3 ~ HIV and AIDS and households

HIV and AIDS is arguably the most devastating disease facing humanity at present. Discovered in 1981, the epidemic now threatens to decimate entire populations, cripple national economies and reverse developmental gains. It has caused unprecedented havoc on mankind, more pronounced at community and household level. This Chapter analyses how HIV and AIDS is affecting Zambian households. HIV and AIDS affected households have been defined as those meeting any of the three criteria:

1) Hosting a person with an AIDS-related disease
2) Hosting a child orphaned by AIDS
3) Having experienced an AIDS-related death.

The Chapter provides evidence of how each of the above three aspects qualifies a household to be known as HIV and AIDS affected. Furthermore, it also highlights the social ramifications of HIV and AIDS and the importance of putting the household at the centre of the response to the epidemic.

The Chapter also emphasises that designing initiatives that are long-term, sustainable and targeting households is a significant strategy. It has the potential of reducing the spread of HIV, reducing its impact on various sectors of the country's economy and achieving the Millennium Develop-ment Goals (MDGs).

Global HIV and AIDS situation

Data on HIV and AIDS highlight the epidemic as a global problem of a great magnitude. A total of 40.3 million people were living with HIV by the end of 2005. Since 1981, more than 25 million people have died of AIDS-related illnesses. In 2005 alone, 3.1 million people died of AIDS, out of which 570,000 were children. Close to five million people were also newly infected with HIV in 2005 (UNAIDS, 2005).

Sub-Saharan Africa has been the hardest hit by the pandemic. It is accounting for huge reversals in human development on the continent. Nothing else has ever reversed developmental gains so profoundly as the HIV and AIDS epidemic in some parts of sub-Saharan Africa. This will have critical long-term impact on human development, economic growth and stability, on society, culture, governance and national capacity, for decades to come (Barnett and Whiteside, 2002).

The epidemic reached countries at different times and the risk factors differ from one country to the other. As a result, HIV seems to spread faster in some countries of the same region than in others. Even within a country several epidemic patterns can be observed - low, intermediate and high prevalence epidemics.

HIV and AIDS situation in Zambia

The high HIV prevalence rates in Zambia should be considered within the regional context. Zambia is among the seven countries most affected by HIV and AIDS in sub-Saharan Africa. The other countries are Botswana, Lesotho, Namibia, South Africa, Swaziland, and Zimbabwe (see Map 3.1 on p. 41). These are all Southern African countries where HIV prevalence ranges between 16 and 35 percent. Currently in Zambia, AIDS-related deaths have overtaken malaria and other diseases especially amongst the 15 to 49 age group.

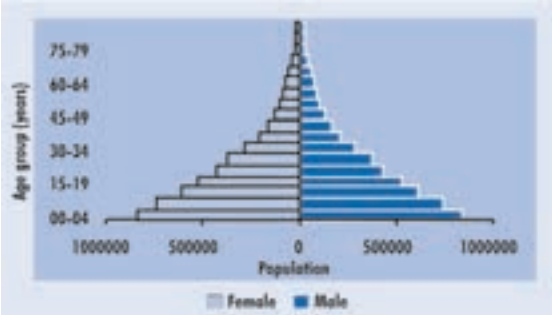
"She just looked at me sad"

She is all alone. Felix mother told me this girls mother and father died of AIDS. I asked how old she was but she didn't answer. I asked if I could take a picture and the older woman said yes. I feel sorry for her.

