

7. THE IMPACT OF HIV/AIDS ON POVERTY AND VULNERABILITY IN ZAMBIA

Margery aged 72, whose son died of AIDS (1996):

It started three years ago. Over these years, we had never had enough food. But before all the deaths and drought, my husband and son had a shoe-making business and we hired laborers to help plough and plant our fields. We used to sell 40 bags of maize in June and July. I was crocheting and making baskets for extra money.

I had eight children; three left and went to town. They never send us money or food. The others stayed: three of them married and left home, my other two sons stayed at home. One of my sons later returned home, but he does not help much because he is mentally ill.

My fifth son, the one working with his father, started getting very weak in 1993. Over time my son's illness grew worse and he was admitted to Monze hospital in 1996. I would walk 15 kms from the hospital to my fields to make sure my crops were growing. I also went to a traditional healer with my son. I tried every treatment available. I was responsible for the farm alone because my husband was also ill and my youngest son injured his leg. All three sons and my husband became my patients. It was very hard.

My son died alone in the hospital in March of last year. I could not come to the hospital before his death because my husband was very ill. My son's body stayed in the mortuary for a few days. My remaining two sons and I removed the doors from our three huts in order to make a coffin. I carried the doors on my head from my home to the hospital. But then the HBC (home-based care) team came to the hospital to find me and help build a coffin. My sons with the help of the HBC driver dug a pit for the burial. My relatives never came to the funeral.

After my son's death, my husband became very depressed and got much weaker. He was sick for another two months then died in June at home. I spent all my savings on the funeral. As my son never got a proper burial at the hospital, I wanted my husband to have a proper one.

One of my daughters passed away soon after her father and she left four children. The children are staying with their father, except for the granddaughter who is staying with me. I want to send her to school but there is no money. I want to send her to Lusaka where we have lots of relatives.

Now I live off begging for food. I am too tired to earn money. My elder son who is mentally disturbed disappears for two weeks at a time. My neighbors never help me look after him. I am always worried he might disappear again. He is unable to work and just sits there talking to himself.

My youngest son and I managed to plant less than a hectare of maize and beans this year. We will use these crops for our own survival. But they are not enough. January and February will be the worst months, we will be without any food supplies. We will eat one meal a day. Perhaps by March we will have some pumpkins to eat, and we will try to get help from neighbors.

Three years ago we were well off. We planted 4-5 hectares of land and had farm animals. Now we have no cattle, no goats, and no chickens. I don't know how I will manage.

Source: case study quoted from "The Impact of HIV/AIDs on Farming Households in the Monze District of Zambia", draft paper by Kate Waller, University of Bath, 1997

Mary aged 70, and her granddaughter Loveness (aged 14 yrs)

Mary was sitting in an open hut warmed by a small fire. She looked thin and tired. She was anxious about her and her granddaughter's persistent poverty and growing hunger. She did not know what they would eat that day.

Mary's husband died of AIDS and she is herself seropositive. Her son also died of AIDS last year, leaving behind her granddaughter Loveness, who is now a double orphan. Loveness' mother died of AIDS several years earlier. Her father remarried and had more children. But the second wife, who is also seropositive, left Mary and Loveness after her husband died.

Mary and Loveness live in a small unkempt grass-roofed hut. They have no cattle or small livestock. They have a small plot of land nearby that Mary's other grandchildren have planted for her. But their mother (Mary's other daughter) is overburdened caring for her own seven children and is unable to provide Mary with financial support because of her husband's debt. He borrowed a large sum of money last year and because they could not pay it back, the credit institution took all their harvest and farming implements.

Mary feels lost and has no energy to maintain her fields. She has no money for fertilizer or to hire laborers. Her granddaughter is currently enrolled in 7th grade but Mary does not have the money to pay for school fees and other costs. She explained "I feel so useless. I used to be very strong and independent, selling my own vegetables and livestock. Now I can do nothing. I am ready to die."

Source: case study quoted from Waller, 1997.

A. Introduction

7.1 Zambia is facing one of the world's most severe HIV/AIDS pandemics. Since the first case of HIV/AIDS was diagnosed in Zambia in 1984, HIV/AIDS prevalence rates have grown to the proportions of a major pandemic. Sixteen percent of all adults are infected with the AIDS virus, and infection rates are particularly high in Zambia's cities and towns: more than 40 percent of urban women in their 30s are HIV-positive. Life expectancy in Zambia has fallen from 51 in 1990 to 37 in 2002 (Chapter 2) and adult mortality rose by 17 percent between 1996 and 2002. The disease has had a devastating impact on the lives of Zambian people and no one is immune from its effects. Despite the widespread suffering cause by the disease, the government has been slow to adequately commit to the fight against HIV/AIDS. This is in contrast to countries like Uganda, where strong leadership from the country's president, allied with civil society, helped to sexual behavior and beat back the disease. Zambia desperately needs a similar commitment from

the nation's political leadership coupled with public health education and other measure designed to reduce transmission and treat those who currently suffer from the disease.

7.2 While the direct effect of HIV/AIDS on its victims is immense, its effects are far more widespread. Victims' families spend enormous time and resources caring for the ill. Following the death of a family member, the household may suffer from the loss of a breadwinner and the burden of paying funeral costs. Orphaned children in particular bear the impact of HIV/AIDS. The consequences do not end there. Zambian society is comprised of a system of overlapping kinship networks whose members are morally obliged to offer each other assistance and support in times of stress. This assistance can include sharing of food and other resources, or daily care for the sick and for orphans. The burden of these obligations has often fallen disproportionately on better-off households in the network. A study of the impact of HIV/AIDS in rural Monze district found that:

On one hand, larger wealthier households...have the human resources to absorb labor shortages, yet because they are seen as wealthier, they also have the highest numbers of ill persons and orphans coming to stay with them. (Waller, 1997)

7.3 Thus, economic damage resulting from HIV/AIDS is not limited to the poor or even to those households with infected members. Wealthier households also suffer economic losses when related households are affected by HIV/AIDS.

7.4 For households whose economic standing already is insecure, the increased dependency ratio and added financial burdens caused by illness and death in related households can push them below the poverty line. If they fully meet their traditional social obligations, then the requirements of HIV/AIDS-affected relatives may drain their savings and render them more vulnerable to impoverishment as a result of any shocks that they themselves might experience. Added to the host of common shocks that have afflicted Zambian households historically, HIV/AIDS threatens not only to prevent many poor households from escaping poverty, but also to propel a number of marginal and insecure households into destitution.

7.5 Ripple effects from the pandemic further undermine the society and threaten the welfare of the next generation. The ranks of both private and public sector professional employees have been decimated by the disease; many teachers and health care personnel in particular have fallen victim. Workers are frequently absent from their jobs to care for sick relatives or to attend funerals. The disease undermines nascent private sector development because firms find long-term planning impossible in the face of high employee mortality rates. Finally, small-scale agriculture production suffers as many families find cultivation limited by the loss of working age individuals. Because of all these effects and the traditional system of inter-locking obligations among families, HIV/AIDS threatens the well-being of the whole of Zambian society.

B. The HIV/AIDS Epidemic

7.6 HIV/AIDS in Zambia is not uniformly distributed across geographic and demographic categories. The evidence suggests that, while males were disproportionately affected during the early phases of the epidemic, the preponderance of new infections now occur among Zambian women; particularly in younger age groups. Only in the cohort aged 40 and above do male prevalence rates equal and exceed female rates. The highest HIV rates among women are found in the 30-34 age group, while the peak for males occurs in the 35-39 age group. This suggests a social pattern in which it is common for older men to have sexual contact with younger women.

