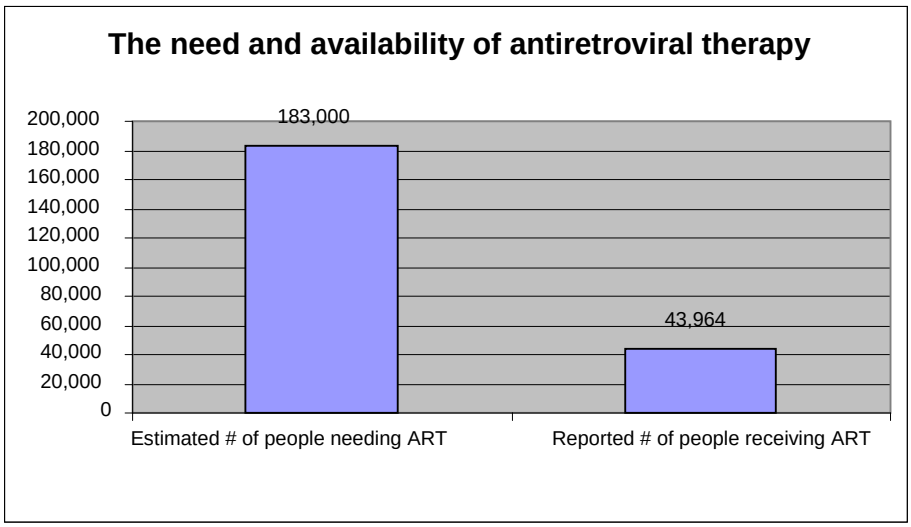
Thirteen point four percent of orphans' and vulnerable children's households receive free basic external childcare support. In 2005, the Ministry of Community Development and Social Services (MCDSS) and the Gender in Development Division (GIDD) introduced a village banking and income generation project in four districts in order to provide socio-economic impact mitigation for women most affected by HIV/AIDS.[40]

Treatment coverage

As of September 2004, an estimated 13,636 people were accessing antiretroviral therapy in Zambia. At the end of 2004, the Central Board of Health reported that 15,328 Zambians were receiving antiretroviral therapy. By November 2005, 43,964 people were receiving antiretroviral therapy in Zambia through the public sector, with at least an estimated additional 2,000 accessing treatment through private-sector sources (see Figure 6.3.4). Public sector coverage accounts for 24 percent of those in need. Some private companies, such as the Konkola Copper Mines, also provide antiretroviral therapy to their employees at a subsidised rate. The number of sites offering ART doubled between March and September 2005, reaching 110 sites.[41]

FIGURE 6.3.4

[40] NAC, 2005.
[41] WHO, 2005.



Source: WHO, 2005.

MEASURING THE EFFORT

Prevention

The AIDS Programme Index sought to measure the effort in prevention programmes. It found that additional prevention activities have been introduced, and perceptions of the level of effort of implementing these programmes have improved since 2001 on the basis of opinions of senior people in the national AIDS programme (See Table 6.3.1.). Zambia's prevention scores are higher than for eastern and southern Africa and globally.

TABLE 6.3.1 PREVENTION NATIONAL EFFORT

Scores (out of 100)		
	2001	**2003**
Implementation of activities score	77	77
Perception of overall effort	50	70
Total prevention effort score	63	73

Implementation of activities in 2003 (beyond the pilot stage to a significant proportion of the target populations, both urban and rural)

Implemented:

- An active programme to promote accurate HIV/AIDS reporting by the media
- A functioning logistics system for condoms and essential HIV/AIDS drugs
- A social marketing programme for condoms
- School-based AIDS education for youth
- Behaviour change communications
- Voluntary counselling and testing
- Special programmes for other vulnerable populations
- Blood safety
- Programmes to ensure safe injections in healthcare settings
- Special programmes for sex workers

Not implemented

- Special programmes for men who have sex with men
- Special programmes for injecting drug users
- Nationwide programme to prevent mother-to-child transmission of HIV

Source: Policy Project, 2003.

Care and treatment

There has been both an introduction of new treatment activities implemented between 2001 and 2003 and an increase in the perceived effort in implementing these programmes (see Table 6.3.3). This gives Zambia a national effort score for care and treatment of 78, which is significantly higher than the average score for the region.

