



**Draft Context  
Mapping Report**

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# Tracking Global HIV/AIDS Initiatives and their Impact on the Health System in Zambia

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# GLOBAL HIV/AIDS INITIATIVES NETWORK

**Researching the national  
and sub-national effects of  
global HIV/AIDS initiatives  
at the country level**

The Global HIV/AIDS Initiatives Network (GHIN) is a network of researchers established in 2006 that aims to track the effects of the major global HIV/AIDS initiatives:

- The World Bank's Global HIV/AIDS Programme including the Multi-country AIDS Programme (MAP)
- The Global Fund to Fight AIDS, TB and Malaria (GFATM)
- The United States President's Emergency Plan for AIDS Relief (PEPFAR).

The Members of the Network are researching the country effects and inter-relationships of these initiatives at national and sub-national levels. This network builds on two earlier studies: the Tracking Study, led by the London School of Hygiene and Tropical Medicine (2003-2004) and the System-Wide Effects of the Fund (SWEF) Research Network (since 2003) coordinated by the Partners for Health Reformplus project.

GHIN countries undertaking 2-4 year studies include: Angola, Benin, China, Ethiopia, Georgia, Kyrgyzstan, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam and Zambia. The Network is facilitating comparative work across these countries and will synthesise research findings.

For further information on the Network, please visit our website:

<http://www.ghinet.org/>

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# Table of Contents

|  |    |
|--|----|
| <b>ACRONYMS</b>  | 4  |
| <b>EXECUTIVE SUMMARY</b>   | 5  |
| <b>1. INTRODUCTION</b>   | 7  |
| <b>2. BACKGROUND</b>   | 8  |
| 2.1 Political and Socio-economic Conditions                            | 8  |
| 2.2 The National HIV/AIDS Picture                                      | 8  |
| <b>3. HIV/AIDS POLICIES AND LEGISLATION</b>                            | 10 |
| <b>4. STRUCTURES AND MECHANISMS FOR HIV/AIDS POLICY IMPLEMENTATION</b> | 12 |
| 4.1 National HIV/AIDS Council  | 12 |
| 4.2 Health system Response to HIV/AIDS                                 | 13 |
| 4.3 Multi-sectoral approach to the fight against HIV/AIDS              | 14 |
| 4.4 Bilateral and Multi-lateral Partners                               | 15 |
| 4.5 The role of Civil Society in the Fight against HIV/AIDS            | 15 |
| <b>5. FUNDING PREVENTION, TREATMENT AND CARE</b>                       | 17 |
| 5.1 Introduction   | 17 |
| 5.2 The Global Fund to Fight AIDS, TB and Malaria                      | 18 |
| 5.3 Multi-Country Programme (MAP)                                      | 21 |
| 5.4 President's Emergency Plan for AIDS Relief (PEPFAR)                | 22 |
| <b>6. CONCLUSION</b>   | 24 |
| <b>APPENDIX 1: GENERAL VIEWS FROM THE KEY INFORMANTS</b>               | 26 |
| <b>APPENDIX 2: REFERENCES</b>  | 29 |



# Acronyms

|        |  |
|--------|--|
| AIDS   | Acquired Immune Deficiency Syndrome            |
| CHAZ   | Churches Health Association of Zambia          |
| DHS    | Demographic health survey                      |
| FPP    | Focal point person                             |
| GFATM  | Global Fund                                    |
| GHI    | Global health initiatives                      |
| HIPC   | Highly indebted poor country                   |
| HIV    | Human Immune Virus                             |
| JFA    | Joint Financing Agreement                      |
| LSHTM  | London School of Hygiene and Tropical Medicine |
| NAC    | National AIDS Council                          |
| NZP+   | Network of Zambian people living with HIV/AIDS |
| OVC    | Orphans and Vulnerable Children                |
| PATF   | Provincial HIV/AIDS Task Force                 |
| PDCC   | Provincial Development Coordinating Committee  |
| PEPFAR | President's Emergency Plan for AIDS Relief     |
| PLWHA  | People living with HIV/AIDS                    |
| RCSI   | Royal College of Surgeons in Ireland           |
| ZANARA | Zambia National AIDS Response                  |
| ZNAN   | Zambia National AIDS Network                   |

