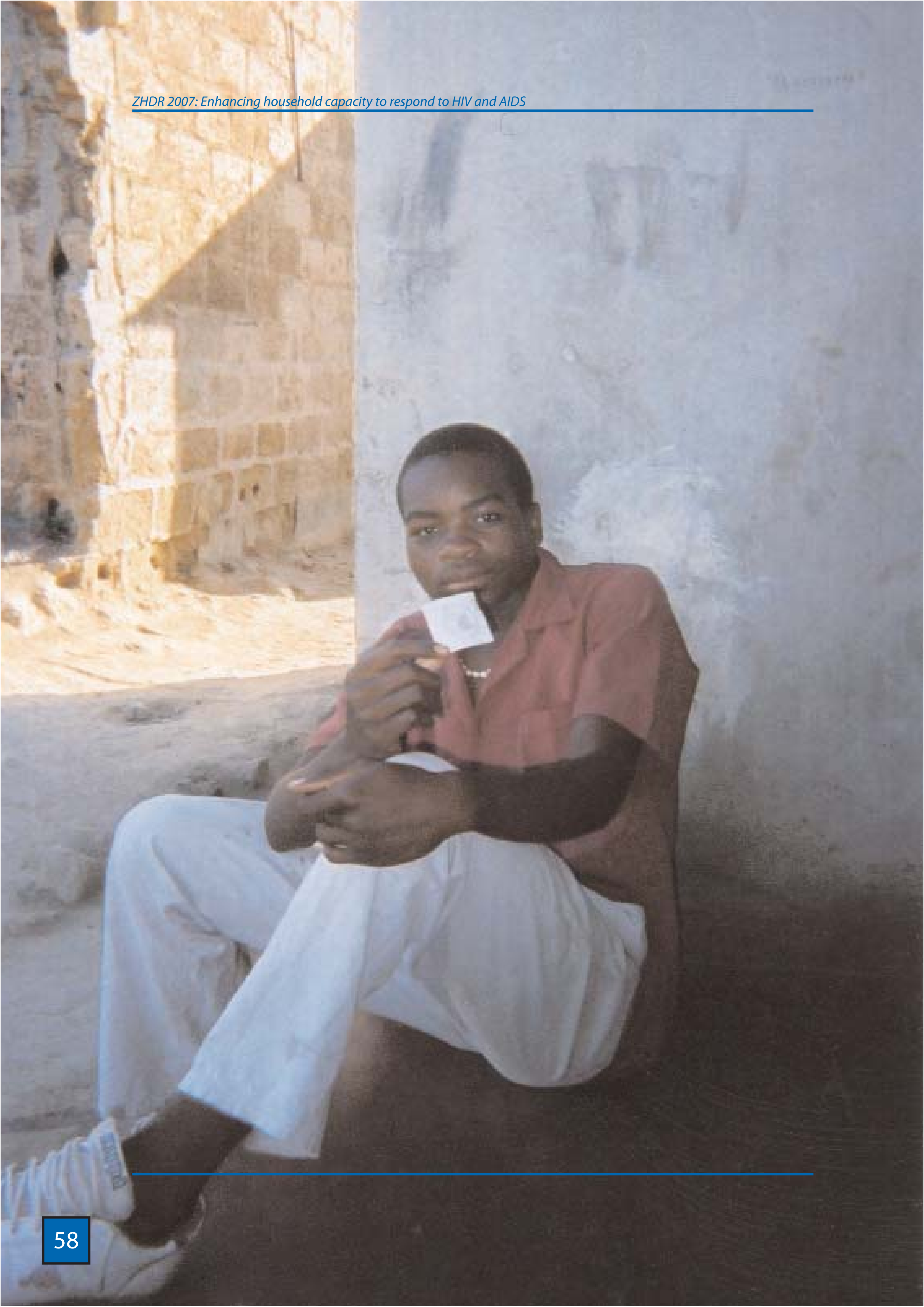

4 ~ The HIV and AIDS response

At this stage of the epidemic HIV and AIDS requires a well coordinated and sustained action, incorporating lessons learned over two decades of AIDS and the wisdom of communities.

(UNGASS, 2001)

This Chapter provides a brief summary of HIV and AIDS response at global, national and household levels. While a great deal of human, financial and other resources have been spent on HIV and AIDS response, the resources have largely by-passed the household, where much of the effort should be focused. In the absence of a strong, institutionalised support, the households themselves have responded to the pandemic through various coping strategies. These provide valuable lessons learned as to what works and what we should be building upon in national and global response. Some household coping strategies are unfortunately, however, unsustainable short-term measures and have serious negative long-term implications.