Photographer: Margaret Chitono

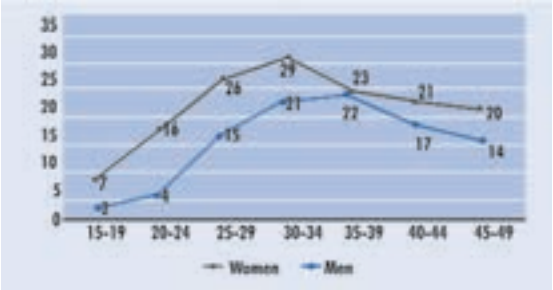
CHAPTER 3

Figure 3.1: Age - sex composition, Zambia 2000



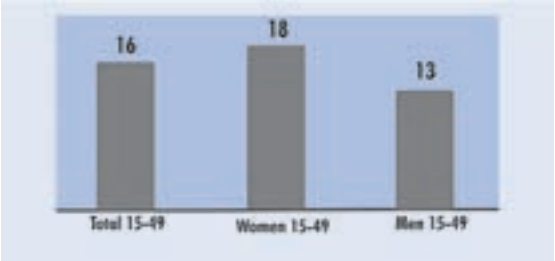
Central Statistical Office, 2003

Figure 3.2: Percentage of HIV positive by age



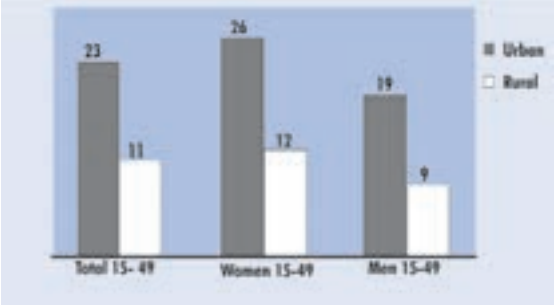
Central Statistical Office, 2005

Figure 3.3: Percentage of HIV positive



Central Statistical Office, 2005

Figure 3.4: Percentage of HIV positive by residence



Central Statistical Office, 2005

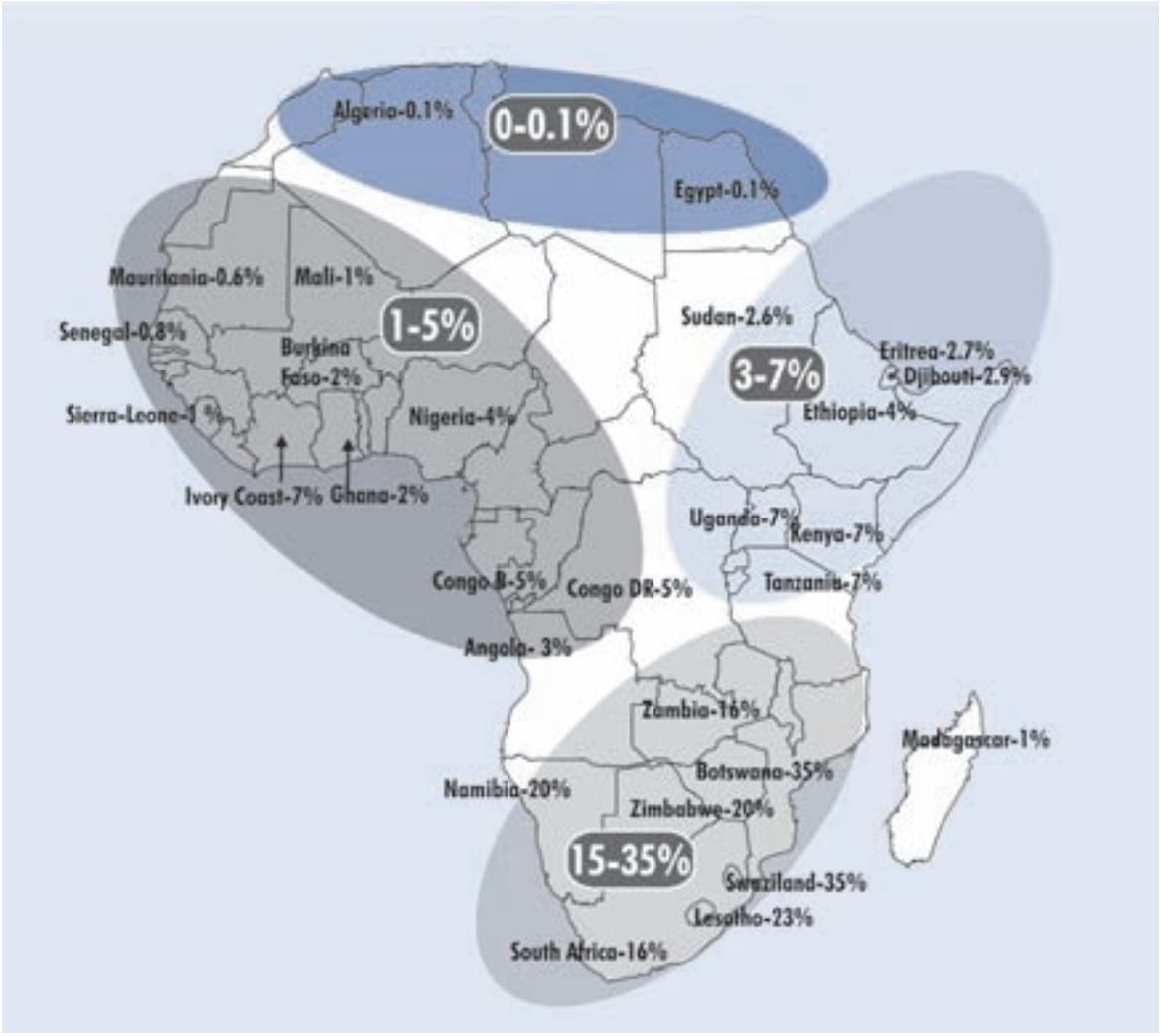
According to the 2001/2002 Zambia Demographic and Health Survey (ZDHS) about 16 percent of the adult population in Zambia is HIV-positive. In addition, approximately 39.5 percent of babies born from HIV-positive mothers are infected with HIV. One of the major problems associated with the HIV and AIDS epidemic is that it mainly attacks the productive age group, peaking at between 30 and 39 years (see Figure 3.2).

There are more women living with HIV (18 percent) than men (13 percent). This is even worse among young women aged 15 to 19 years who are five times more likely to be infected than males in the same age group (Figure 3.2). However, there are more men than women infected with HIV in the 35-45 years age category. The HIV infection gender disparity is as a result of more young women being more susceptible to infection than their male peers.

Regionally, infection rates range from about 21 percent in Lusaka to 15 percent in the urban provinces along the line of rail and between 8 percent in Northern Province to 13 percent in Eastern Province (see Map 3.2 and Figure 3.5 on p. 42). In general, HIV prevalence is more than twice higher in urban areas than in rural areas (23 percent and 11 percent respectively, Figure 3.4). More urban dwellers are likely to die earlier, especially those living in unplanned sites with no access to sanitation and water. They tend to be more susceptible to opportunistic infections. In urban areas, when there is a death of a breadwinner, households adjust to shock by developing quick fix survival strategies. Such include begging on the street, brewing alcohol for sale and/or sex work.

Intra-provincial variations in HIV prevalence are also evident. The range can be seen in the differences between districts in the same province (see Map 3.3 on p. 43). The range can be as wide as between 7.5 and 30.9 percent, like for Southern Province. This is a difference of 23.4 per-

Map 3.1: HIV prevalence in Zambia and other African countries



UNAIDS 2004 estimates used (unless where recent national population-based HIV survey available)

centage range. Others can be as low as between 5.2 and 12.6 percent, like is the case for Northern Province. In general, districts that are predominantly urban have higher prevalence rates than those that are mostly rural. Livingstone had the highest prevalence rate of 30.9 percent in 2004 followed by Ndola at 26.6 percent. Kaputa, Mungwi and Mporokoso in Northern Province had the lowest prevalence rate at 5.2 percent (see Map 3.3 on p. 43).

AIDS is also causing an orphanhood crisis. At the end of 2005, Zambia had 1,197,867 orphans Out of these, 845,546 were orphaned by AIDS. (The total population was 10.3 million.)

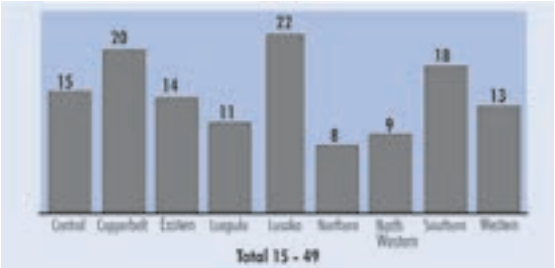
Future outlook of Zambia's HIV and AIDS situation

The epidemiological projections for Zambia are quite optimistic. It is estimated that 917,718 people were infected with HIV in 2004 of which 411,181 were males and 506,537 females. By 2010, the number is projected to decline to 881,143, with 393,233 males and 483,910 females. The prevalence rate is projected to come down from the estimated 14.4 percent in 2004 to about 11.9 percent in 2010. By 2010 the prevalence would decline to 17.1 percent in Lusaka, 15.5 percent on the Copperbelt, 13.3 percent in Southern, 12.2 percent in Central and 6.7 percent in Northern Province.

Map 3.2: HIV prevalence by province

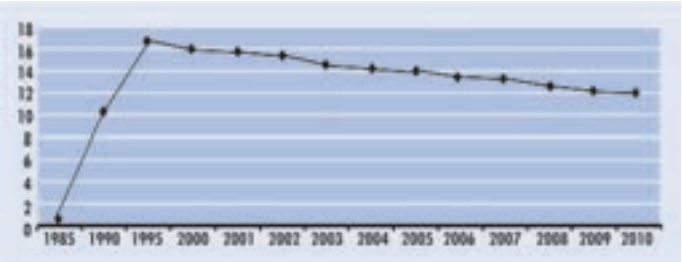
Central Statistical Office, 2005

Figure 3.5: HIV prevalence by province



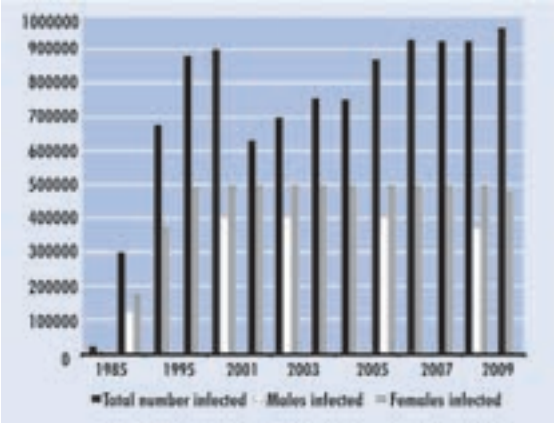
Central Statistical Office, 2005

Figure 3.6: Projected HIV prevalence, 1985-2010



Central Statistical Office, 2005

Figure 3.7: Projected number infected with HIV, 1985-2010



Central Statistical Office, 2005

Despite the projected decline in the prevalence rate, the incidence of new HIV cases and annual deaths from AIDS-related illnesses will continue to rise and only start to fall around 2008 (Figures 3.6 and 3.7). This decline would be facilitated by an increase in condom use, voluntary counseling and testing uptake, more women seeking prevention of mother-to-child trans-mission HIV and the success of the ART programme.