The table below displays HIV/AIDS prevalence rates, knowledge levels, and condom use for various age groups, based on the results of the Zambia Demographic and Health Survey (ZDHS):

Table 7.1 Selected HIV/AIDS Indicators for Zambia – 2001/02

Background Characteristic	HIV Prevalence Rate (%)			Knowledge of AIDS (%)		Use of Condoms (Spouse or cohabiting partner) (%)		Use of Condoms (Non-cohabiting partner) (%)	
	Female	Male	Total	Female	Male	Female	Male	Female	Male
Age									
15-19	6.6	1.9	4.6	98.4	94.7	9.5	17.8	28.0	32.5
20-24	16.3	4.4	11.4	99.4	99.4	8.5	16.0	36.0	51.9
25-29	25.1	15.0	20.4	99.6	100.0	6.7	15.0	39.7	46.7
30-39				99.8	99.8	5.1	9.9	31.8	49.3
30-34	29.4	20.5	25.1						
35-39	22.6	22.4	22.5						
40-49				99.3	100.0	2.2	5.3	15.4	40.1
40-44	17.3	20.5	18.9						
45-49	13.6	20.2	16.5						
Residence									
Urban	26.3	19.2	23.1	99.9	99.7	8.2	12.2	45.4	52.1
Rural	12.4	8.9	10.8	98.9	98.0	5.1	8.0	20.4	37.2
Province									
Central	16.8	13.4	15.3	99.8	99.6	6.1	7.5	25.5	44.8
Copperbelt	22.1	17.3	19.9	99.7	98.9	5.1	12.9	41.3	52.8
Eastern	16.1	11.0	13.7	99.4	98.8	6.5	10.5	34.7	54.7
Luapula	13.3	8.6	11.2	99.4	98.9	1.4	1.6	16.7	18.9
Lusaka	25.0	18.7	22.0	100.0	100.0	12.7	15.8	48.2	55.6
Northern	10.0	6.2	8.3	99.1	98.8	6.8	9.7	22.4	47.1
North-Western	8.8	9.5	9.2	99.3	99.6	4.1	6.3	26.6	40.0
Southern	20.2	14.6	17.6	99.4	95.6	3.8	5.5	30.1	33.7
Western	16.9	8.3	13.1	96.5	97.5	6.0	5.7	14.5	23.3
Total	17.8	12.9	15.6	99.3	98.6	6.2	9.5	31.2	44.1

Source: Zambia Demographic and Health Survey, 2001-2002, Central Statistical Office, Central Board of Health Lusaka, Zambia and Measure DHS+, ORC Macro, U.S.A

7.7 As Table 7.1 demonstrates, while knowledge of HIV/AIDS is nearly universal in all age groups, HIV/AIDS-related behavior is less satisfactory, at least as measured by condom use. Use of condoms with cohabiting partners is very low, particularly for women. Even with non-cohabiting partners, condoms are used by less than half of most age categories. Males aged 20-24 use condoms more often (51.9 percent) than do women or men in other age groups. Only 36 percent of females in the same age group do so, however. The finding that fewer females in all age groups use condoms may partially explain the fact that HIV prevalence rates among women have overtaken and begun to surpass those among men.

7.8 In addition, HIV/AIDS rates vary by location. Rates are much higher in the urbanized provinces of Copperbelt and Lusaka, while they are relatively low in the Northern and North-Western provinces. The rate of infection in urban areas is double that of rural areas. The Zambia Demographic and Health Survey (ZDHS) of 2002 found 23 percent of urban residents to be HIV positive. The most severely affected are Zambians who are both urban and female: 26.3 percent of urban women are infected by HIV, according to the ZDHS 2001-2002. In view of the fact that about 38 percent of Zambia's population is urban, the consequences of this soaring infection rate among urban women are difficult to overestimate. Up to 40 percent of the children born to these

HIV positive women will be themselves infected by HIV. The remainder will lose their primary caregiver, probably in early childhood.

C. The Relationship Between Poverty and HIV/AIDS

7.9 The causative relationship between HIV/AIDS and poverty is an ambiguous one. On one hand, it has been observed that, at the global level, “Cross-country evidence indicates a strong statistically significant association between high HIV prevalence and poor socio-economic performance.”⁵⁹ This association is present whether socio-economic performance is measured by per capita income, income inequality, absolute poverty or the UNDP Human Development Index. On the other hand, within Africa itself the opposite pattern prevails. The countries with the highest HIV/AIDS rates within Africa are among the richest

7.10 Similarly, at the individual level, better-off Africans appear to be at greater risk of HIV infection than are the less affluent. One possible explanation of this pattern is that, at least in the early stages of the epidemic, affluent individuals experience higher exposure to HIV/AIDS because they are better able to purchase commercial sex and have greater geographic and social mobility. There are suggestions that, at a later stage of the epidemic, HIV/AIDS rates among the better-off (and particularly the better-educated) begin to level off and decline as a consequence of good access to information and to commodities such as condoms. For example, the documented drop in prevalence among females aged 15-19 during the late 1990s was more pronounced among girls with higher educational attainments. (Loewenson et. al, 2004). HIV prevalence rates among the poor, who may have acquired HIV through contact with the affluent, continue to rise during later phases of the epidemic as a result of poor access to information or, among those with adequate awareness of HIV/AIDS and its modes of transmission, the inability to take appropriate action to protect themselves. (UNAIDS, 2000).

7.11 That poverty maintains and promotes the existence of high-risk groups within society is an inescapable conclusion. It is widely acknowledged that extreme poverty fosters the propensity to engage in high-risk sexual behavior. Many Zambian women are forced into commercial sex by destitution – which often occurs when they lose a breadwinner to chronic illness and death as a result of HIV/AIDS. Since even their regular partners are expected to provide women with gifts of food or money in this society (Zambia MOH, 1999), the line between transactional sex and non-transactional sex may not be clearly drawn among the poor, and hence the slide into commercial sex work under conditions of economic stress may be all too easy. The PVA’s urban participatory study noted that, in urban households, commercial sex work is a common coping mechanism after destabilizing shocks. During a study of street and nightclub-based sex workers in Lusaka (Agha and Nchima, 2001), informants said they resorted to sex work because they could not find formal sector employment due to poor educational qualifications. They described available employment options (such as braiding hair in a salon) as too low-paying to cover basic rent and food costs. These women, then, are exposed to HIV/AIDS, and expose their sexual partners to HIV/AIDS, primarily as a consequence of severe poverty.

7.12 Among disadvantaged men, poverty propels the unemployed towards migratory labor, which is a well-known risk factor for HIV/AIDS. The 2003 Zambia Sexual Behavior Survey found a high level of mobility among the Zambians sampled – during the four weeks preceding the survey, 22.7 percent of women and 16.9 percent of women had spent at least one night away

⁵⁹ Bloom, David E., and Sevilla, Jaypee. Health, wealth, AIDS and poverty. River Path Associates, January 2002. p. 6.

from home. In the year preceding they survey, 18.8 percent of men and 18 percent of women had spent at least one month away from home (CSO, MOH, and MEASURE, 2003). Many of these journeys were undoubtedly associated with the search for temporary or seasonal employment. Men who are separated from their families and in temporary employment situations often go alone or with other men to bars and nightclubs, where they encounter commercial sex workers. Engaging in 'temporary marriages' is also common for people who regularly travel, and the epithet provides an aura of respectability for the women who regularly 'marry' temporary visitors to the area.

7.13 In the formal sector, the largest migrant labor force is the sugar cane cutters, although truck drivers, bus drivers and private sector drivers also form a significant group of formal sector migrant workers. In recognition of their high risk status, active HIV education and STI treatment programs have been aimed at sugar cane workers and truck drivers. Migrant labor, however, is now chiefly in the informal sector (particularly cross-border trading and charcoal selling) where migratory workers are less likely to be reached by HIV/AIDS prevention programs and services. Informal sector workers may also be poorer than those in the formal sector, and low-income men are less likely than others to use their scarce resources to purchase condoms, or to secure medical treatment for sexually transmitted infections (STIs).

7.14 What is more, the constant barrage of shocks and misfortunes that afflict the poor (including the high rate of mortality caused by other diseases) has blunted the popular awareness of and sense of urgency surrounding the problem of HIV/AIDS. Informants who were consulted during the rural participatory study commented that "This is just another disease to us." Although every community agreed that the frequency of economic losses associated with chronic disease and premature death had escalated in recent years, many felt they had much more immediate and pressing worries than HIV/AIDS. The very poorest may be forced to chance exposure to HIV/AIDS (through transactional sex) in order to meet their children's minimum nutritional requirements. An analysis of the conditions that intensify the growth of HIV/AIDS would suggest, then, that when poverty is extreme and shocks are frequent, individuals are poorly motivated to take the steps necessary to protect themselves against HIV infection.

7.15 While poverty fosters exposure to HIV/AIDS at the individual level, it is clear that the existence of a high number of infected individuals in turn exacerbates poverty at the household level, the community level and beyond. Although the primary economic impact of HIV/AIDS is felt at the household level, there is an aggregate impact at the community and national levels, particularly in later stages of the epidemic. First, households may lose their ability to function independently after the death of a breadwinner. According to African tradition, these households are entitled to assistance from within their larger kin groups. They may therefore become a net drain on the resources of related households; particularly when these households are required to absorb orphans who are too young to contribute economically.

7.16 Second, the presence of chronically ill individuals increases the stress on communities by straining the capacities of health services and, in some cases, by fostering a rise in the prevalence of opportunistic infections even among those who are not infected. This is of particular concern with respect to the spread of tuberculosis (TB). Zambia is currently experiencing a TB epidemic, primarily caused by HIV/AIDS. TB is the proximate cause of death of one third of AIDS patients. By increasing the likelihood of exposure to TB for members of the general population, HIV/AIDS may also be responsible for a quarter of all TB deaths among HIV-negative people. (World Bank, 1997) HIV/AIDS, therefore, is increasing the disease burden for both infected and uninfected community members.