Global response

Two years after its first appearance in 1981, HIV had spread to 60 countries (Merson, 2005). Since then, it has spread worldwide and to date, over 25 million people have died. Clearly, a global crisis of this magnitude demanded a truly global response to bring together resources, political power and technological capacity. However, up until 1987, HIV and AIDS was treated just like any other disease (a cure could be found in due course). It took the World Health Organisation in the UN system to respond to the reality that millions of people had been infected with HIV on all continents and hence the need to set a Global Programme on AIDS (WHO, 1987). A few years later, the Programme was disbanded and replaced with the Joint United Nations Programme on AIDS (UNAIDS) which was going to be coordinating AIDS-targeted programming by the UN system, including the World Bank.

Regrettably, global HIV and AIDS response has suffered setbacks due to, in some cases, hostile political environments, poorly designed and targeted programmes, misapplication of resources and lack of consideration of household needs. The debate over HIV prevention has injected controversy because of moral politics associated with the dominant mode of transmission. Further, institutional infighting together with a reluctant political leadership have hampered the emergence of a coordinated response.

The solemn challenge for effective global response has been that of sustained sources of funding. For most low and medium income countries, the action against HIV and AIDS has for a long time been dependant on external funds, and this has over the years increased the vulnerability and complicated abilities to respond (Kates, 2004).

The first new major funding came in 2002 with the setting up of the Global Fund to fight AIDS, Malaria, and Tuberculosis proposed by the United Nations. Shortly after this initiative, President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR), a five year $15 billion programme for 15 countries with 80 percent AIDS cases. In addition, the World Bank also stepped up AIDS funding through the Multi-Country HIV and AIDS Programme. With these new initiatives, it is estimated that the world committed a total

"Prevention is better than cure!"

Use a condom before having sex. So prevention is needed all the time. Isack is 18 years old and is encouraging people to use a condom before having sex. No condom no sex.

Photographer: Kelvin Chembo

Box 4.1: The *3 by 1* initiative

The *Three by Five* initiative, launched by UNAIDS and WHO in 2003, was a global target to provide antiretroviral treatment to three million people living with HIV and AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment by the end of 2005. The objective was not met. However, the number of people receiving ART in the target countries more than tripled to 1.3 million in 2005 from 400,000 in 2003 and the campaign provided valuable lessons for achieving universal access by 2010.

In Zambia, the number of treatment sites increased from only three to over 110 facilities in just two years. The number of people receiving ART in December 2005 was estimated between 45,000 and 52,000.

WHO and UNAIDS, 2006.

Box 4.2: The *Three Ones* principles

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

They endorsed the *Three Ones* principles, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- *One agreed HIV and AIDS action framework*
- *One national AIDS coordinating authority*
- *One agreed monitoring and evaluation system*

Zambia is a good example of a heavily affected country with a great number of partners providing resources for HIV and AIDS response and implementing their own programmes. Without the application of the Three Ones, there would be duplication of efforts while some important intervention and geographic areas would remain under funded.

of almost $8 billion on HIV and AIDS response in 2005. This is 30 times the amount spent ten years ago (UNAIDS, 2006).

As many recipient countries and institutions do not have structures to effectively ensure that HIV and AIDS funds reach the intended beneficiaries, disbursement has been limited. The big question is how to structure programmes and systems that will help translate global efforts into reality at country and household level.

The biggest impediment to the global HIV and AIDS response, however, is poor donor coordination, duplication and competition. For example, in some cases, Global Fund and PEPFAR get caught up in overlapping goals. This entangles receiving countries and it becomes extremely difficult to achieve the desired targets in the country. The 2004 "Three Ones Principles" (Box 4.2) has attempted to harmonise the various global AIDS institutions.

National HIV and AIDS response from 1985 to 2006

When HIV was first reported to the Ministry of Health by a team of medical experts in the mid 1980s, a national surveillance committee was set up. The membership was drawn from medical experts, Ministry of Health officials and researchers from various research institutions. The major activities of this committee were monitoring and surveillance of the epidemic throughout the country.

In 1987 an emergency Short Term Plan was put in place, which saw the establishment of 33 blood-screening centres all over the country to ensure the provision of safe blood and blood products. This programme was strengthened further and developed into a National Blood Transfusion Service. The laboratories were also reorganised and upgraded, two reference laboratories were established at the University Teaching Hospital and Tropical Diseases Research

Centre and a state of the art virology laboratory was constructed.

From 1988 to 1992 the first Medium Term Plan was developed with the following operational areas: information, education and communication, counselling, laboratory support, epidemiology, STD/clinical management and home-based care.