TABLE 6.3.3 CARE AND TREATMENT NATIONAL EFFORT

Scores (out of 100)		
	2001	**2003**
Implementation of activities score	59	71
Perception of overall effort	45	65
Total care and treatment effort score	52	68

Implementation of activities in 2003 (beyond the pilot stage to a significant proportion of the target populations, both urban and rural)

Implemented:

- HIV screening of blood transfusions
- Psychosocial support for PLHA and their families
- Palliative care
- Treatment of common HIV-related infections (pneumonia, diarrhoea, oral thrush, vaginal candidiasis and pulmonary TB)
- STI prevention (including condom use) and care
- Universal precautions
- Intensified case finding and treatment for TB
- Preventative therapy for TB among HIV-infected people
- Systematic antifungals for systemic mycosis
- Treatment of HIV-associated malignancies (Kaposi's sarcoma, lymphoma and cervical cancer)
- Treatment of extensive herpes

- Highly active antiretroviral therapy (HAART)

Not implemented

- Nutritional care
- Cotrimoxazole prophylaxis among HIV-infected people
- Post exposure prophylaxis of occupational HIV exposure and for rape
- Diagnosis and treatment of HIV-related infections that are difficult to diagnose and treat
- Advanced treatment of HIV-related malignancies

Source: Policy Project, 2003.

6.4 SCALE-UP PLANS

3-by-5 Initiative

WHO describes the progress towards the "3-by-5" Initiative: "In 2003, WHO/UNAIDS estimated that Zambia's total treatment need was 140,000 people, and the WHO "3-by-5" treatment target was calculated as 70,000 people (based on 50 percent of estimated need). In 2005, WHO/UNAIDS estimated that Zambia's treatment need had risen to 183,000 people. The government declared a national treatment target of 100,000 people by the end of 2005, with the ultimate goal of providing universal access to treatment to everyone in need. In 2004, the government committed to providing antiretroviral therapy free of charge in the public sector and, in June 2005, declared that the entire antiretroviral therapy service package would be provided free of charge in the public sector." Zambia did not meet the "3-by-5" target but made good headway, with over 43,000 on ART by 2005. [42]

WHO estimated that between US$157.3 million and US$161.6 million was required to reach the "3-by-5" target by the end of 2005. The Global Fund, PEPFAR and World Bank Multi-Country HIV/AIDS Programme for Africa, as well as many other bilateral and multilateral agencies, are all supporting scale-up of ART as well as VCT and PMTCT services.[43]

Global Fund

The Global Fund granted Zambia US$92.8 million over five years in Round 1 for a comprehensive prevention, treatment and care proposal. As of October 2005, a total of US$47.1 million had been disbursed. Zambia also submitted a successful Round 4 proposal to the Global Fund with a five-year funding request of US$253.6 million, focused on scaling-up access to antiretroviral therapy. As of October 2005, a total of US$13 million had been disbursed to begin implementing activities.[44]

6.5 SOCIAL MARKETING

Major socially marketed condoms in Zambia include:

Organisation	Product	Details
Population Services International/Society	Maximum – male condom, Care – female	Maximum since 1992. Repackaged as Maximum Classic and Maximum

[42] WHO, 2005.
[43] Ibid.
[44] Ibid.

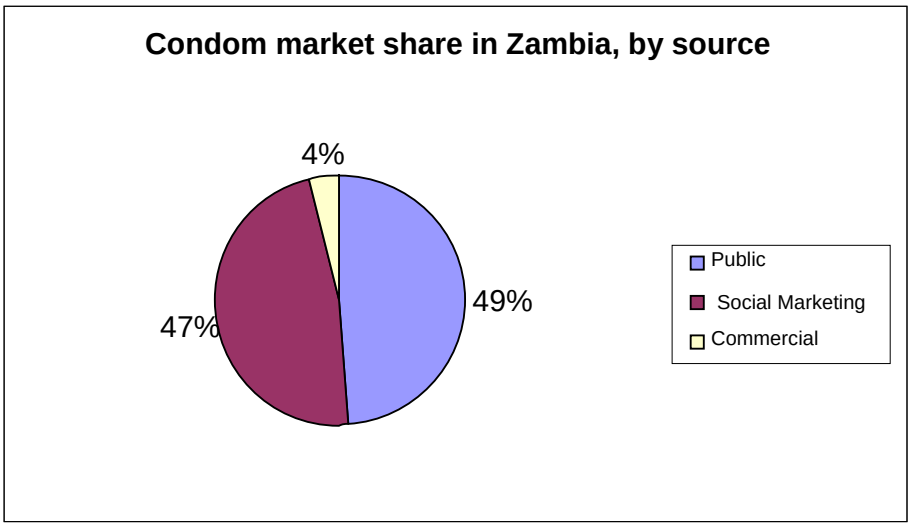
for Family Health	condom	Scented in 1994. Care since 1997. Plans to scale up Care female condoms 2005 onwards.