7.17 At the national level, HIV/AIDS poses a clear obstacle to strong economic growth and poverty reduction strategies, first by decimating the skilled labor force and second, by straining public services. Because the affluent and better-educated are at higher risk during the early phase of the epidemic, a large number of public servants and health professionals may already have been removed from the labor force as a result of HIV/AIDS by the time that the need for services rises significantly among the poor. UNDP reports that, in Malawi and Zambia, health care personnel have been reduced by a five-to-six-fold increase in illness and death rates. (UNDP, 2001) In the private sector, profit margins will suffer losses as a result of higher absenteeism and turn-over (including increased training and recruitment costs). Among smallholder agriculturalists, the acreage under cultivation is likely to be limited by the loss of able-bodied laborers. For these and other reasons, UNDP has concluded that “In much of Africa and other affected regions, the epidemic will prove to be the biggest single obstacle to reaching national poverty reduction targets and the development goals agreed on at the United Nations Millennium Summit.” (UNDP, 2001)

D. Poverty and Vulnerability in Zambia

7.18 Zambia is one of the world’s poorest countries. The 2003 Human Development Report ranks Zambia’s Human Development Index at 163 out of a total of 175 countries. Results of the 2002-2003 Living Conditions Monitoring Survey (LCMS) indicate that approximately 56 percent of the population is existing at a level of consumption that is below the poverty line, while 36 percent fall below an even lower “core poverty” line. Zambia’s HDI is reported to have declined from 0.448 in 1975 to 0.427 currently; and its GDP per capita fell by 1.5 percent between 1991 and 2002. This decline is in part a consequence of lack of diversification and over-dependency on the copper mining industry during the post-independence period. The collapse of the copper industry after the 1970s led to a dramatic rise in unemployment and a general decline in economic well-being, both at the macro and household levels. This parallels the period in which the HIV/AIDS epidemic took hold and began growing to crisis levels.

7.19 Global comparisons have led some analysts to conclude that, although the relationship between poverty and HIV/AIDS is ambiguous at the level of the individual as noted above, at the societal level there is likely to be a mutually reinforcing cycle of causation between the growth of poverty and increases in the prevalence of HIV/AIDS. If so, then the rise of poverty attendant upon the failure of the copper industry may have been one of several factors that have pushed HIV/AIDS rates to their current levels. High rates of HIV/AIDS, in turn, constitute one of the barriers Zambia is confronting in its attempts to achieve sustainable growth and improve household incomes among the poor and vulnerable.

7.20 The HIV/AIDS crisis, which is now entering its third decade, thus presents a major challenge to poverty reduction strategies developed by government, donors and international agencies. Drawing on existing information and on qualitative studies of rural and urban poverty carried out in 2004, this paper will examine the contribution of HIV/AIDS to poverty and vulnerability in Zambia. It assumes that poverty is a complex and multi-faceted phenomenon that encompasses various types of deprivation in addition to income and consumption poverty. It will therefore examine the role of the HIV/AIDS epidemic in supporting or exacerbating three essential components of poverty: *poverty of private assets, poverty of access to public goods and services, and poverty of social relationships.*

7.21 Poverty may be defined as an unacceptable level of deprivation. There are many components to deprivation, however. These components can be grouped into two broad

categories: 1) low incomes and inadequate consumption, and 2) deprivation of human capital and capabilities in terms of skills, education, health, and nutrition. Material and human capital deprivations are closely related, in that material poverty undercuts the household's capacity to develop and utilize human capabilities, while lack of human capital is a prime barrier to securing employment or other means of accumulating material wealth. Households with little access to public services (clean water, sanitation, education and health care services) suffer an added disadvantage, since effective basic services provided by government can compensate for the inability of the poor to purchase these services. What is more, material and human capital deficiencies are often compounded by social deprivations. An economically disadvantaged household is under greater strain when it suffers from discrimination, social exclusion or insufficient social capital (i.e. a lack of useful relationships of mutual assistance).

7.22 During the 2004 Zambia Rural Poverty and Vulnerability Study, the various dimensions of poverty were examined at the community and household levels using a set of qualitative methods and instruments. These interviews, discussions, and exercises revealed that, because chronic illness of or loss of a breadwinner is one of the most serious and common shocks that affect poor households, there is a clear relationship between high HIV/AIDS rates and poverty for many individuals and households. In addition, both government and traditional informal safety nets and services are under strain due to the increase in demand, and they are threatening to fail in their role of providing both emergency and routine assistance to impoverished Zambians.

HIV/AIDS and Poverty of Private Assets

Material Deprivation

7.23 The centrality of material deprivation as the fundamental factor in poverty was underlined during discussions with rural Zambians. When asked to rank the village population into categories based on relative wealth, Zambian informants in the rural qualitative poverty and vulnerability study generally cited various aspects of material deprivation as definitive of the very poor. Food insecurity and malnutrition were described as the most important indicators of extreme poverty, and paucity of clothing, bedding, stored grain and livestock were also mentioned as key characteristics of the very poor. In the companion urban study, although inability to send children to school was also mentioned, the household's inability to eat more than one meal a day was viewed as a clear sign of extreme poverty. In both rural and urban settings, then, failure to meet basic nutritional requirements was described as the key defining characteristic of extremely poor households.

7.24 In consultations with urban informants, they identified households headed by orphans, elders, widows and the terminally ill or disabled as the poorest and most vulnerable. While a wide variety of factors were advanced to explain the differences in economic standing between the poor and the better off in the rural areas, rural informants commented that the very poorest were often the "new poor"—which include households that have lost a breadwinner or are elder- or female-headed as a result of HIV/AIDS or other diseases, as well as individuals returning to their natal villages for care because they are chronically ill from TB or active AIDS. These households are the most disadvantaged because they have simultaneously suffered losses in both of the essential components of economic well-being: material and human capital. The incomes and material assets of these households are rapidly depleted because they experience loss of earnings, while expenditures are simultaneously increasing due to high treatment costs incurred for drugs, transport and hospital user fees. UNDP estimates that the incomes of AIDS-affected households can be reduced by up to 80 percent; and a 1999 study of AIDS orphans reported that, for 2/3 of

Zambian households that have suffered paternal death, disposable income fell by 80 percent in the first year alone. (Serpell, 1999)

7.25 When income-earners are incapacitated and household expenses have burgeoned, poor households quickly exhaust any savings and stored foodstuffs they managed to accumulate before illness struck them. Once this has occurred, the second-line coping strategy is usually to sell any material assets the household may possess, in order to meet immediate consumption needs and to purchase medicines for the ill family member. In the case of the poorest, this is not an option since they have no saleable assets. In slightly better-off households, items such as metal roofs, bicycles and livestock are likely to be sold off.

7.26 The emergency sale of household assets is a significant threat to the ultimate viability of the household. The sale of livestock is particularly likely to damage the household's long-term economic well-being. The loss of an animal may remove the household's access to plough cultivation if the lost animal is a draught animal. Because households rely on the sale of smaller livestock to see them through periods of food shortage, the loss of any domestic animal is perceived to be actually life-threatening by members of very poor households. At the very least, the household has lost a productive asset when a breeding animal must be sold to support shortfalls in consumption. Sale of a bicycle may also remove a productive asset from the household, since bicycles may be used to access centers of employment or, more commonly, markets where horticultural surpluses can be sold. The decimation of household assets in response to chronic illness or death can lead the household into a downward spiral from which it may be unable to recover.

Deprivation of human resources

7.27 The elements of human capital – particularly good health and higher education – are benefits in themselves that should be pursued and supported on humanitarian grounds. In addition, however, good health, education, and work-related skills also function as productive assets that can improve the capacity of the individual to earn income and accumulate wealth. The productive asset that impoverished households can least afford to lose, in fact, is its capacity to labor. Physical labor may be the only private asset that is possessed by the very poor. Labor may also constitute the household's main coping mechanism during shocks. Rural informants stated that, during economic emergencies caused by drought, crop failure, etc., a common coping strategy among the very poor is to seek employment as casual agricultural day laborers in the fields of well-off households (called *ganyu* labor). These opportunities are available only in the peak growing seasons, however, and what is more, this strategy is not available to many AIDS-affected households. The household member living with HIV/AIDS – usually an adult in the most productive age group – will pass through an extended period in which s/he is not only too ill to provide physical labor but also requires constant physical care. A study of the impact of HIV/AIDS on livelihoods found that this period averaged 19.1 months in female-headed households and 15.5 months in households that are male-headed. (Development Cooperation Ireland, FAO, and GRZ)

7.28 During this period, other household members will be compelled to provide full-time care to the person living with HIV/AIDS in the household. In almost every case, the caregiving burden falls primarily upon girls and women. Even under normal conditions, women work longer hours in both the home and the agricultural fields than do men. (Araki, 1996) When women face the added responsibility of providing full-time nursing care to a chronically ill family member over a period of several months, their ability to carry out these routine duties – which include tasks essential to successful cultivation -- is seriously undermined. In the worst case, all adult

labor of the household is absorbed by the crisis. This is a catastrophe for the poor household. The better-off are also likely to lose ground economically when affected by HIV/AIDS, but they can compensate for the loss of productive household labor by hiring *ganyu* labor as needed. In consequence, the better-off can continue to cultivate and produce food while caring for the chronically ill – but the AIDS-affected poor may be forced to leave their fields uncultivated and unproductive. Some households have left crops unharvested because the only healthy adult – a woman – was busy providing nursing care for a family member in the last stages of HIV/AIDS. In some households, older children are withdrawn from school to compensate for the loss of adult labor. Since women share caregiving and other tasks among themselves, teenaged girls may curtail their education in order to assist (or to serve as) the primary caregiver.