More women than men will continue to be infected with HIV and die. Between 2005 and 2010, more than half of all adults living with HIV will be females. A similar pattern is evident with regards to new HIV infections and related deaths.

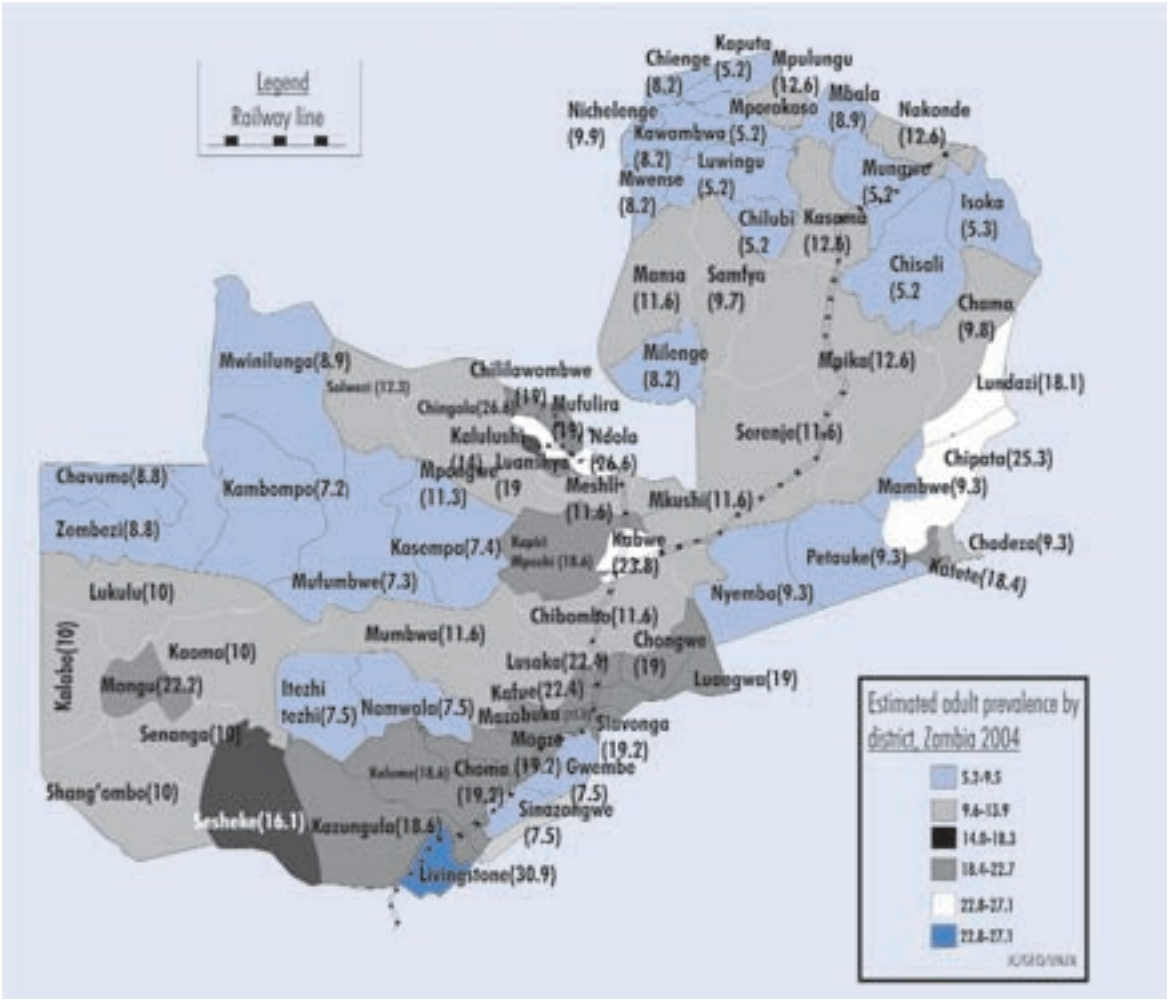
With regards to orphans, the projections are pessimistic. The total number of orphans is expected to increase by about 16 percent to 1,328,000 in 2010. Of these, 42 percent are expected to be maternal orphans, 45 percent paternal orphans and 13 percent dual orphans (see Figure 3.9 on p. 44). Implications of such a large number of orphaned children on society and families have recently been well studied in Zambia and are highlighted below.

Drivers of HIV prevalence in Zambia

There are many drivers of the spread of HIV in Zambia. The primary driver is the sexual activity itself, as HIV infection in Zambia is principally through heterosexual intercourse.

Whether sex occurs for procreation, pleasure, exchange, ritual purposes or experimentation, it will carry with it the risk of infection of HIV and other sexually transmitted infections. This risk can, however, be reduced by changing on the sexual behaviour of the persons involved. What becomes of a critical importance is awareness of basic facts about HIV and AIDS and whether people use this information to take actions to protect themselves and others from HIV infection.

Map 3.3: HIV prevalence by district



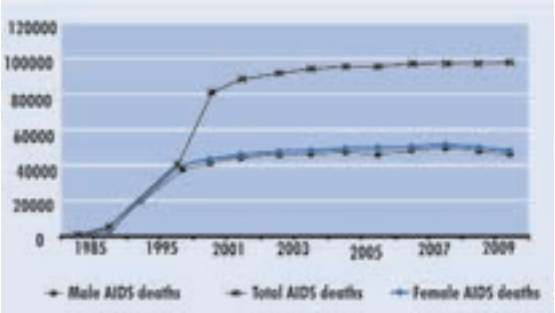
Central Statistical Office, 2005

General awareness of HIV and AIDS is nearly universal among both men and women of reproductive age in Zambia. According to the Zambia Sexual Behaviour Survey (ZSBS) 2005, 97 percent of both men and women and 96 percent of the rural dwellers are aware about HIV and AIDS. This awareness has been on the rise. The proportion of respondents who knew that HIV can be avoided increased to 91 percent in 2005 from 78 percent in 1998 among females and to 94 percent from 84 percent among males. Among females, 89 percent knew that a healthy looking person could be carrying HIV. This was 93 percent for males.