# Executive Summary

The HIV/AIDS epidemic has become the major public health challenge for Zambia. During the last three decades, Zambia's life expectancy has dropped from 58 to about 39 years mainly due to the high disease burden. HIV/AIDS, tuberculosis and malaria have all combined to cause high levels of morbidity and mortality. Zambia has a generalised heterosexual HIV epidemic whose prevalence has remained high and mostly unchanged for the last decade. In adults aged 15-49, the prevalence rate is 17% (UNAIDS 2006).

Global funding for HIV/AIDS has increased massively during the past five years. The study specifically seeks to investigate effects of global HIV/AIDS initiatives<sup>1</sup> (GHIs) on the national and district health systems in Zambia focusing on: scale up, access and equity, coordination and harmonisation and human resources. The study is part of the Global HIV/AIDS Initiatives Network (GHIN), a network of research institutions in Africa, Europe, Asia and South America. The aim of the Network is to research the effects of the global HIV/AIDS initiatives at country and district level and to use the findings to inform policy development at both national and international levels. This report presents the national context mapping exercise.

This current draft is work in progress, has helped to inform district field work in 2007 and will inform the research to be carried out at district and national levels in 2008. The national context mapping exercise addressed the following study objectives:

- Provide a description of the relevant GHIs in the country, the aims and approaches of each GHI and how far each GHI is coordinated and harmonised within the overall HIV/AIDS national policy and strategy;
- Map the range of HIV/AIDS-related interventions/services
- Review relevant national legislation and policies, the programmes and operational plans of state and NGO service providers & how these are influenced by the relevant GHIs.
- Describe the amount of resources coming from GHIs and where they are being expended

This report has reviewed national legislation, policies, programmes and operational plans. Qualitative in-depth interviews with five key informants relating to the global HIV/AIDS initiatives in Zambia were also carried out. The context mapping exercise was carried out between August and October 2006.

Based on the findings from this level of the research, this report generates some important research questions which will be pursued at the district levels:

## **(i) Scale up**

Whilst it is clear that scale up is indeed occurring, it is not yet clear how and in what way. What are the different models of care being provided and what is the (patient-perceived) quality of the services provided by these providers? It will also be useful to look at other priority non-HIV/AIDS services? Are they scaling up? Are some being neglected because they lack GHI funds?

## **(ii) Human Resource Capacity**

The report states that increased training is taking place. This poses questions to follow up regarding issues such as types of training and is it appropriate to health worker needs. The informants interviewed for this report mention lack of motivation as a problem; issues around motivation, incentives, time spent on HIV control versus other services will need to be explored in more detail at the district level.

<sup>1</sup>This study investigates: Global Fund to Fight AIDS, TB and Malaria (GFATM); the World Bank Multi-country HIV/AIDS Program (MAP)

### **(iii) Coordination, Harmonisation and Alignment**

The findings from this report show that coordination is occurring in varying degrees. What is the capacity of the districts to coordinate HIV/AIDS control? How do the different GHIs integrate with one another and with the wider government policies, both at national and district level? What coordinating structures exist? What is the coordination of services at provider level?

### **(iv) Access and Equity**

While the findings show that there has been some improvement of access to HIV/AIDS related services, there are still many barriers to access for some groups. The district level research will need to assess the effects of GHIs on equity of access to HIV/AIDS interventions and services at district level, focusing on barriers to access for key target groups: for example the poor, the young, rural dwellers, women. Models of delivery that help increase/overcome these barriers will also be explored.

# 1. Introduction

The HIV/AIDS epidemic has become the major public health challenge for Zambia. During the last three decades, Zambia's life expectancy has dropped from 58 to about 39 years mainly due to the high disease burden. HIV/AIDS, tuberculosis and malaria have all combined to cause high levels of morbidity and mortality. Zambia has a generalised heterosexual HIV epidemic whose prevalence has remained high and mostly unchanged for the last decade. In adults aged 15-49, the prevalence rate is 17% (UNAIDS, 2006).