7.29 In its analysis of the causes of poverty at the household level, the rural participatory study concluded that the primary obstacles faced by various impoverished households differ, and that the same assistance strategy will not work for all. Although production in most small-holder households is constrained by lack of agricultural inputs or water, there is a distinct subset of poor households whose greatest constraint is lack of labor. Most of these labor-deficient households have lost productive adult members to fatal illnesses such as HIV/AIDS, and many are headed by the elderly or by mothers of small children. They are likely to be food-deficient, particularly if there is no healthy adult capable of cultivation within the household. These labor deficient households will not be able to benefit from poverty reduction or agricultural improvement programs aimed at improving access to inputs or irrigation; or from other programs that require physical labor, such as food for work (FFW).

7.30 In addition to losing productive labor in the short-term, HIV/AIDS-affected households may also suffer from the lowering of its human capital stocks in the future. There is pressure on overcrowded Zambian schools to meet the needs of a growing population; and children affected by HIV/AIDS may be poorly positioned and under-motivated to compete for scarce spaces in these schools. Even though user fees for primary education have been removed, households confront educational expenses in the form of school supplies, transport and, in some areas, PTA fees. At the secondary level, school attendance entails both the payment of fees and an opportunity cost to the extent that it absorbs the time of a household member who could otherwise earn income for the household. When the household is under stress as a result of chronic illness or the death of a breadwinner, therefore, one or more children may be withdrawn from school as a coping mechanism. This is especially likely to occur when there is no physically able adult left in the household, and older children are the only household members who are capable of physical labor. In this connection, a recent study concluded that HIV/AIDS would significantly reduce Africa's supply of human capital:

The epidemic will have this effect not only from the supply side by reducing the capacity of the educational system to train the next generation, but also from the demand side by making investments in schooling less attractive by foreshortening time horizons and increasing the opportunity costs of children's time. These effects will slow the rate of Africa's accumulation of human capital.⁶⁰

When the HIV/AIDS epidemic touches an already-poor household, it may halt the household's efforts to improve its human capital resources through education.

⁶⁰ Hamoudi, Amar and Nancy Birdsall. AIDS and the Accumulation and Utilization of Human Capital in Africa. Presentation at the 2001 meeting of the African Economics Research Consortium, Nairobi, Dec. 2001.

7.31 Although the evidence is mixed, the education horizons of low-income children whose parents have died are particularly likely to be lowered. A World Bank study on educational targeting in 28 countries reports that, although the greatest differentials in school attendance are found between poor and non-poor children, nevertheless orphans are less likely to attend school in both the highest and lowest income groups. The orphan effect was found to be particularly strong among the poorest 40 percent of the population. (Ainsworth and Filmer, 2002) Analyses done specifically for Zambia (Chapter 5) show similar patterns for orphans living in lower income households, and moreover find that girls and double orphans are particularly at risk of low school attendance. Low-income orphans, then, are disadvantaged in the competition for scarce educational resources. The higher propensity of orphans to withdraw from school could have a number of explanations, including grief and emotional turmoil. It is likely, however, that the poorest orphans are either without adult support or are under the care of equally poor relatives: many live with elderly grandparents, who not only look after their orphaned grandchildren, but manage without the support traditionally provided by their own (grown) children. These low-income caregiver households may be unable to support orphaned children beyond the provision of the basic food and clothing that are required for survival. Under these circumstances, the human capital resources of these orphans are likely to be limited lifelong to unskilled physical labor. Manual labor, particularly when it is casual agricultural labor, usually provides the lowest returns of any type of work. Low-income children who lose their parents to the epidemic, therefore, have poor prospects for escaping poverty during adulthood.

HIV/AIDS and Poverty of Access to Public Goods and Services

7.32 It is usually a challenge for essential public services to keep pace with the growth of public needs in developing countries, due to the fact that populations are increasing faster than the revenues available for collection by government. In a country heavily affected by the HIV/AIDS epidemic, this problem intensifies dramatically. As is the case at the household level, HIV/AIDS poses a double and self-reinforcing problem for governments: AIDS-related increases in morbidity and mortality push up the demand for services (particularly health services) while they simultaneously reduce the supply of public servants and professionals who are trained and available to meet these escalating needs. Because better-off households can normally turn to costly private services when public services prove inadequate, the impact of failing public services is felt primarily by the poor.

Health Services

7.33 The most obvious strain on public services occurs through the stress placed on the health system by opportunistic infections associated with the deterioration of persons living with HIV/AIDS immune systems. In 1996, it was reported that 25 percent of the Zambian population was sick within any given two week period; that 10 percent of the population was chronically ill; and that 23 percent of the sick receive no treatment from any source. (Diop, Sheshaani, and Mulenga, 1997) This suggests that access to health services was poor at that time; and levels of chronic illness may have increased in the period since. A 2003 survey in four zones of Zambia found that 29.7 percent of the sample households included at least one chronically ill person. (CARE International, Catholic Relief Services, and World Vision, 2003) Particularly alarming is the resurgence and rapid spread of TB as a consequence of HIV/AIDS. The MOH/CBOH (1999) reported a five-fold increase in TB between the advent of the AIDS epidemic and 1996. Although HIV/AIDS cannot be transmitted by casual contact, TB can be. As a result, the TB epidemic may spread even faster than has the HIV/AIDS epidemic – particularly among the lowest income groups, who are more likely to go untreated for longer periods. What is more,

antibiotic-resistant strains of TB are now appearing in Africa as a result of incomplete or insufficient drug treatment.

7.34 The loss of health care personnel to illness is only one aspect of the human services dilemma. Because the health system is poorly funded, skilled personnel are underpaid and easily persuaded to relocate to developed countries with far better pay scales. Although Zambia's schools of nursing are still training more nurses than are being lost, the number of qualified physicians in Zambia is dropping. The supply of physicians (as well as nurses, technicians and other skilled health workers) is under strain as a result of the "brain drain" that affects most poor countries. The problem is compounded, however, by the loss of health workers to HIV/AIDS.

7.35 Even if it is able to maintain current staffing levels, however, the health system's ability to respond to the crisis will be far below optimal. If it is to move beyond a purely defensive response to the epidemic, the health system must do more than treat opportunistic infections as they arise. To make inroads against the spread of HIV/AIDS, a number of additional services must be put in place. These include intensified HIV/AIDS prevention initiatives, voluntary counseling and testing (VCT), the prevention of mother-to-child-transmission (PMTCT), and anti-retroviral (ARV) therapy. The government of Zambia is offering these services in a few pilot sites throughout the country, but scaling them up to the national level will require a significant increase in drugs, personnel and other resources.

7.36 Although the bulk of the required drugs and reagents may be supplied by external donors, the additional personnel and staff time burden will fall upon the health system. A study (University Research Company, 2004) of the health system personnel requirements for scaling up these services has recently been implemented. The report noted that delivery of many HIV/AIDS services relies on midwives and laboratory technicians; and that qualified staff in both of these categories are in extremely short supply. What is more, the quality of existing services is questionable, and supervision is weak to nonexistent at many of these sites. Looking to the future, the researchers estimate that, depending on the level of scale-up anticipated, either 379 or 573 full-time positions will need to be created and staffed. Under the higher scale-up scenario, the annual salary cost of these additional positions would be US \$1.3 million – a significant challenge to a health system that is not only poorly funded but is also losing personnel to the epidemic on an ongoing basis.

7.37 Ensuring that health care services are fully staffed is not the only challenge facing the health system, however. Even if the government health system is able to find the resources to respond adequately to the needs of low-income PLWHA, there is evidence that resources alone will not provide the needed care. A study of HIV/AIDS-related stigma in several countries found that, in Zambia, the most extreme forms of discrimination and stigmatization of HIV/AIDS sufferers occurred in health care settings:

This included denial of drugs and treatment; being left in the corridor; being dealt with last; being labeled or called names; being subjected to degrading treatment and breaches of confidentiality. Care providers themselves claimed they found patients with HIV/AIDS more difficult because of their multiple infections, their "hysteria," their "attention seeking" and their "many thoughts" (i.e. the need for psychological as well as medical support). They also admitted that HIV/AIDS patients were often not given the same services because doctors know they are going to die and, therefore, spent less time on them.⁶¹

⁶¹ Stigma, HIV/AIDS and prevention of mother-to-child transmission: A pilot study in Zambia, India, Ukraine and Burkina Faso. The Panos Institute, London, and UNICEF.