Despite this near universality of HIV and AIDS awareness, only 15.1 percent of respondents in the ZSBS 2005 were reported to have gone for voluntary counseling and testing. The reasons for avoiding VCT were many, including fear of results, which was associated with apprehensions concerning stigma and discrimination. Stigma is still a big issue despite the efforts directed at eradicating the problem. The ZSBS 2005 found that 36 percent of the respondents believed that one's HIV status should be kept a secret. 20 percent reported to know someone who had suffered stigma and discrimination as a result of their status. An even higher proportion (27 percent) believed HIV positive people should be ashamed of themselves.

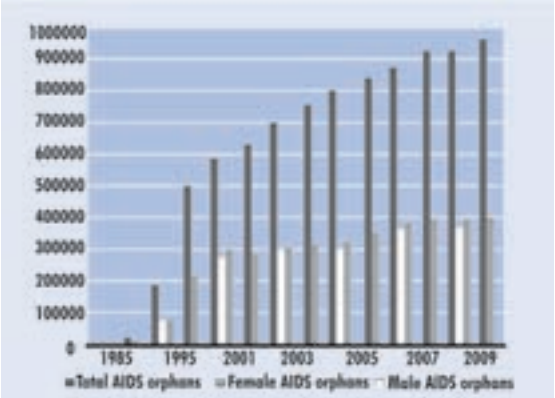
Although there is near universal awareness about HIV and AIDS, sexual behaviour still remains a matter of great concern. According to the ZSBS 2005, condom use

Figure 3.8: Projected total, male and female AIDS deaths



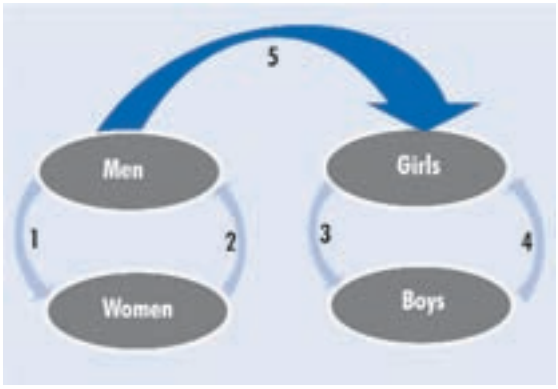
Central Statistical Office, 2005

Figure 3.9: Children orphaned by AIDS by 2010



Central Statistical Office, 2005

Figure 3.10: Direction of sexual relationships



Patrick Chilumba, 2006

among married couples is very low and has declined slightly from 7.9 percent in 2003 to 5.5 percent in 2005. This is worrying in a generalised HIV prevalence context. Of further concern is that a significant proportion of sexually active respondents reported having sex with a non-regular partner (non-marital or non-co-habiting) in the previous 12 months. This was 27.6 percent for males and 15.8 percent for females which averaged at 29 percent for urban respondents compared to 18.5 percent in rural areas.

Although condom use among non-regular sexual partners is higher (48 percent for urban and 25.9 percent for rural), this is still too low in light of the scale of the AIDS epidemic. It is even more worrying that this dropped from 55 percent in 2003 to 50 percent in 2005 among urban males and 26 percent to 16 percent among rural females. Even among men who reported to have had sex with a sex worker, only 53.1 percent used a condom.

There is also the issue of forced sex perpetrated mainly by husbands in marital relationships or other men well known to the victims. In the ZSBS 2005, 15.1 percent of sexually active females reported forced sex. Considering the likelihood of underreporting on this matter, this is a very significant proportion. A double tragedy of this is that condom use is very unlikely.

Some of the reasons for high infection rates among women include socioeconomic problems, social norms, biological reasons, behavioural reasons, the social status of women and their inability to negotiate for safer sex. Young women also more susceptible than their peers because they are more likely to have sex with older men already exposed to HIV (see Figure 3.10). Early marriages and sexual cleansing are the other risk factors. When a household comes under stress due to poverty, at times induced by HIV and AIDS itself as livelihoods fail, there is pressure on girls to engage in prostitution or even occasional sex to buy some form of support.

Box 3.1: Stigma and discrimination

"There is no help that comes from my friends. We do not get on well with my friends, because they always laugh at me. They say we are sick and advise their family members not to interact with my family. When they laugh, they make fun of us, "look the way that person has lost weight. They are so sick of AIDS." But we do not take it to heart, because everyone is certainly affected with the pandemic; just ignore the people, no matter what they say. Only God understands." *42-year-old HIV-positive male, married, Lusaka*

"When I go even to the bus stop, women start singing, "that man is sick". These are situations you experience every other day. Stigma is still a very big problem. I always forgive these people because I think they are ignorant. It never angers me personally but there are those who take it even deeper." *PLWHA, 2006*

"Some people in the community treat households affected by HIV/AIDS with stigma and discrimination. It [HIV and AIDS] also robs one of self esteem. You just find that certain people just start isolating themselves, even from peers, church members and start living a closed life." *Kapiri Mposhi, key informant 2006*

"There isn't actually a home that has not lost a loved one to HIV and AIDS. However, this is still being kept behind closed doors. People do not want to admit that HIV is now in every corner." *Kapiri Mposhi, key informant*

Urbanisation is another strong driver of HIV infection. Zambia is one of the most urbanised countries in Africa, with urban migration characterised by movement from smaller towns to bigger cities. This mobility is of direct relevance to the HIV prevalence. The higher population density in urban areas* means that there is more human interaction and consequently sexual activity. The urban population also has more liberal attitudes towards sex.

The vast majority of people living with HIV in Zambia do not have access to treatment. Of the 153,000 people estimated to be in need of antiretroviral therapy, only an estimated 26,000 to 30,000 (14 to 18 percent) were receiving treatment as of June 2005. This makes Zambia one of the countries defined by the World Health Organisation as having unmet need for antiretroviral treatment.

The low voluntary counseling and testing uptake combined with low condom use suggests that HIV infection rates will remain high in Zambia in spite of the optimistic projections of the prevalence rates (presented on p. 41).

There is enough evidence that suggests that a lot of people, especially the young, deal with socioeconomic problems, society pressures and problems related to poverty by resorting to alcohol. A rapid assessment carried out in Zambia to assess the linkage of alcohol to HIV and AIDS revealed that there is a very strong link between alcohol and the spread of HIV and that young people, especially the orphaned, are the most affected. (STI Situation Analysis, 2004).

Most people living with HIV and AIDS (PLWHA) cited alcohol as being responsible for their HIV infection. Participants in focus group discussions with PLWHA in Lusaka, young people in Solwezi and sex workers at the Tasintha Programme agreed that alcohol impairs judgment and often leads young people to engage in sex with a sex worker and get exposed to HIV. The sex workers said alcohol and substance abuse gives them the courage to have sex with strangers (Luo and Morris 2006).

** For example, Lusaka Province had a population density of 63.5 people per square kilometers compared to 13.1 people per square kilometers for Zambia as a whole.*

HIV and AIDS in the household

HIV and AIDS has put enormous economic stress on households as they care for the sick family members, experience the loss of productive adults or absorb orphans.