It was later recognised that the national response to the HIV and AIDS up to 1993 was inadequate and should have looked beyond medical issues. Consultations made within the Second Medium Term Plan for 1993 to 1998 found that:

- The medium term plans had a blanket approach and were not tailored for different populations.
- There was no mechanism to evaluate the implementation or impact of the plans.
- Collaboration with government was highly fragmented.
- There was no high-level political commitment or advocacy and no management of programmes at central level.

These shortfalls consolidated the need to respond to the HIV and AIDS problem through a multisectoral approach. In this regard, HIV and AIDS, STIs, TB and leprosy programmes were consolidated into one programme. The Second Medium Term Plan was implemented from 1994 to 1998. This plan's major strength was intersectoral coordination and collaboration.

In addition, the non-governmental organisations and faith-based organisations worked tirelessly to complement Government's efforts. The Chikankata AIDS programme developed and initiated the home-based care concept. The Churches Health Association of Zambia then established this model of care in most of its institutions. Government also adopted home-based care as an alternative model of care for patients with AIDS-related illnesses. This has since been adopted globally as an effective option in fragile environments where institutional care is unable to cope with the scale of the epidemic.

Kara Counselling developed and initiated counselling, including training for lay persons. People living with HIV came out in the open and established a network of people living with HIV and AIDS. Issues affecting women were also brought to the fore by the Society for Women and AIDS in Zambia and sex workers were mobilised through the Tasintha programme.

As the problem of orphans became apparent, Children in Need was established to coordinate all activities on orphans and vulnerable children. Health education activities were spearheaded by the Copperbelt Health Education Project.

Through these different structures and initiatives by non-governmental organizations and faith-based organizations outlined above, Zambia has implemented various programmes aimed at reducing HIV prevalence and mitigating the impact of HIV and AIDS. However, in spite of the so many HIV and AIDS initiatives and programmes, the epidemic has been spreading silently and rapidly in the population. Although it is stabilising, this stability is occurring at very high seroprevalence levels.

In addition, earlier on in the evolvement of the epidemic, certain pronouncements by political players contributed to the silent spread of HIV in Zambia. For example, there used to be an unwritten rule not to discuss the presence of HIV and AIDS in Zambia, so as not to discourage tourism (The Panos Institute, 1988, Aids and the Third World).

Today, many people are infected with HIV and there are many patients with HIV and AIDS related illnesses in hospitals across the country. To cushion the impact of HIV and AIDS on hospitals, home-based and community care of patients with AIDS-related illnesses has been adopted as an alternative way of patient care. It has also been argued that such patients prefer to die at home amongst their loved ones.

The public announcements by a few Zambians about their HIV positive status, and the formation of the Network of Zambian People Living with HIV (NZP+), made many people realise that one could be HIV positive and yet look very healthy. People also learnt that living positively could help an infected person live longer.

Government further recognised the increasing number of children who were being born with HIV infection. To respond to the situation, the prevention of mother-to-child transmission of HIV (PMTCT) programme was established. The programme was aimed at enabling HIV positive mothers to have HIV negative babies.

In order to attract more people to know their HIV status and benefit from programmes such as PMTCT and others, voluntary counseling and testing (VCT) programmes were rolled out the same year. In addition Government appointed working groups to spearhead various activities such as PMTCT, VCT, vaccines, ART, traditional remedies, epidemiology, counselling and referral. VCT, unfortunately, is primarily delivered in health institutions up to date and access is very limited. It was only in 2006 that mobile VCT services were launched in one part of Lusaka.

In order to improve coordination and collaboration of the different players in HIV and AIDS response and monitor the activities, the National AIDS Council (NAC) was created in 2000. Although the Council was functioning from the time it was set up in 2000, the Act of Parliament was only passed in 2002. At present, NAC is the single high-level institution responsible for coordinating the actions of all segments of all stakeholders in the response to HIV and AIDS.

Initiatives at household level

Evidence available shows that although households may be overburdened and do not have adequate resources, they continue to be the primary support system for the vulnerable, such as children and the elderly (Luo et al, Situation analysis of OVCs in Northern Province, 2004).

Although Zambia has developed a lot of innovative programmes in the health sector, especially in the area of prevention, care and support, very little effort has been directed at addressing social issues and in particular, mitigating the impact of HIV and AIDS on households and communities, who are mostly affected by not only HIV and AIDS but the social ramifications of the epidemic. This gap is surprising because households have always been the most important support system in the various communities of Zambia.