7.38 One of the study's Southern Province informants had witnessed an incident in which an HIV/AIDS patient had been left outside the hospital in a wheel chair, where he was taunted by health workers and deprived of food because health workers did not want to clean him of excrement. Clearly, most government health workers do not have the training or support necessary to provide acceptable care for people living with HIV/AIDS. They have not been trained to cope with HIV/AIDS, they are overworked due to the increased disease burden, and many of them fear their medical duties will expose them to infection. For low-income and impoverished PLWHA, there is little or no possibility of accessing private sector health care services as an alternative. Tabulations of the results of the 2002-2003 LCMS reveal that government health care providers were consulted most often by members of all income quintiles. The better off, however, more often utilized government hospitals, while the lower income quintiles used government clinics. Of those utilizing private health care institutions, most were in the highest two income quintiles. Government clinics and home care (including self-medication, which is common among the poor) are usually the only options for the poor. The poor, therefore, suffer diminished access to public health care services when they are afflicted with HIV/AIDS -- caused at least in part by discrimination and stigma within the government health system.

Educational Services

7.39 Access to and quality of education for low-income households is deteriorating as a consequence of HIV/AIDS. This decline is a result of the diversion of public sector resources to the health sector and other sectors that are coping directly with the epidemic, plus the reduction in force among personnel in the education sector itself. For reasons that are not entirely clear, educators appear to constitute a high-risk group in some countries of southern Africa. The World Bank has estimated that mortality rates among Zambian teachers are 70 percent above those in the population at large. (World Development Indicators, 2001) The number of trained teachers in Zambia is declining, therefore, at a time when the number of students is growing due to increases in population. Based on CSO projections, the rate of growth among the school-aged population is expected to remain around 2.1 percent per year during the 2000-2007 period.

7.40 What is more, the many demands upon the federal budget have made it difficult to hire or replace teachers. The task of training a large number of teachers to replace those lost to HIV/AIDS will be costly; and in addition, the supply of personnel qualified to train the next generation will also be reduced by the epidemic. This dilemma is an instance of a larger pattern, whereby "By skimming off the most skilled workers in the economy (at least in the first wave), HIV/AIDS threatens to forestall the emergence of a critical mass of the more skilled workers."⁶²

7.41 The MOH/CBOH (1999) has predicted that the HIV/AIDS epidemic will have the following impacts on education in Zambia:

- Reduction in the number of trained teachers
- Increased teacher absenteeism
- Reduction in the number of education officers
- Reduced public finance for schools
- Reduced family resources for schooling
- Fewer children, especially girls, able to attend school or afford education
- Fewer children able to complete schooling

⁶² Hamoudi and Birdsall, 2001. p. 27.

- More orphans with less access

7.42 Even in schools that are fully staffed, teacher absenteeism caused by HIV/AIDS can have a negative impact on learning. A 2002 survey of education and service delivery in Zambia (Das, 2004) revealed that absenteeism is high – 17 percent of all teachers were found to be absent during random checks; and teachers who were absent for personal reasons lost an average of 3 days of work each time. The same study found that frequent negative shocks to teachers had a negative impact on student learning, at least among students who remained with the same teacher for two or more subsequent years (a common practice in the Zambian educational system.)

7.43 Although the education of all Zambian children other than the wealthiest will suffer as a result of the impacts of HIV/AIDS, some of them affect the poor disproportionately. Fewer poor children will complete school when their parents are chronically ill or deceased, because the loss of adult labor and the high price of treatment has placed school supplies or secondary education fees beyond the economic reach of their households. Some of these children will be withdrawn from school to earn an income in compensation for the lost earnings of chronically ill adults. Girl children in particular are likely to drop out of school when a family member (particularly the mother) is ill, since home care of the sick and disabled is traditionally the task of girls and women. Orphans living in low-income households are more likely to withdraw from school because the household caregivers may be unable to support both the subsistence and educational expenses of additional children. What is more, they may be unwilling to educate the orphan (usually a niece or nephew) at the expense of their own children. The access of many impoverished children to educational services, already lower than that of well-off children, is therefore likely to diminish further when they are affected by HIV/AIDS.

HIV/AIDS and Poverty of Social Relationships

Weakening of the Extended Family Welfare System

7.44 As in many other countries of southern Africa, Zambian society is characterized by an ethic of economic equality, particularly among kin group members. A number of social traditions and practices – such as communal meals and voluntary labor-sharing -- have an equalizing function, but most common among them is the expectation that better-off households will share “excess” resources with other extended family households that are in acute need.

7.45 This is an effective safety net during periods in which the kin group is prosperous. Its effectiveness, however, relies on the ability of some households to achieve surplus production that can be diverted to a smaller number of deficit households during shocks or shortfalls. The results of the rural participatory study indicate that this system is now under serious strain, and in some cases is unable to meet the needs of the most impoverished. The 2004 OVC Situation Analysis found that extended family obligations were “narrowing” in a variety of ways:

The first “narrowing” is the increased emphasis on close family, and blood relatives. People are increasingly likely to offer care to children only when they are directly related to them, and for married households only where the relationship is through the wife. Women in particular appear to be more and more reluctant to offer care to children unless they are their own, or their

*immediate brother's or sister's children – this reluctance even extends to caring for the previous children in a new marriage.*⁶³

7.46 A second type of narrowing was observed in so far as the richest Zambian households appear to be distancing themselves from their extended families. While middle-income households still attempt to meet their extended family obligations in so far as is possible, the wealthiest are now less likely than formerly to accept indigent orphans and remnants of AIDS-affected households, even when these are close kin.

7.47 Rural PVA Study informants commonly attributed the erosion of the traditional family support network to a generalized increase in poverty – extended family members were said to have fewer resources to spare for relatives experiencing economic stress. However, although national statistics indicate that poverty may have increased slightly in recent years, the increase has not been dramatic enough to bring about a significant social transformation. HIV/AIDS, on the other hand has increased significantly in both urban and rural settings. Chronic illness and death of male breadwinners has left a growing number of households with no adult other than a mother or grandmother. These households were described as among the most impoverished in the villages; and they are almost by definition deficit households in the extended family redistribution context.

7.48 What is worse, if one parent dies of AIDS, it is likely that before death he/she will have transmitted the infection to the other parent. The household will then be left with no adult in charge. Very large families are the norm in Zambia; and so some who die leave behind as many as 6-8 children. These children must be absorbed by other (extended family) households that may already be supporting an equal number of children of their own. Providing for the food, clothing and educational expenses of these additional children can have an impoverishing impact on economically precarious households. If several households within a kin group have lost breadwinners, then the capacity of the group to serve as a safety net is certain to be further eroded. In the words of the MOH/CBOH, “This surge in the number of orphans comes at a time when the traditional roles of the extended family have already been breaking down with urbanization and prolonged economic pressures.”⁶⁴

7.49 The rise of single-parent households has led to a partial breakdown of traditional gender roles in rural settings. When their husbands are ill or have died, women are forced to take on the rougher work and heavy labor that is normally reserved for men. These tasks usually include clearing fields for cultivation, re-thatching the roof of the house, building animal pens or other outbuildings, etc. A woman who is caring for a chronically ill person or small children faces an escalating challenge when she must assume these additional tasks. In some cases, even necessary work is neglected due to an absolute labor shortage in the household.

7.50 While freedom and flexibility in assigned gender roles may be desirable, the practical outcome of the decline of gender-specific tasks is often that a widowed or deserted mother will be required to assume the heavy labor of absent men in addition to her own traditional tasks. On the other hand, the dissolution of traditional gender roles may ease the burden of women in a family with adult males. In 2004, when rural focus group participants were asked whether men or

⁶³ Harland, Charlotte. Orphans and Vulnerable Children in Zambia: 2004 Situation Analysis. Summary Report. GRZ: Ministry of Sport, Youth and Child Development. December 2004. p. 13.

⁶⁴ Ministry of Health/Central Board of Health, 1999, p. 35.

women should be responsible for common agricultural tasks (many of which were known through the ethnographic literature to be traditionally gender-specific), they unanimously responded that the entire household would share responsibility for all agricultural tasks. In a few cases, men have been found caring for small children and/or nursing sick wives – in clear violation of traditional gender role expectations. This was reportedly due to the fact that, with increasing illness burdens in so many households, there may be no appropriate caregiver (a female relative) who is free to provide care. In most cases of maternal disability or death, however, it is the children who assume the tasks, such as cooking, drawing water, and processing cassava and millet, which would otherwise be undertaken by an adult female. Since the epidemic infected men disproportionately in its early stages, however, the greater number of existing single-parent households are headed by female rather than male parents.