A household usually goes through formation when two people start living together. The people could be siblings or spouses, who could start having children. The children later mature into adults. A household goes through dissolution as children grow up and start leaving home. In some cultures the children may not leave home but may be joined by their spouses and children in their households. When the parents become too old, they then die. There are, however, other reasons for dissolution of households now and these include HIV and AIDS.

The demographic impact of HIV and AIDS on a household, comprising a family unit, affects its ability to reproduce itself. Households where adult females are infected with HIV experience lower birth rates and higher infant and child mortality rates. Therefore, in cases where a female parent is HIV-positive, fewer children will be born and out of these, some will die in infancy or early childhood.

These gaps may not be filled. Thus what has been seen from epidemiological evidence provided above, that there are more women infected with HIV than men, has obvious implications for the continuity of households. Even more important is that high infection rates amongst women have far-reaching implications for the household coping capacities given their traditional roles as caregivers, breadwinners and providers of food. The loss of so many women will negatively impact the capacities of Zambian households.

A number of things happen as a result of AIDS-related death, especially in cases of the loss of a breadwinner. Family members may be separated and forced to join other households. Sometimes the children left behind are sent to live in another household, in some cases from urban to rural areas. In certain instances children leave home in search of means of food and/or employment. Although loss of a household reduces the size of the household, this is usually temporary, as one or more new members (orphans) may be added to the household.

In the recent past, the family structures have changed due to considerable number of children orphaned by AIDS and other vulnerable children. Worse still, a household affected by AIDS may disintegrate. Heads of households have been reported to comprise of grandparents, women and children themselves. Evidence is available that suggests that child headed households are vulnerable to exploitation and this can take any form such as sexual and child labour.

Although grandparents are now looking after orphans, they are usually too old to work and adequately care for the children. The older orphans may assume the role of looking for food, caring for the sick and sometimes begging on the street (street children). Sex work is not an uncommon social consequence. Tasintha, a programme that targets sex workers has established a linkage between loss of parents and sex work. Girls usually engage in sex work as a means of survival. Sex work in turn may expose these girls to sexually transmitted infections including HIV (OVC Situation Analysis, 2004).

Impact of HIV and AIDS on the household

Zambian families are usually very large and loss of one or both parents has very serious consequences on the remaining household members. Some of the challenges include added costs, the impact on women and children and the need to assist the "survivors". Families and communities coping with HIV and AIDS related illnesses and death shoulder most of the burden. The epidemic has taken the heaviest toll at the household level and in particular women (Over, 1998).

Some of the major characteristics of the HIV epidemic are the silent nature of the infection, disease progression and eventually death. Its impacts vary with time and from household to household, ranging from immediate and severe shock to complex, gradual and long-term changes. An example of immediate and sharp shock is where the primary breadwinner dies. The living conditions of such a household are immediately affected. Children may find themselves being sent to live in a different place, removed from a good school or withdrawn from school completely (see Box 3.2).

HIV and AIDS has a great bearing on the household. Its effects depend on a number of factors which may include:

- *The number of people infected in the household:* Up to one in five households are looking after someone who is chronically ill (Population Council and RuralNet Associates Limited, 2006). An individual infected with HIV usually requires frequent hospitalisation and may be unable to work, may require treatment of opportunistic infections and/or antiretroviral drugs. As a result of these commitments, household income may decline to such low levels that it becomes difficult to retain the same lifestyle even before the sick members of the household die.

- *The status in the household of the individuals who die:* There is a big difference whether they were parents or not and the contribution they made to the family. The impact is almost immediate if one or both parents become too sick to work effectively. The other members of the family who have to spend time looking after the sick also may lose out on their income generation activities. In cases where the breadwinner is not able to work and there is loss of income, the lifestyle and structure of this household

Box 3.2: The plight of a widow and the family after the death of a spouse

Mr. Kaindu was the only educated person in his family. He was a bank manager and lived in a beautiful one storey house in Kabulonga, an up market residential area in Lusaka. When he died his wife was also not in good health. Worse still, his brothers and sisters grabbed the property the family owned, shared his terminal benefits and his life savings.

The wife died a year later. After the funeral the four children left behind were told that they would be going to live with their grandmother in a village in Mbabala. They are now in a village school and they have learnt to fetch water from the stream like other children. They have very little access to food. They sleep on the floor and have to share the few blankets available with other children in the house. The children talked about how life had become a nightmare.

Box 3.3: The aftermath of property grabbing

Mr. Mulenga was diagnosed HIV-positive in 1991 in Kitwe. He presented to the hospital with recurrent fevers. Shortly afterwards he was hospitalised suffering from pneumonia. The home was crowded with family members who had come to help the wife nurse him due to frequent hospitalisation. Mrs. Mulenga was unemployed and depended on his husband's salary for medical bills, school requirements for the children and food at home. At the time of his death they had used up all his savings. Although his employers bought the coffin and gave a small funeral grant, the major bills had to be paid by the family.

After burial Mr. Mulenga's family members demanded for his bank book, car keys, divided the household assets and his clothes, without any consideration for the children and wife. Today Mrs. Mulenga and children are struggling to survive and have been forced to live with her old parents in Kasama, Northern Province.

Society for Women and AIDS in Zambia, Kasama, Northern Province

is likely to change. Usually the loss of income leads to poor food security, poor access to health services and school children may be withdrawn from school.

- *The asset base of the household and what is left for surviving members:* In households where there is a patient suffering from an AIDS-related illness, family assets may be sold as a source of income when livelihood opportunities diminish, because of high expenditures on medical bills, procurement of food, transport costs and purchase of washing powder. Usually such households become very poor. The situation may become even worse in the event of death as family members may grab all the family assets (see Box 3.3 on p. 47).

- *The capacity and attitudes of extended family members, community members, non-governmental organisations, faith-based organisations and community based*

Table 3.1: Impacts of HIV and AIDS on livelihood assets

Human assets	▪ More frequent incidences of illness and death ▪ Increased expenditure on health and diminishing expenditure on other important areas such as food, clothing and school ▪ Changed household size and composition ▪ Loss of labour and intra-household reallocation of labour ▪ Increasing numbers of affected households are headed by elderly people ▪ Higher dependency ratios for households that keep orphans and foster children ▪ Female headed households take care of greater numbers of orphans and have the highest proportion of total orphans ▪ Increased numbers of school drop-outs ▪ More girls than boys drop out of school ▪ More children in affected households assist in farming/domestic activities ▪ Inter-generational knowledge and skills gap created
Social assets	▪ Emotional stress due to loss of members of the family especially the heads of households ▪ Affected female-headed households participate less in CBOs ▪ HIV and AIDS entrenches gender inequality ▪ Stigma, discrimination and sometimes rejection ▪ Few affected households are members of co-operatives ▪ Affected households have very limited access to community-based support ▪ Lessened reciprocal relationships ▪ Weakens institutional capacity to deliver services ▪ Pressure on the stability and relationships within extended families ▪ Reduced linkages to formal and informal organisations ▪ Emergence of informal non-traditional organisations ▪ Emergence of street children and an increase in sex workers
Natural assets	▪ Affected female-headed households have much smaller portions of agricultural land ▪ Soil fertility decline owing to decreased availability of farm inputs and cattle manure ▪ Increased exploitation of fuel wood and wild foods leading to deforestation and declining wild food resources
Physical assets	▪ Loss of intergenerational knowledge and skills in traditional natural resources conservation and management ▪ Liquidation of assets to meet costs for food, gifts during care and funeral and medical care ▪ Many households own fewer physical assets due to high incidence of property grabbing ▪ Less access to improved farming technologies

organisations to help the affected household.