Public sector

The Social Welfare Department in the Ministry of Community Development and Social Services, in partnership with the Department for International Development and the Germany Technical Aid to Zambia, has established a mechanism to provide foster-parent household allowances for orphans and vulnerable children (OVC). This is being piloted in Southern and Eastern provinces. It involves cash transfers of 40,000 to 50,000 Kwacha to vulnerable households. In Eastern Province the support is from UNDP in form of a soft loan of 500,000 Kwacha for income generation activities. The results of these initiatives are yet to be disseminated (DFID, 2005). In addition, the introduction of community schools has been a mitigating strategy for OVCs affected by HIV and AIDS. In 2002 alone, the Ministry of Education recorded in excess of 176,629 OVCs as having enrolled in community schools.

Although the challenge is enormous, it is a step in the right direction as the country continues bracing itself to taking action against HIV and AIDS. However, on the whole, the National Social Welfare Policy although recently developed, is not geared to comprehensively cater for the aged and

Figure 4.1: Conceptual framework for coordination of the multisectoral response

Source: GRZ and NAC, 2006

huge numbers of orphans, who are increasingly dropping out of school, have very little access to health services, are abused and are street children.

Private sector

Private companies and public institutions have also been major players in responding to the challenges of HIV and AIDS. In relation to the private sector, several companies have been very instrumental in responding to the epidemic. They have developed workplace programmes for HIV and AIDS in the interest of their employees and family members. For example, Chloride Batteries, Barclays Bank, Bank of Zambia, Chilanga Cement, Zambia National Commercial Bank and Konkola Copper Mines have developed programmes aimed at sensitising members of staff on HIV and encouraging them to undergo voluntary counselling and testing (VCT).

Chloride Batteries, with about 42 employees, has a workplace policy that encourages HIV positive employees to go for monthly CD-4 count paid for by the company. However these initiatives do not target or benefit the households. They benefit individual employees of the company.

On the other hand, the policies and workplace programmes for Assets Holding Company - Mining Municipal Services and Phoenix Contractor target not only the employees, but also communities where these employees reside. As a result household members have not only benefited but

have been leaders in responding to the social ramifications of HIV and AIDS, such as the support to OVCs.

Non-governmental organisations and faith-based organisations

In the recent past, there has been a dramatic rise in the number of communities with people offering care and support to PLWHA. The major players at this level are non-governmental organisations (NGOs) and faith-based organisations (FBOs).

Some of the NGOs and FBOs that have been making a difference at household level include: Churches Health Association of Zambia (ZHAZ), Copperbelt Health Education Project (CHEP), Society for Women Against AIDS in Zambia (SWAAZ), and Catholic Archdiocese of Ndola, Lusaka, Mpika and Mbala, Extended Hand Community Foundation, The Tasintha Programme, Youth Alive, Youth of Roan, Kara Counselling, Kwasha-mukwenu, FLAME, Zambia Inter-Faith Working Group (ZINGO), the Network of Zambian People Living with HIV/AIDS (NZP+), Community Youth Concern, Society for Family Health, World Vision etc.

Required response to empower households

HIV and AIDS programmes being offered at all levels in Zambia have been tremendous and encouraging. However, most of these programmes are short-term, not holistic by design with no inbuilt sustainability and have not taken into account all the needs and issues affecting households.

For example, households requiring support are overwhelmed with high numbers of orphans, requiring not only educational support but other forms of support, including psychosocial. Most of these households are impoverished and therefore require support that target poverty reduction. Poverty, as a result of HIV and AIDS, at the household level, is a serious problem. Part of the problem has been an absence of a developmental framework to help gain a holistic understanding of the HIV and AIDS impacts on the household and an agreement on what ought to be the minimum package that should be provided to an AIDS-affected household. NAC in its programming activities, review and strategic planning for a long time did not have a framework to help it target initiatives at household level.

Prior to the adoption of a new strategic framework in May 2006, NAC was supported by eight standing technical committees: (i) Promotion of safer sex practices; (ii) Prevention of mother-to-child transmission of HIV; (iii) Safe blood, blood products and body parts and adoption of infection control measures; (iv) Improvement of the health status of HIV-positive people with symptoms; (v) Promotion of positive living and prevention of opportunistic infections among people living with HIV; (vi) Improvement of care for orphans and vulnerable children; (vii) HIV and AIDS information network and monitoring system; and, (viii) Coordination.

This structure could not help NAC clearly target households and take into account the changing dynamics of the epidemic at the household level.