7.51 Informants commented that the rural widow is now less likely to remarry than in the past. A number of explanations were offered, most of them related to the rise of HIV/AIDS:

- Because more men were infected in the epidemic's early phase, there is now a shortage of men (HIV infection rates have since risen more rapidly among females than among males).
- Widows are now less attractive as wives because prospective mates are aware that the deceased husbands may have died of AIDS.
- Polygamy is also on the decline, for economic reasons and from fear of HIV/AIDS.
- Inheritance of the widow by her deceased husband's brother (levirate) is a traditional practice that once served the function of ensuring that surviving dependents would continue to have a social and economic position within the extended family of the deceased. This practice is now thought to be conducive to the spread of HIV/AIDS; and so it is being discouraged by traditional leaders at the behest of the GRZ and international organizations.
- A growing number of men have abandoned their families because they feel unable to meet the responsibilities of a breadwinner.

7.52 Low-income widows, therefore, now have no assurance that they will ever find a second partner or breadwinner. Women in matrilineal social systems (which are characteristic of many of Zambia's tribal groups) could once rely on their brothers and other matrilineal kin as an emergency back-up support system throughout life. Now, matrilineal systems of inheritance are breaking down, in part because of legislation aimed at protecting the property rights of widows and children. Under traditional matrilineal inheritance systems, a deceased man's goods and lands are expected to be distributed among his sisters' children rather than to his own. The HIV/AIDS epidemic and equal rights campaigns have drawn national and international attention to these traditions; and they have been interpreted as a form of "property grabbing" that disinherits orphans and widows.

7.53 Zambia has therefore created legislation that protects the widow and orphan from loss of goods and property upon the death of their male breadwinner. In all villages visited by the rural participatory study teams, villagers asserted they are obeying the new legislation. The legal system of inheritance may protect the widow from being disinherited, but it effectively relieves her brothers of the responsibility of providing a lifelong safety net. The danger is that some widows and orphans will fall between the two systems – deprived of the husband's property on the basis of matrilineal traditions, while being rejected by the brother on the basis of modernity. The breakdown of traditional social practices that once provided safety nets for widows and orphans may be occurring independently of HIV/AIDS to some extent. Nevertheless, there is

strong evidence that fear of HIV infection and HIV/AIDS stigma are certainly contributing factors.

Stigma and Discrimination Associated with HIV/AIDS

7.54 One of the most pernicious and persistent aspects of the social response to HIV/AIDS worldwide is the continuing HIV/AIDS stigma problem. Contempt for and avoidance of people living with HIV/AIDS are common to virtually every country affected by the epidemic. These attitudes are linked to discrimination in hiring, promotion, educational access and even access to good health care. In addition, HIV/AIDS stigma and discrimination can damage social capital networks. The common tendency to stigmatize and avoid HIV-positive family members, neighbors and friends can undermine the willingness of the household and extended family systems to provide traditional economic safety nets for members who are in distress.

7.55 In Zambia, HIV/AIDS stigma is a surprisingly persistent phenomenon, in view of the fact that nearly every family has been affected at some level by the epidemic. It appears to be a complex system of fears and attitudes, including the fear of contamination or infection, the fear of death, and unfavorable views of the types of behavior that are thought to cause HIV infection. In Zambia, the latter are particularly important. A 2001 study of HIV/AIDS stigma in four countries (UNICEF and Panos Institute, 2001) notes that in rural Zambia, the discourse on HIV/AIDS is dominated by blame and condemnation. It is assumed that HIV/AIDS is transmitted only through promiscuous or inappropriate sexual behavior; and the study notes that it is common for the blame for HIV/AIDS to be placed on women rather than men. Because of the near-universal stigmatization of people living with HIV/AIDS, most sufferers take advantage of the fact that lingering, degenerative illnesses are commonly thought to be caused by witchcraft. Victims of witchcraft are not socially condemned, and there is no shame associated with chronic illness if it is supernaturally caused. Households will claim that that a person living with HIV/AIDS is a victim of witchcraft, therefore, even if they suspect HIV/AIDS. They may even continue to visit traditional healers (perhaps wasting scarce household resources in doing so) to demonstrate their conviction that the cause of illness is witchcraft, not HIV/AIDS.

7.56 Although HIV/AIDS stigma and discrimination may be best documented at the health system level, there is evidence that people living with HIV/AIDS also encounter neglect and disdain within their communities and households. Household and community members may have heard HIV/AIDS information messages assuring them that HIV cannot be transmitted by casual contact, but the behavior of many caregivers and household members demonstrates that they are not convinced. Persons infected with the virus have reported being forced to stay physically distant from other household members or relatives, and having to eat alone using a separate spoon, cup, and plate that no other family member will touch. Chronically ill people living with HIV/AIDS have also commented that they have lost the respect of other family members by virtue of being unable to participate in the exchange of labor and favors that constitutes and maintains the household and extended family network. Commitment to the social obligation of assisting and caring for a chronically ill relative may be undermined by the knowledge that the HIV/AIDS sufferer will be never be able to reciprocate or return the contributions and services rendered.

7.57 In some urban communities, NGOs and CBOs and are attempting to fill the gap. The urban participatory study describes a wide range of urban community groups and organizations that have sprung up in response to the AIDS crisis. Many of them offer home-based care to AIDS victims and their families, while others organize support groups for widows and HIV/AIDS-affected children, or establish income-generating activities. Some of these activities

are under the leadership of NGOs, some are church-based, and some have developed spontaneously. These small programs cannot be expected to meet the needs of the majority of people living with HIV/AIDS, however. They lack the resources that would be required to significantly expand their operations and reach a larger proportion of AIDS-affected households. What is more, rural communities remain largely uncovered by these initiatives, since rural CBOs do not appear to be developing in response to the rising level of assistance needs associated with HIV/AIDS. The need for home-based care and orphan support groups may be lower in rural areas, however, because the rural HIV prevalence rate is lower and because there may be more extended family members on the scene to provide care and assistance.

7.58 The burden of HIV/AIDS stigma and discrimination also falls upon the children of people living with HIV/AIDS. Even before the death of their parent(s), children of the chronically ill may be taunted and socially excluded if the community has begun to suspect that the parent's illness is caused by HIV/AIDS. HIV/AIDS orphans often are isolated or bullied at school, which may increase their propensity to drop out early. What is more, relatives may be less willing to undertake responsibility for the child if they fear he/she is HIV-positive; since many fear even casual contact with AIDS victims. A small minority of those who have been accepted by extended family relatives have found that they are neglected, discriminated against or abused in their new homes. This is particularly likely if the caregiving household is economically insecure or low income, since providing for the additional child may be resented as an insupportable burden.

7.59 Most caregiving households do make an effort to provide adequate physical and psychosocial care for the orphan. Nevertheless, many of these orphans have been removed from a familiar setting – there is evidence that many urban orphans are sent to rural relatives for care⁶⁵ -- and separated from their siblings. They are vulnerable to displacement, discrimination and social isolation at a time when their need for economic and psycho-social support is at an all-time high. What is more, children who have lost their mothers have lost an important champion and guardian of their rights. A study of educational services and expenditures in Zambia found that significantly less was spent on the schooling of children who had lost their mothers, while no differences were found between spending on children who had lost their fathers and spending on non-orphans – despite the fact that paternal orphans live in households that are poorer than others, while maternal orphans' households are no poorer than the average. (Das, 2004) In safeguarding educational expenditures for children affected by HIV/AIDS, then, the presence of the mother appears to compensate to some extent for the loss of income incumbent upon loss of the father.

E. The Institutional Response to HIV/AIDS

7.60 By the time that the HIV virus was identified as the cause of AIDS, it had already taken a firm foot-hold in Zambia. Once the magnitude of the problem was recognized, the national response to HIV/AIDS was quickly established in the 1980s. The GRZ has attempted to work in coordination with civil society in its approach to HIV/AIDS control and mitigation. The 1990s saw a significant increase in NGO, CBO and civil society participation in issues concerning HIV/AIDS, to complement the National AIDS Control Program introduced by government. Several NGOs and missions were instrumental in identifying strategies for working with HIV/AIDS, developing home based care programs and community education, and promoting basic knowledge and behavior change. Organizations representing people living with HIV/AIDS

⁶⁵ Second Situation Analysis of Orphans and Vulnerable Children in Zambia.