The sum total of these impacts are summarised in Table 3.1. The table groups the effects according to the different components of the sustainable livelihoods framework introduced in Chapter 1.

The asset pentagon which is the heart of the sustainable livelihoods approach is brought under very serious threat as each of the assets at the disposal of a household is eroded by AIDS. Coping mechanisms discussed in Chapter 4 are usually not only inadequate but also escalate the medium to long term impacts of the disease.

There are reports that people living with HIV may be discriminated or stigmatised by their friends, at work, in the community or by members of their families. A baseline survey for RAPIDS revealed that stigma varied from community to community. While some communities may report stigma and discrimination, others reported a reduction in stigma and discrimination with the recent access to drugs, other services such as voluntary counceling and testing, prevention of mother-to-child-transmission and care (Population Council and RuralNet Associates Limited, 2006).

Changing household structures

The very essence and social fabric upon which Zambian communities are founded are being denuded and destroyed as a result of the HIV and AIDS.

Cultural and social bonds and ties that have developed over many generations have come under massive pressure and trial from the epidemic. They are being challenged in ways that have no historical precedence and are likely to yield to the expediencies of dealing with and responding to HIV and AIDS (OVC Situation Analysis, 2004).

In some cases where children have lost one or both parents, they have been forced to live with members of the extended fami-

Box 3.4: Impact of HIV and AIDS on the family

"As the effects of AIDS starts showing, financial pressure occurs in varying degrees. The person starts to get sick and is suffering from opportunistic infections. This leads to frequent hospitalisation. The patient then gets too sick and is bedridden either in the home or hospital. Eventually the patient dies leaving behind orphans who will need care and support." *Kapiri Mposhi, Key Informant, 2006*

"As a result of an HIV-positive person having more frequent attacks of opportunistic infections, production in anything is reduced." *Kapiri Mposhi, Key Informant, 2006*

Box 3.5: HIV and AIDS and the extended family system

"In Zambia, our family system has been eroded. Before, we had the extended family system. We deemed our brother's child as our own child. Now we have terminologies where one's brother's child is a nephew. It all boils down to a level where you start looking at your family as being only your wife and your own children and all this comes about because we are failing to even provide what is supposed to be a good standard of living for our own children. If you cannot provide for your own children, providing for the next family is an impossible undertaking. Zambians have been pushed against the wall. They would like to do something, but they don't have the capacity". *Person living With HIV, Lusaka.*

"Zambia has always had a culture of the extended family, but now your brother is either sick or absent because of death. You find that the household has no resources and the family unit falls to pieces and there is no one to take care of orphans". *Person living With HIV, Lusaka.*

Box 3.6: An orphan's quest for school

"I was living with my step brother for the past four years. I was doing very well at school and told my teachers that I shall be a doctor when I grow up. One morning my step brother informed me that he would be sending me to live in one of the remotest parts of Zambia, Kaputa, because his own brother had died and would therefore have the responsibility of looking after the children he had left behind.

My dreams were immediately shattered. The next day I was on my way to Kaputa to live with grandparents whom I had never met or known, leaving my friends and family members I had lived with for several years. This all happened within a few days. I left by bus to Kasama, slept at the bus stop and the next day I was on a van to Mporokoso. I spent a few days in Mporokoso at the bus stop with nothing to eat, until a truck going to Kaputa carried me.

On arrival in Kaputa, my grandparents welcomed my desire to continue with school. Unfortunately the school wanted a transfer letter from my previous school, which I had not brought with me. My grandparents had no money to support my travel back to collect the transfer letter. All they had was a bicycle.

I told my grandparents that I would cycle back to Mbala to collect the transfer letter. The journey took two weeks. I cycled through the forest, stopped at any village overnight and depended on their generosity for shelter and food."

'Mwaba" in OVC Situation Analysis in Northern Province, 2004
(The time Mwaba met the NHDR team he had been accepted at Kaputa Secondary School.)

ly or become street children (Box 3.6). They may also live in orphanages. Some children drop out of school, get abused, lack social guidance, live with neighbours or be left on their own. In situations where children are left on their own, the oldest child is expected to look after the young ones. This phenomenon is known as the child-headed household. (OVC study 2003.)

Even as the family units are being destroyed, the social security system continues to be extremely weak. Community social structures and support systems which existed to support households during illnesses and bereavements are breaking down as they fail to cope with the number of sick people and deaths.

As a result of the impact of HIV and AIDS, new forms of households have emerged in Zambia (OVC Situation Analysis, 2004). These include:

- Elderly/grandparent headed household
- Child-headed household
- Single parent (mother, father) headed household
- Cluster foster care; A group of children cared for formally or informally by neighbouring adult household
- Children in subservient, exploited or abused fostering relationships
- Itinerant, displaced or homeless children
- Neglected, displaced children in gangs or groups

These changing structures may not fully match the support that a regular household was able to provide to its member. For example, in a grandparent-headed household, many children drop out of school, the nutrition of the children is affected, children have poor access to health services and are usually very poor. Grandparents may be too old to walk long distances to health institutions, work and produce for the family (OVC Situation Analysis, 2004 and OVC Situation Analysis in Northern Province, 2003).

In a household that comprises the young and elderly, dependency on others increases because they are not able to contribute to any productive activity. In house-

Box 3.7: Voice of a sex worker

"My parents died when I was eleven years old. We had very little to eat because my grandparents were too old to work and provide for me, my young sisters and brothers who were younger. I left for the city for survival.

On arrival I joined the gangs of thieves and I was arrested the very first night of attempted aggravated robbery. I was jailed at the Mukobeko Maximum prison. During my stay there I was abused sexually by the prison wardens.

When I was released from prison, I joined a group of sex workers up to the time I was recruited to the Tasintha programme. Life on the street was rough. A lot of my friends were killed and we contracted a lot of diseases but we had no choice, as money earned on the street was our only means of survival." *Reformed sex worker, Tasintha 2006*

holds where the children are older, they play the role of the parent, such as providing for their siblings. In rural areas they till the land and grow food for the family, cook, collect firewood and water. In the urban cities the children resort to selling or begging on the street.

Overall, the coping mechanisms of households have been weakened by the HIV and AIDS pandemic and the available support networks may be unable to cope with the new situation.