Realising this, NAC has made revisions to its institutional framework in its National HIV and AIDS Strategic Framework 2006-2010. Six new working groups have been created around the following themes: (i) Intensifying prevention of HIV; (ii) Expanding treatment, care and support for people affected by HIV and AIDS; (iii) Mitigating the socioeconomic impact of HIV and AIDS; (iv) Strengthening the decentralised response and mainstreaming HIV and AIDS; (v) Improving the monitoring of multisectoral response; and, (vi) Integrating advocacy and coordination of the multisectoral response. The revised strategic framework is supposed to be coordinated as shown in Figure 4.1. on p. 63.

It should be pointed out that the framework has been evolving over the years as NAC responded to some of the challenges not specifically addressed in its previous strategic framework.

The establishment of sub-national structures - specifically provincial, district and community AIDS task forces - have been supported by donors including the United Nations Development Programme and Development Cooperation Ireland. These have been integrated as sub-committees on HIV and AIDS in Provincial and District Development Coordinating Committees. It is hoped that a similar arrangement would be made at sub-district level once decentralised structures are consolidated under the National Decentralisation Policy.

These revisions answer much of the concerns expressed in this document. However, there is still need to sharpen further the focus on households which is assumed in the new framework but not explicitly stated. Chapter 6 highlights a number of ways in which this should be done.

Household coping strategies

Due to the limited programmes and formal structures focusing on the households, households have developed their own strategies and coping mechanisms which include (Population Council and RuralNet Associates Limited, 2006):

- A heavy dependency on beer brewing and petty trading as an economic activity, in both rural and urban households.
- Many orphans, widows and family members engaging in piece work.
- Girl children, especially orphans, getting involved in sex work as a way of earning a living.
- Young girls getting pregnant, hoping that their boyfriends or man friends will take care of them. In most cases, unfortu-

Box 4.3: Coping strategies

"Our parents died several years ago leaving the eight of us.

I have five thousand Kwacha which I use to buy charcoal to resell at the market. My profit is five hundred Kwacha and I use it to buy vegetables at the end of each day.

My brother has ten thousand kwacha and he buys paraffin which he resells in the village door to door. The profit of one thousand kwacha he buys one kg of mealie meal. This is how we survive.

I met a freelance prisoner who promised to marry me. When he was freed he abandoned me leaving me pregnant. I have since delivered a set of twins." *Luwingu 2004*

Box 4.4: Prostitution and the orphanhood crisis, the link

In some households you find that both mother and father are chronically ill and they cannot even get up. There is no one to care for the children to check if they have gone to school or if they have eaten.

And when these parents die, the children are left homeless because they have no base; the house was for rent so they are chased. Hence they become street children.

In this community, the problem of orphans is big because if you count these houses you find that there is no house without orphans. Worse still, those who are caring for them do not work and also those cared for by grandparents are even more disadvantaged.

So if these children grow up, they too will not do anything in terms of work and will end up doing prostitution. *Lusaka women focus group discussion*

nately, these young girls end up being abandoned by these men, ending up with the additional burden bringing up babies.

- Young girls being forced to enter into early marriages in order to get support from the men. While some of them may end up being happy, the majority are sexually, physically and psychologically abused.
- Boys and sometimes young girls stealing and may be involved in other criminal activities.
- Children sleeping by the fire to keep warm, as most households lack basic necessities such as blankets.
- Families consulting traditional healers when there is sickness, as they cannot access health services due to distances or cost of transport and services.
- Some households engaging in agricultural activities to ensure food security. Most of them depend on the rain or may put up vegetable gardens along the riverbanks. This therefore is a seasonal and not meaningful activity.

Overall, coping strategies adopted by households are not sustainable and usually have not yielded much success or made an impact. The Tasintha programme, which is focusing on support to sex workers, has documented the association between orphaned children and sex work. The programme has showed that when these women or children are supported with life saving skills and entrepreneurship they do stop sex work, flourish and reintegrate back in society.

Conclusions

Like many countries in Africa, Zambia will have to find innovative, pragmatic solutions to increase household capacities to cope with the social ramifications of HIV and AIDS. It is clear from the evidence provided both in Chapters 3 and 4 that traditional kinship relations and the classical institutional solutions are currently not adequate to deal with this new phenomenon. HIV and AIDS is a major human crisis that Zambian households have to cope with and their capacities to prevent its spread and mitigate the impacts are inadequate. Little can be achieved in terms of improved human development if households are not provided with the capacity to respond to the epidemic.

Recent revisions to the strategic framework of the National AIDS Council give hope that these issues would start to be addressed. However, the household focus in the new framework is not sharp enough and there is need for the National AIDS Council to take steps urgently to revise this.