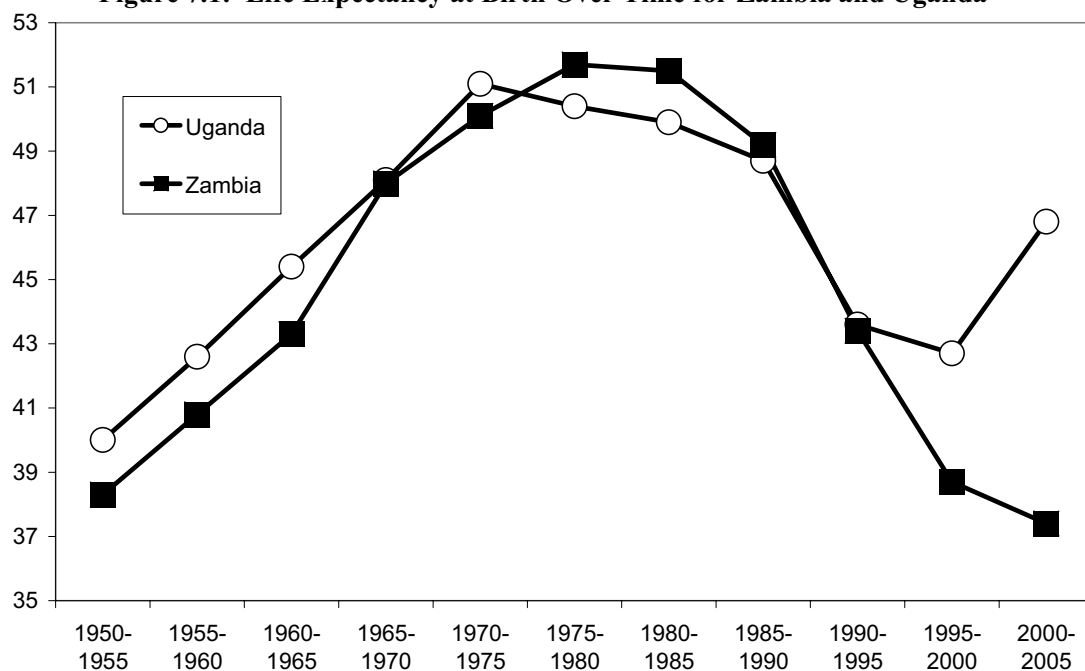
emerged, and issues of HIV/AIDS became mainstreamed into many areas of Government, the media, the private sector, the churches and the traditional authorities.

7.61 Since 2000, two significant global initiatives, the 3-Ones and the 3-by-5 agreements, have amplified the national response. The 3-Ones, that promotes “one plan, one channel, one monitoring system”, encouraged the establishment of the Zambian National AIDS Council in 2001. The NAC was intended to provide a coordinating body for a stronger and more effective response to HIV/AIDS. However, its establishment was heavily donor-driven, and its performance has been hampered by under-staffing, under-funding and a lack of political commitment to its goals. The 3-by-5 initiative, which aims to provide ARVs to 3 million people world wide by the end of 2005, includes a target of 100,000 people in Zambia. Significant additional external funding has become available to support this, and ARVs are increasingly becoming available on an affordable basis, at least in urban areas.

7.62 The National HIV/AIDS/STI/TB Intervention Strategic Plan (NAISP) 2002-2005 was developed by the NAC to address issues of prevention, mitigation and care, as well as the social and economic impacts of the epidemic. A new NAISP will be developed for the period 2006-2010, supplemented by specific sub-sectoral strategies focusing on specific areas of response. Since its creation, however, the NAISP has not provided significant guidance for the national response. This apparent failure is rooted in the extremely comprehensive nature of the plan, which provides broad goals without specifying which actors should assume responsibility for its various components. It is thus a very passive plan; it does not make any clear commitments to prioritized and achievable objectives, nor does it include an explicit workplan with identified resources. The plan has failed to provide a firm framework to guide stakeholders, and has left NAC in a weak position to lead the response to HIV/AIDS.

7.63 The institutional response to HIV/AIDS in Uganda provides a marked contrast to what has occurred in Zambia. In Uganda, the government responded quickly and forcefully to the epidemic at a relatively early stage. The government’s approach has been characterized by openness, and honest discussion of the causes of HIV. In 1986, the year the Ugandan government acknowledged the presence of HIV in the country, the nation’s president toured the country and told people that it was their patriotic duty to avoid contact with HIV. Working with government ministries, NGOs, and faith-based organizations, he promoted simple prevention messages through churches, schools, and personal networks. These efforts succeeded in breaking down the taboos on talking about sexual matters. As a result, Uganda saw large declines in HIV infection rates in the late 1990s. Uganda’s example demonstrates that even a country with few resources can beat back the scourge of HIV. Most analyses credit Uganda’s success in large part to a strong commitment on the part of the country’s leaders to a frank public health campaign.

7.64 Uganda’s campaign employed the mixed “ABC” approach which encouraged abstinence until marriage, faithfulness to one’s partner, and condom use among the sexually active. Simple messages, such as “zero grazing” to promote faithfulness, were key to the campaign. With reporting of AIDS deaths, communities openly acknowledged the disease’s impact, which may have catalyzed community action better than anonymous testing.

Figure 7.1: Life Expectancy at Birth Over Time for Zambia and Uganda

Source: United Nations, World Population Prospects: 2004 Revision

7.65 Historical trends in life expectancy at birth in Uganda and Zambia have been very similar. Both saw rapid gains in life expectancy from the 1950s and 1960s as the result of improved public health programs and then a fall in the late 1980s and early 1990s as the impact of HIV/AIDS was first felt. In the first half of the 1990s, both nations had a life expectancy at birth of approximately 43 years. From there, the trends diverged sharply. In Zambia, as the AIDS pandemic deepened, life expectancy fell to 37.4 years, while in Uganda it rose to 46.8 years, as the nation's forthright prevention campaign began to succeed.

HIV/AIDS Prevention Programs

7.66 HIV/AIDS prevention programs in Zambia often take the form of IEC campaigns, targeting the general public or specific groups with information through leaflets, posters, TV and radio programs etc. Many IEC materials are produced through NGOs and the international community, and there is no on-going GRZ funded IEC campaign. While some organizations seek approval from the NAC for their campaigns, others do not. From time to time, materials are banned - invariably those that refer to the sexual activity of young people, or condom promotion.

7.67 The effectiveness of prevention messages is limited by the fact that they are often embedded in a context of contradictory or misleading information. This contradictory information may come from a trusted source - a church, an elder, a teacher - and may be difficult to disregard. Community outreach workers for NGOs report that correcting inaccurate beliefs is a constant challenge at the local level. At national level, two newly formed umbrella groups, the Expanded Church Response to HIV/AIDS and the Zambia Interfaith Network, are seeking to help all FBOs to provide factual information, and avoid misinformation.

7.68 Many young people and parents agree that schools are potentially an excellent place to teach children of all ages about HIV. The school curriculum has included sex education and HIV/AIDS awareness for many years, through science and social studies, and the community school official curriculum also addresses HIV/AIDS. However, the curricula reflect conventional conservative social views, aiming to inform children about HIV rather than to engage them as individuals at risk of HIV. The timing of information is also delayed, since children may become sexually active at an early age. Teachers often lack the confidence to talk to children about sex, and need more appropriate skills and strategies as well as more time, space and materials if they are to be effective. NGOs that have supported school-based Anti-AIDS clubs have helped to overcome some of these deficits, particularly since teachers leading anti-AIDS activities are self-selecting, and hence are usually committed and willing to talk. However, the challenge of making AIDS education exciting and interesting means that recruitment of teachers for this initiative is often slow.

7.69 Interventions addressing traditional leaders have been carried out in many rural areas. These efforts are generally aimed at increasing awareness of the dangers of certain traditional practices, and asking Chiefs to discourage early marriages. In some cases, Chiefs are now promoting VCT before marriage. These interventions have notably been led by long-established missions, most of which run health centers and hospitals, and success has been based on building a long term relationship and dialogue between outreach workers and local leaders.

Care and Impact Mitigation Programs

7.70 Zambia has been at the forefront of the development of home based care (HBC) services, usually under the auspices of churches and, at times, NGOs. Over the past decade, HBC has moved towards the development of community cadres of care givers. The objective of community HBC is to make care more local, more accessible and less stigmatizing. Most HBC programs receive support through the Food Program Management Unit (a joint GRZ / World Food Program unit). Since HBC relies on the services of volunteers who must work under highly stressful conditions, some HBC programs have found that volunteers become over-burdened by their commitment, and may give up. However, recent experience demonstrates that linking HBC groups and micro-credit programs has increased the volunteers' sense of reward and strengthened their commitment to care activities.