Orphans

Zambia has one of the highest proportions of children orphaned by AIDS in the world. The number of such orphans rose from 842 in 1985 to 845,546 in 2006. This is projected to rise to 936,167 in 2010. A study conducted in Northern Province showed that more widows and grandmothers are taking care of orphans. Sample data from participatory livelihood analysis showed that female-headed households maintained three times more orphans than

Box 3.8: HIV and AIDS: a consequence of poverty

"HIV has increased because people are failing to meet food requirements in their homes. We have become very 'movious' to manage to feed those at home. Some even end up not using a condom so as to get more money. In the process one gets HIV infected." *Woman in focus group discussion, Kapiri Mposhi, 2005*

"Most of the time in this community the men do not work and the women do not have any money for business. So most of the times, the women would like to sleep with a man who can just give them some money to buy a small packet of mealie meal for home. And usually the money given to these women is about K10, 000. Therefore, HIV keeps increasing. So poverty is causing HIV to increase." *Lusaka women focus group discussion, 2005*

"In some households in this community people cannot afford a number of things like a bag of mealie meal, a bar of soap or a bag of charcoal. They can only buy small packets (Pamela). Most men do not work. As a result of husbands not working, women are forced to sleep with other men, whose HIV status they may not even know. All this is just done so that they do not sleep hungry. They do not even think of VCT." *Lusaka women focus group discussion, 2005*

"When I'm looking after a patient with an AIDS-related illness, at the same time looking after children and I'm not working but I would wish that the children eat adequately, I would end up throwing myself at men so that they can assist me." *Kapiri woman in a focus group discussion, 2005*

male-headed households. The female-headed households also bore the brunt of looking after the orphans. (FAO, 2004). Orphanhood is not a new phenomenon in Zambia. What is different is that the traditional Zambian society had systems in place that took care of children who lost parents for one reason or another. One such system has been the extended family system. The recent unprecedented increases in mortality rates due to AIDS-related illnesses, coupled with widespread poverty brought about by prevailing poor economic conditions, has weakened the extended family system.

The burgeoning numbers of children orphaned by AIDS needing support and care are overloading the caring capacity of the traditional extended family systems. By deepening poverty due to partial loss or disappearance of adult labour and the costs associated with caring for the chronically sick and funerals, HIV and AIDS is stretching the capacities of households and other traditional community safety nets beyond their limits.

Many of the children whose parents have died may lack not only parental care and guidance, but also cultural, social and family ties and life skills that are usually passed on from generation to generation. Most of these children are deprived of their childhood and the opportunity to go to school.

When life becomes difficult, orphans and other vulnerable children tend to be attracted to big cities and towns. Economic hardships lead them to look for means and some of the choices of survival, such as migration to big cities, increase their vulnerability to HIV infection. In big cities, children may be exposed to alcohol and substance abuse, child labour, sex work and delinquent behaviour. Alcohol and substance abuse lead to impaired judgment and may thus lead children to engage in casual and indiscriminate sex. This leads to exposure to sexually transmitted infections, including HIV.

In an increasing number of situations, children orphaned by AIDS when rejected, opt to stay together instead of living with relatives. Child-headed households are becoming increasingly common. Children as young as eight years old act as heads of households and take on responsibilities normally carried out by parents, including providing care to other children.

Child-headed households face a wide range of problems that include grief, stigma, discrimination and inadequate support from the community. The most pressing and immediate need of child-headed households relate to survival needs in the midst of poverty.

The creation and existence of child-headed households in Zambia is evidence that the extended family system and indeed other traditional support systems are unable to cope with the challenges created by HIV and AIDS.

Poverty and HIV and AIDS interface

The linkages between HIV and AIDS and poverty or its proxy, food insecurity, are bi-directional. AIDS is a determining factor of poverty as well as a consequence of it. The epidemic is compounding pre-existing problems of chronic poverty thereby presenting a major obstacle to Zambia's developmental agenda (Salinas, IMF, 2006).

HIV and AIDS is an underlying cause of vulnerability to poverty, food insecurity and other shocks. The pandemic fuels poverty by adversely affecting human, social, natural, physical and financial assets essential to household livelihood strategies. Using these assets and capabilities, households are able to develop coping strategies to deal with the physical, social, economic and political environments.

The vulnerability context of households has deteriorated due HIV and AIDS (see Table 3.2) and other factors such as economic decline and widespread failure of the country's service delivery system. House-

Table 3.2: Impacts of HIV and AIDS on the sustainability of livelihoods

Resilience	▪ Livelihood failures as assets are degraded and social structures become less supportive. ▪ Difficulties to recover from shocks, seasonal factors and long-term adverse trends.
Ecological integrity	▪ Rising morbidity adversely affecting intergenerational transfer of capacity. ▪ Increased reliance on natural resources as livelihoods fail. ▪ Property grabbing and gender inequality in traditional land tenure systems. ▪ Institutions important for the management of natural resources at both local (traditional) and higher levels losing capacity at a fast rate.
Social equity	▪ Intensifying poverty widening social inequality in society. ▪ Widening gender disparities as women shoulder greater burden in caring for the sick and orphans. Female rate of infection is also higher.
Adaptive governance systems	▪ Weakening of the extended family system and less able to act as a social safety net. ▪ Capacity of local institutions negatively affected.

hold ability to cope with factors that diminish the opportunities for beneficial livelihood outcomes is also diminishing as a result. Widespread poverty is the face of the widening vulnerability context.

Mapping the vulnerability context itself is a complex matter because of the interplay of so many factors. However, at the root of a deteriorating vulnerability context for Zambian households are failing livelihood systems. This is where AIDS has been very vicious. AIDS is known to turn relatively well-off households into a situation of high vulnerability. Households quickly lose labour due to chronic illness, looking after patients and attending funerals.

Studies (e.g. De Waal and Tumushabe, 2003) have found a strong relationship between the deepening household food insecurity in Zambia and other Southern African countries and HIV and AIDS. This was well illustrated by the 2001-2002 drought and the consequent food shortages in Zambia.

Drought-stricken households had sufficient resilience through use of coping strategies. However, AIDS-affected households could not cope in the same way. Effects were much more for them because

Box 3.9: Observations on nutrition and AIDS

"In the past years, the Red Cross used to assist. They used to give mealie meal to AIDS patients. These used to recover and look well. Even the number of deaths in the community reduced. The patients also used to receive beans, cooking oil and washing soap. Patients used to feel happy about this. They also received blankets and towels. This was good. But since they left, deaths have also increased." *Kapiri women focus group discussion*

Box 3.10: Do not give us fish, teach us how to fish

"It is not enough to be receiving food at all times. It is better that people affected by HIV and AIDS are assisted in income generating activities. So, instead of bringing Kapenta that will only finish in two days, it is better someone brings income generating activities that will sustain our lives. We can help ourselves by keeping some animals like goats and when we are given something, we should contribute our labour. For example, if you give me beans, I should contribute by planting." *40 year old widow living with HIV, Chikankata*

of a number of factors. First of all, the loss of household labour - both quality and quantity - to illness, caring for the sick, funerals, protracted nature of illness, psychological impacts of the illness and loss of skills and experience.