Sources: NAC, 2005; PSI, 2006.

Socially marketed condoms are prominent in Zambia, with SFH's Maximum being the market leader. Free public sector condoms obtained from Medical Stores Limited are also distributed through the health system and some NGOs. Demand for socially marketed condoms has been steadily increasing in recent years, while pubic sector distribution has decreased. They now hold an approximately equal share of the market, with commercially sold condoms having a very small share (see Figure 6.4). SFH also links with local district management teams, providing extra supplies in case of stock-outs.[45, 46]

[45] DFID, 2006.
[46] NAC, 2005.

FIGURE 6.5



Source: DFID, 2006.

7 RECOMMENDATIONS FOR MICROBICIDE PLANNING AND RESEARCH

7.1 IMPLICATIONS

- Attitudes to condoms, high levels of stigma around HIV/AIDS, and an emphasis on abstinence-focused programmes present major challenges for potential acceptability and up-take of microbicides.

- The Government of Zambia is highly concerned with the fragmented and parallel systems in place, particularly in drug procurement and distribution, and is making concerted efforts to improve cohesion and coordination between organisations involved. This is a major consideration for commodity logistics planning.

7.2 RECOMMENDATIONS

- The fact that almost half of Zambian women do not take part in decision-making about their own healthcare must be taken into consideration when planning microbicide introduction – social marketing aimed at men will be particularly important in this context.

- The weaknesses in state drug supply mechanisms mean that government-managed microbicide procurement and distribution would require significant support.

7.3 DATA GAPS AND CHALLENGES

There were limited statistics available on the public/private mix of health sector service delivery, and proxy indicators for family planning had to be used. Standardised data on the availability of essential medicines could not be found. There was also a lack of useful information on HIV external funding, for example absolute and proportion of external funding by source by financial year.

Using the same data sources, where possible, for all six countries, has helped to keep the country profiles comparable. There are occasions where this has been to the detriment of using the newest data available. Where this is the case, and new data show any important changes, information has also been included.

It should also be remembered that this report is based on desk research (from international and standardised sources where possible) only and is intended as an overview rather than an in-depth analysis on issues for the introduction of microbicides. It is useful to read this report in conjunction with the JHPIEGO report for further information on these issues.

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ANNEX - SUMMARY INSTITUTIONAL MAPPING

This section includes summary information on key responsibilities, main programmes and influences, as well as a brief commentary on key alignments or issues in working with these institutions, NGO advocacy, government policy process and levels of donor collaboration.

KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

ORGANISATION	RESPONSIBILITIES/ACTIVITIES	NAMES AND CONTACTS
Government Agencies		
National HIV/AIDS/STI/TB Council	Coordinates the national multisectoral response to HIV/AIDS, including the health response	Dr. Alex Simwanza – Director of Programmes, aidsec@zamnet.zm
Ministry of Health	Provides leadership in planning and resource mobilisation and sets health policy related to HIV/AIDS	
Central Board of Health (CBOH)	Implements the health sector response to HIV/AIDS	Dr. B.U. Chirwa – Director, hritchir@zamnet.zm
Medical Stores Ltd	Storage and distribution of drugs and supplies for the public sector	
Care and Treatment Technical Working Group	National working group established by NAC to provide technical guidance to national coordinating bodies (consists of technical experts in stakeholder organisations).	
Ministry of Education	Oversees life-skills-based HIV/AIDS education programme with school-going youth	Mrs. Barbara Chilangwa – Permanent Secretary, bchilangwa@moe.gov.zm
Ministry of Community Development and Social Services	Implements OVC foster care support scheme	Mr. Peter Mwamfuli – Permanent Secretary, msycd@zamtel.zm
Donors		
PEPFAR	Prevention, treatment and care programme support	
CDC	Supports the strengthening of the health system	
EU	Supports the strengthening of the health system	
Government of Japan	Supports the strengthening of laboratory infrastructure, assistance packages for two disadvantaged districts	
USAID	Supports the expansion of HIV/AIDS services in five provinces, in collaboration with FHI, MSH and International HIV/AIDS Alliance	
Norwegian Agency for Development Cooperation	Technical assistance to the national HIV/AIDS response (prevention and care)	
DFID	Technical assistance to the national HIV/AIDS response (prevention and care), health system strengthening	
Japanese International Cooperation Agency	Technical assistance to the national HIV/AIDS response (prevention and care)	

German Technical Cooperation Agency (GTZ)	Technical assistance to the national HIV/AIDS response (prevention and care)	
Swedish International Development Agency	Technical assistance to the national HIV/AIDS response (prevention and care)	
Danish International Cooperation Agency	Support for prevention and impact mitigation of HIV/AIDS in catchment populations of church health institutions	
Multilateral Agencies		
World Bank	PMTCT scale-up (through MAP)	Dr. Rosmary Sunkutu – Health and Nutrition Specialist Focal Point for Zambia, rsunkutu@worldbank.org
WHO	Support for developing a national operational plan for scaling up ART, developing tools and guidelines (e.g. ART, VCT), PMTCT activities	Dr. Stella Anyangwe – Representative, sanyangwe@who.org.zm
UNDP	Supports the strengthening of the health system	
UNICEF	Supports PMTCT activities, drug procurement and capacity building for drug supply management	
WFP	Provision of nutritional support to PLHA	
UNAIDS	Technical assistance to the national HIV/AIDS response, coordinates UN agencies on HIV/AIDS through collaborative programme	Dr. Namposya Nampanya-Serpell – Country Coordinator, nserpell@who.org.zm
UNFPA	Support for SRH activities, provides a small contribution to the national basket fund	
NGOs		
Churches Association of Zambia (CHAZ)	Coordinates the programme of faith-based health facilities	
Zambia National AIDS Network	Umbrella organisation for NGOs serving PLHA	Mrs. Elizabeth Makata - Executive Director, znan@zamnet.zm
Network of People Living with HIV/AIDS	Support for PLHA	Mr. Ngosa Chela – Vice Chairperson, ngosa@nzp.org
International HIV/AIDS Alliance	Support to CBOs particularly in strengthening community and home-based care responses and provision of ART	
Zambia Business Coalition on HIV/AIDS	Leads the private sector in addressing HIV/AIDS issues in the workplace	
Family Health International	Technical assistance to the national HIV/AIDS response (prevention and care)	
Society for Family Health/ Population Services International	Implementing social marketing programmes	

Care International	Implementing multisectoral programmes that strengthen linkages between HIV/AIDS, food security and income support	
Oxfam	Implementing multisectoral programmes that strengthen linkages between HIV/AIDS, food security and income support	
SHARe	Supporting the strengthening of decentralised planning and coordination structures	
SNV	Supporting the strengthening of decentralised planning and coordination structures	
Concern International	Supporting the strengthening of decentralised planning and coordination structures	
Copperbelt Health Education Project	Youth-focused peer education prevention programmes	
Traditional Health Practitioners Association of Zambia (THPAZ)	Skills training and strategic planning workshops on HIV/AIDS for members	
Zambia Interfaith NGO Network (ZINGO)	National network of faith-based organisations	
Research and academic institutions		
University of Zambia, School of Medicine	Lead role in training of health workers	Prof. Geoffrey Lungwangwa – Deputy Vice Chancellor, dvc@admin.unza.zm
JHPIEGO (part of John Hopkins University)	Support for developing training materials	

Source: WHO, 2005; GFATM, 2005; NAC, 2005.