CHAPTER THIRTEEN

HIV / AIDS

Situation Analysis

Zambia reported 15,000 AIDS cases in 1991. By 1993 and 1994 AIDS had become the second major cause of mortality among adults in hospitals at 14 percent of the total deaths. In 1998, the estimated national adult (15 – 49 years old) prevalence rate was 19.7 percent. By 2000, it was estimated that 650,000 Zambians, out of a population of approximately 9.1 million, would have died thus far in the epidemic. If current trends continue, 1.6 million more may die before the year 2015.

Since the beginning of AIDS, tuberculosis case rates have increased five-fold to more than 40,000 in 1996. By the year 2014, it is estimated that the number of new cases each year attributable to HIV infection alone will exceed 41,500. By any standard this is an enormous burden of disease for the population of Zambia.

There are, however, some hopeful indications. The prevalence of HIV positive tests in 15-19 year-old youths has dropped over most of the country between 1994 and 1998. In Lusaka, for example, while the rate was 28 percent in 1993, it had dropped to 15 percent in 1998. At the same time the overall prevalence of positive tests in the whole population appears to be stable and is not increasing. This has been attributed to behaviour changes. The recent Sexual Behaviour Survey has documented further evidence of behaviour changes. Although the current burden of infection will continue to impact Zambia for many years, it is hopeful that the tide may be turning.

The Relationship Between HIV/AIDS and Poverty

The inter-relationship between HIV/AIDS and poverty is complex. The manifestations of HIV/AIDS lead to poverty, and the state of poverty directly or indirectly creates vulnerability to HIV/AIDS. HIV/AIDS leads to poverty by eliminating the productive sector of society, the 15 - 45 year age group. Its effect on society is primarily through the premature loss of human capital. It is estimated that with HIV prevalence of 20 percent (the current rate in Zambia) mortality in the 30 - 35 year age group goes up by approximately 40 deaths per 1,000 populations

Life expectancy at birth has dropped by nearly 14 years to approximately 37 years. The epidemic has left an estimated 620,000 orphans (in 2000), projected to reach 974,000 in 2014 - most of whom will have no hope of obtaining formal education - this in turn will affect the quality of the labour force. With Zambia's HIV prevalence rate as high as 20 percent, the GDP is likely to be one percent lower than otherwise.

At the individual level, poor people tend to have low education and this makes them less able to communicate with other people. They are therefore disadvantaged in getting information about the cause, transmission and preventive measures of AIDS. Zambia's worsening poverty levels may explain (although there is no scientific proof) the country's high HIV/AIDS prevalence.

At the family level the loss of a parent usually means the loss of a breadwinner and high medical expenses prior to death decrease expenditure on other family needs. The loss of a parent is eventually followed by the loss of the other, resulting in the increase of the orphans-burden on society. In some cases a surviving widow or even children may be forced into prostitution to support the family or grandparents are burdened with the raising many orphans.

The decline, in real terms, in government expenditure on health and education has indirect effect on HIV/AIDS. The decline in health expenditure means that the quality of STI management is compromised. With the shortage of medication, STIs are either inadequately managed, or not managed at all. STIs being co-factors for HIV means substandard management of infections, results in increase transmission of HIV.

The impact of HIV/AIDS on the health care system itself has been profound. It is projected that AIDS patients will utilize 45 percent of all hospital beds by 2014, crowding out other patients. It is estimated that about $200 per AIDS patient per is needed for hospitalisation. This is against the current per capita expenditure on health by the government of approximately $3 per year. With AIDS expenditures rising from about 3.4 million USD in 1989 HIV/AIDS will inexorably consume more resources at the expense of other diseases.

Limited resources impede the acceleration of HIV/AIDS education in schools. The Ministry of Education has less that two Full Time Equivalent (FTE) staff addressing the sector's response to AIDS although over 1600 teachers died of it in 1999 alone. Zambia must now plan to train 2 teachers for each one who will actually teach.

Regarding agriculture and food security the rising prevalence in rural areas poses a serious threat. Labour time is reduced by sickness or the need to care for sick family members. Moreover, assets such as land, equipment, and livestock are sold to raise funds to look after the sick.

AIDS disproportionately impacts women. It is estimated that 1.2 times as many women are afflicted with AIDS than are men. Women are thought to be 2 to 4 times as susceptible to infection with HIV during unprotected intercourse, and more vulnerable to other STDs. Furthermore, women are culturally relatively weaker to protect themselves against a spouse suspected to be infected.

Main Strategies From the National AIDS Plan

After an extensive consultative process, a National Strategic Framework has been developed, validated and costed. The goal are as follows:

- To enhance and strengthen Political participation.
- To meet increasing demands for services more effectively
- Improve the targeting of services to vulnerable groups
- Increase the efficient use of resources
- Take advantage of increasingly coordinated donor response
- Define catalytic projects and plans of action
- Establish National guidelines for Best Practice
- Define main steps for going to scale
- Formulate policies and actions to overcome political, social, institutional and structural obstacles
- Establish management procedures for implementation, monitoring and evaluation

Priority Interventions

1. Mobilization of a multi-sectoral response
2. Promotion of behaviour change/Reduction of high risk behaviour (Multiple partners, ritual cleansing, Abstinence, mutual faithfulness or condom use)
3. Increase and improved STD prevention and control
4. Destigmatisation of HIV/AIDS
5. Voluntary Counselling and Testing
6. Reduced Mother-to-child-transmission of HIV
7. Improved Home Based Care and support for People Living with HIV/AIDS
8. Community based support for orphans and vulnerable children
9. Improved drug supply for the treatment of STD, TB and HIV positive clients
10. Improved Hospital level care

Table 1. Care and support packages, according to resource availability

Package	Contents
The essential package	• Voluntary HIV counseling and testing • Psychosocial support for HIV-positive people and their families • Palliative care and treatment for pneumonia, oral thrush, vaginal candidiasis and pulmonary tuberculosis • Prevention of infections with cotrimoxazole prophylaxis for symptomatic HIV-positive people • Official recognition and facilitation of community activities that reduce the impact of HIV infection
The intermediate package	All of the above plus one or more of the following: • Active case-finding (and treatment) of tuberculosis among HIV-positive people • Preventive therapy for tuberculosis for HIV-positive people • Systemic antifungals for systemic fungal infections (such as cryptococcosis) • Treatment of Kaposi sarcoma • Surgical treatment of cervical cancer • Treatment of extensive herpes with acyclovir • Funding for community activities that reduce the impact of HIV infection
The advanced package	All of the above plus: • Triple antiretroviral therapy • Diagnosis and treatment of opportunistic infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytmegalovirus infection, multiresistant tuberculosis, toxoplasmosis and HIV-associated cancers • Specific public services that reduce the economic and social impacts of HIV, to supplement community efforts that reduce the impact of HIV infection

Source: UNAIDS (2000a). 96-98