7.71 The recent increase in the availability of ARVs has rapidly improved opportunities for treatment, especially in urban areas. Patients can access free or heavily subsidized ARVs through programs run by Government and by several international NGOs. Generic ARVs have made private sector treatment more affordable. There are no official estimates of coverage, and numbers are changing rapidly. However, doctors involved agree that approximately 35,000 patients may currently be accessing treatment through various channels. Access to ARVs is much easier in urban areas than in rural areas, however, the lack of health staff in rural districts limits the GRZ's prospects of achieving more equitable access. Indeed, with the number of doctors falling on an annual basis, the extension of the ARV program to the targeted 100,000 patients will be challenging. Further, continuing reluctance to take up VCT, and widespread poverty (which prevents patients from paying for the necessary transport and a good diet) also presents difficulties for scale-up and expansion planning.

Addressing the Impact of HIV/AIDS on Orphans and Vulnerable Children (OVCs)

7.72 The number of NGOs, CBOs and FBOs addressing the problems of orphans and affected families has risen over the past five years, to nearly 500⁶⁶. There are many more organizations working in urban areas than in rural areas, however, and the most remote provinces have the lowest coverage⁶⁷. The most common activities amongst these organizations address the economic status of affected households. They also promote improved access to services, especially health and education. Recently, psychosocial support activities intended to address the emotional, psychological and social well-being of orphaned children and the households they live in have also been developed. There are around 150 organizations involved in institutional care, mostly orphanages.

7.73 Government has achieved significant improvements in services for orphans and households affected by HIV/AIDS in the past five years:

- The Free Basic Education policy of 2002 has removed a significant barrier to the access to primary education (although other barriers remain).
- GRZ also provides bursary support for a limited number of children to access primary and secondary school, and grant support to and teachers for selected community schools.
- The Public Welfare Assistance Scheme (PWAS) assists households affected by HIV/AIDS with health and education support, basic household needs, and cash transfers.
- The Victim Support Unit has expanded to over 300 police stations that provide support to victims of property grabbing and intervene in cases of violence, child abuse and sexual abuse.
- The Food Security Pack has provided free farm inputs to up to 150,000 ‘vulnerable but viable’ rural families per year, including widows and households affected by HIV/AIDS. This program is aimed at enabling them to plant enough food to provide a daily meal.

Nonetheless, orphans from poor households do not have secure access to basic education or essential health services.

7.74 The National OVC Steering Committee was established in 1999, with the intention of improving the design, implementation and coordination of programs that provide services to OVCs. Its slow performance has delayed the redesign of the National Child Policy, and reduced the level of attention paid to children and families affected by HIV/AIDS at a senior level.

7.75 Zambia’s private sector and international privately run charities and NGOs are also providing a variety of HIV/AIDS-related programs and services. The activities of these organizations are difficult to monitor, and so efforts to ensure that their activities are consistent with government programs and policies should be strengthened. However, it appears that there are substantial resources channeled to OVC by such organizations. These resources support education costs, institutional care and household economic security programs.

7.76 More work is needed to address the specific problems of children living without parents or adult care-givers. These children are found in child-headed households, or on the street. Child headed households are estimated at 1 – 2 percent of all households, while estimates of street children vary so widely that little can be said about prevalence. Little qualitative or quantitative

⁶⁶ This estimate refers to registered NGOs, FBOs and CBOs with budgets that exceed US\$5000 per year.

information on either group is available to help design or monitor activities, and the good examples of work with street children are not well documented or easily accessed.

F. Priorities for Action

7.77 There are no simple solutions to the HIV/AIDS and poverty predicament in Zambia. If HIV and poverty are in fact mutually reinforcing phenomena, however, then there is reason to hope that the reverse is also true – that any progress in reducing poverty levels will also help to limit the spread of AIDS, while successes in reducing HIV/AIDS prevalence will remove an obstacle to greater productivity and growth. In fact Zambia can claim some successes, such as the decline in prevalence among young women (particularly educated women) aged 15-19. The country can build on this and other successes. The following are suggestions that might facilitate this attempt:

- 1. Provide Strong Political Leadership for Prevention Campaigns:** What has been lacking in Zambia is a clear commitment on the part of the national government to a public health campaign to change sexual behavior. The public awareness of HIV/AIDS is still characterized largely by misinformation and reluctance to discuss sexual matters. The Uganda example demonstrates that with will from the national leadership, a society can overcome societal taboos, change sexual behavior, and defeat HIV/AIDS.
- 2. Focus Prevention Efforts on Youth:** HIV/AIDS prevention and behavior-change initiatives focused on adults have proved to be notoriously ineffective in most countries of sub-Saharan Africa. Where progress in reducing incidence and prevalence has been made, such as in Zambia, it is the youngest cohorts of the population who seem most ready to adopt healthier behavior. This openness to change among youth should be fostered and supported. Teachers can be encouraged to become leaders in prevention programs aimed at children and young people by providing them with improved knowledge, communication skills, confidence, formal and informal curricula, time and space for these activities. Although promotion of consistent condom use is key, peer-based initiatives aimed at delaying the age of sexual debut and at discouraging inter-generational sex should also be central components of the HIV prevention package. The fact that prevalence rates have declined faster among the educated suggests that promoting educational achievements, particularly among girls, can be viewed as a plausible component of HIV/AIDS prevention.
- 3. Correct Misleading Information:** Communities are harboring errors and misunderstandings concerning HIV/AIDS as a result of informal rumors, traditional beliefs, condemnation of PLWHA by some churches, as well as partial or incomplete understanding of publicly disseminated messages. These errors limit the effectiveness of prevention campaigns and foster the stigmatization of PLWHA. The GRZ and civil society should support the development of IEC guidelines that promote the production of factual educational materials, and that protect the production of appropriate and accurate HIV/AIDS educational materials.
- 4. Target Programs According to the Labor Status of Households:** Households with abundant labor are in an excellent position to benefit from agricultural improvement schemes, such as crop diversification, improving access to inputs, irrigation, etc. Households lacking adequate adult labor are unable to benefit from these or other rural development programs (such as Food for Work) that require labor. In addition, they cannot undertake the casual daily labor (*ganyu*) that serves as a safety net for the able poor. Although community labor-

sharing arrangements and community gardening projects have assisted labor-deficient families in a few communities, it is probable that long-term nutritional assistance and other direct support programs will have to be provided to members of these households.

- 5. Significantly Increase Commitment to Staffing Essential Public Services:** Because the poor have no recourse but to rely on publicly provided health and educational services, they are most likely to be hurt by the loss of public sector personnel to HIV/AIDS. Government must ensure that it has an adequate plan to buffer the impact of the AIDS crisis on low-income services users. It should intensify HIV/AIDS prevention efforts in the workplace, create flexible guidelines for redeployment of staff, and make realistic plans for the recruitment and training of workers who can replace employees who will die of HIV/AIDS.
- 6. Protect Access to Education:** Particularly for young girls, higher education appears to have been a positive factor in the reduction of HIV/AIDS prevalence rates among the young. Programs that support access to education and promote educational achievements can therefore have a double pay-off for Zambia: improving human capital while combating the spread HIV/AIDS. Ensuring that low-income children (particularly girls) can remain in school during and after shocks to the household should be a priority objective for the GRZ and international organizations.
- 7. Improve Health Worker HIV/AIDS Training:** To combat the persistent stigma and discrimination that is undermining quality care of PLWHA within health care facilities, health workers at all levels should be better prepared to manage the patient with HIV/AIDS. Basic counseling skills should be included in the pre-service (as well as in-service) training of nurses and medical officers, so they will not feel helpless and resentful when the psychosocial needs of HIV/AIDS patients arise during treatment.
- 8. Scale Up and Coordinate Care and Mitigation Programs:** An intensified effort to the address the problems of children (including orphans) and families affected by HIV/AIDS is urgently needed. Zambia has a variety of fine programs that provide social protection, increase access to basic services, provide psychosocial support, and improve livelihoods amongst marginal households. However, demand is greater than supply, and most affected households are thus unable to access such programs. What is more, there is little coordinated planning among the organizations and entities implementing these programs; and so gaps and redundancies in coverage are the norm. Scaling up the response requires greater political commitment and prioritization by Government. If the GRZ is able to effectively demonstrate that its commitment is significant and genuine, then it is likely that commensurate support can be secured from the international community.
- 9. Support and Encourage Local Initiatives:** To ease the strain on the health system, local groups and organizations can be tasked with developing and implementing plans for improving home-based care of PLWHA, fighting stigma and promoting safer behavior. Community Based Organizations have been found to be responding to the HIV/AIDS crisis in some informal urban settlements, usually under the leadership of church groups and NGOs. Interventions that involve traditional leaders in prevention or mitigation programs have created successful long term relationships between communities, NGOs and the health system. To foster replication of these and other successful local initiatives in rural areas, Government should offer support to experienced NGOs and faith-based organizations, and encourage them to expand, replicate or scale up their initiatives. In addition, appropriate components of these approaches should be adapted for introduction to urban communities as well.