Second is the reduction in available cash income and asset base. This results in reduction in food consumption, erosion of asset base to finance health needs, inability to hire labour and buy inputs, sale of productive assets, consumption of seeds, sale of land, loss of land through dispossession, loss of remittance if affected person was the source and limited access to credit.

Third is the declining capacity of the social environment to offer support to AIDS-affected households. The traditional extended family and non-formal networks are changing as their capacity declines, demand increases, and a reversal of roles between urban and rural areas occurs. There is also the loss of knowledge of agricultural practices and skills, as women (less exposed to agriculture knowledge for cash crops due to gender discrimination) and children take over agricultural tasks.

There are other ways in which HIV and AIDS is entrenching poverty and creating ground for its spread. For example, once individuals live in abject poverty, they may engage in lifestyles that expose them to HIV infection. There are women who have taken up beer brewing for survival once widowed as a result of AIDS. Once drunk, their patrons may end up having sex with them or their girl children. Furthermore, girl children may become sex workers as a means of survival, a vice which puts them at risk of HIV and other sexually transmitted infections.

In poor or food insecure households, individuals, especially women, are poorly motivated to take precautionary steps to protect themselves against HIV infection and engage in unprotected sex. In many cases this may be the only means of providing for one's family.

Malnutrition is another aspect which is not only a consequence of HIV and AIDS but in turn reinforces its devastating impacts. According to the Food and Agriculture Organisation in households affected by AIDS, the food consumption of all members frequently declines, resulting in malnutrition. This results from the factors that undermine food security in AIDS-affected households already discussed above. AIDS, therefore, threatens the nutritional security of HIV-positive individuals and their families. Due to an increased susceptibility to opportunistic infections, poverty-induced malnutrition is likely to lead to an early onset of AIDS. Poor nutrition enhances the progression of AIDS. Community members are aware of the link between nutrition and progression of AIDS (see Box 3.10 on p. 53)

AIDS is not the sole factor that is worsening the vulnerability context for households in Zambia. However, it is deepening this context to levels that make it difficult to recover from shocks and seasonality factors when they occur. Therefore, actions against HIV and AIDS must be at the centre of any strategy that seeks to lessen the vulnerability context for households.

HIV and AIDS and the feminisation of poverty

Even before the advent of HIV and AIDS, in development circles, there was a lot of discussion on feminisation of poverty. This was closely linked to the economic crisis in the country, the social status of women and an increase in female-headed households. HIV and AIDS has however worsened gender-based differences in access to land and other productive resources like labour, technology, credit and water.

In situations where a wife survives the death of her husband from an AIDS-related illness, the weak position of women and the stigma attached to the disease contribute to excessive stripping or grabbing,

by family members, of productive assets from the surviving widow and her children. The widow and the children may sink into more poverty and this forces women into activities that may expose them and their girl children to sexual abuse and sex work. They may even have limitations of access to knowledge about how to protect themselves (UNDP, 2002).

Results from a qualitative study in Northern Province of Zambia (FAO, DCI and GRZ 2004) provide more insights on the disproportionate negative impact of HIV and AIDS on the various livelihood assets of female headed households. Main findings of the study are summarized in Table 3.4 on p. 56.

The negative impact of HIV and AIDS is quite intense in female-headed households. Box 3.12 gives a glimpse into their plight through the story of a 40-year-old widow "M" with only seven years of formal education.

Conclusions

The HIV and AIDS pandemic is a crisis of unequalled proportions in Zambia and in other developing countries as well as at the global level. This is clearly seen in its immense negative effects on the Zambian households described in this Chapter.

The best chance to respond to HIV and AIDS is at the household level because that is where the velocity of its negative impacts is most directed. The household is under attack from different dimensions as captured by the sustainable livelihoods framework (pp. 17-18).

HIV and AIDS is widening the vulnerability context of Zambian households. At the time when households should take measures to protect themselves from the spread of HIV and respond to the negative effects and be able to pursue livelihood strategies of their own choice, they are increasingly finding their capacity seriously eroded by the epidemic itself. It is clear

Box 3.12: A female-headed household

Currently, M is head of a household of seven people, four daughters, one son and her 75 years old father. The children are aged between nine and twenty years. She became head of the household when her husband died about two years ago. The house they live in belongs to her father whose wife died sometime back. The household has very little in terms of assets because when M's husband died almost everything they owned, including beds, was grabbed by her husband's relatives. Now even the children sleep on the floor. Three children share one room while the father has his own room.

The household grows some maize. Sometime back, they used to grow groundnuts but because of M's ill health and the age of the father they cannot manage. They also used to have chickens but a certain disease killed them all.

According to M, she has experienced a lot of problems since her husband died. These include finding food for the children and sending them to school. Most of the time, the household survives on only nshima and vegetables, which she considers inadequate. At the time of the interview, the household had no food and the storage was empty. Sometimes the household receives some food rations from the church but this is irregular and when it comes, it is not enough. The house is in disrepair because they cannot manage to cut the grass or get money to buy grass in order to repair the roof. There is no help from neighbors, government, relatives, or other family members because, according to M, the entire community lives in abject poverty. However, some local non-governmental organizations and support groups provide basic support like beddings and some food like sorghum once in a while.

Every day, M asks herself what she is going to give the family to eat. As for the future, her main concern is if the family is suffering now when she is still alive, what will happen to them when she is dead. She prays that she continues receiving ARV treatment from the hospital.

Table 3.3: HIV and AIDS affects female-headed households disproportionately

Female-headed households keep about three times as many orphans as male-headed households. In particular, female-headed households taking care of people living with HIV (PLHIV) bear the brunt of looking after orphans, supporting an average of about 3.6 orphans each.
Female-headed households taking care of PLHIV have few income sources and rely mainly on sales of crops and beer to obtain cash.
Only a few female-headed households with orphans are members of cooperatives, owing to lack of time and financial constraints.
Only few female-headed households looking after PLHIV and/or orphans participate in the community-level area satellite committees.
Female-headed households, particularly those taking care of PLHIV, own fewer physical assets such as axes, shovels and radios owing to distress sale and property grabbing.
Female-headed households taking care of PLHIV and/or orphans use less fertilizer and fewer improved varieties and chemicals than male-headed households. They lack the financial resources to purchase these inputs.
Female-headed households with PLHIV own very few ruminants compared with other household types, owing to constant selling in order to meet immediate cash needs.
Female-headed households experience more property grabbing than male-headed ones. Property grabbing is particularly high among female-headed households taking care of PLHIV.
Female-headed households taking care of PLHIV spend most of their financial resources on purchasing food and on medical expenses, leaving fewer resources for paying school fees and investing in agricultural production.
Female-headed households taking care of orphans, especially those headed by grandmothers, decreased the areas they cultivated owing to competing demands on their time and the inability to purchase farm inputs.

FAO, Development Cooperation Ireland and the Government of Zambia, 2004

from the discussion in this Chapter that to engage the household as an effective partner in responding to HIV and AIDS would require doing so from several angles. The household must be provided with capacity to protect itself against infection and infecting others. It must also be assisted to mitigate the negative impacts of the epidemic. The two are related and are mutually reinforcing.