WHO ranked Zambia in 2005 as having the 6th highest TB incidence rate world-wide (Global TB report, 2007). The main reasons for the rapid increase of TB cases are due to HIV/AIDS and poverty (National HIV/AIDS Policy 2005). The increase in TB infection rates closely correspond to the spread of HIV/AIDS as about 70 percent of TB patients in urban hospitals are also HIV positive.

A network of research institutions in Africa, Europe, Asia and South America was established in March 2006 following a workshop held in London represented by 17 institutions from the above-mentioned regions. The aim of the network is to research the effects of the global HIV/AIDS initiatives<sup>2</sup> at country and district level and use the findings to inform policy development at both national and international levels. In Zambia, Frontiers Development and Research Group is undertaking the research with technical assistance from the London School of Hygiene and Tropical Medicine (LSHTM) and the Royal College of Surgeons in Ireland (RCSI). The study specifically seeks to investigate effects of global HIV/AIDS initiatives (GHIs) on the national and district health systems, focusing on scale up, access and equity, coordination and harmonisation and human resources. The Zambian study is funded by the Open Society Institute (OSI). OSI is funding similar studies in Kyrgyzstan and Ukraine which are also part of the Global HIV/AIDS Initiatives Network.

This report presents the national context mapping exercise. This current draft is work in progress, has helped to inform district field work in 2007 and will inform the research to be carried out at district and national levels in 2008. The national context mapping exercise addressed the following study objectives:

- Provide a description of the relevant GHIs in the country, the aims and approaches of each GHI and how far each GHI is coordinated and harmonised within the overall HIV/AIDS national policy and strategy;
- Map the range of HIV/AIDS-related interventions/services;
- Review relevant national legislation and policies, the programmes and operational plans of state and NGO service providers & how these are influenced by the relevant GHIs;
- Describe the amount of resources coming from GHIs and where they are being expended.

The report highlights the three major global HIV/AIDS initiatives in Zambia: Global Fund to Fight AIDS, TB and Malaria (GFATM); the World Bank Multi-country HIV/AIDS Program (MAP); and the President's Emergency Plan for AIDS Relief (PEPFAR). The report reviews national legislation, policies, programmes and operational plans relating to HIV/AIDS. Interviews with five key informants<sup>3</sup> were also carried out. (see appendix 1). The context mapping exercise was carried out between August and October 2006.

<sup>2</sup>These are Global Fund to Fight AIDS, TB and Malaria, PEPFAR and World Bank MAP

<sup>3</sup>Representing the World Bank supported Zambia National AIDS Response (ZANARA), two of the Global Fund Principal Recipients – (Zambia National AIDS Network (ZANAN) and the Churches Health Association of Zambia), the President Emergency Plan for AIDS Relief (PEPFAR) and the Network of Zambian People Living with HIV/AIDS (NZP+).

## 2. Background

### 2.1 Political and Socio-Economic Conditions

Zambia has a population of about 11 million people, who represent more than 70 different ethnic groups (CSO 2005). About 35 percent of the population lives in urban areas making Zambia one of the most highly urbanized countries in sub-Saharan Africa. In the last 42 years, Zambia has moved from being one of the middle income countries in Sub-Saharan Africa (SSA), with US \$1200 per capita at Independence in 1964, to being one of the poorest. In 2004, it was ranked 165 out of 174 countries for human development. This was a decline from 153rd position in 2000 (UNDP 2006), reflecting an ongoing slide into poverty. The downward trend has been due to both internal and external factors – e.g. decline in terms of trade for copper, economic mismanagement, and acceleration of the implementation of structural Adjustment Programme (SAP) measures since 1991. Consequently, Zambia came to be classified as a Highly Indebted Poor Country (HIPC). Even under this status, however, the country still had to make substantial foreign debt repayments, so that repayments relief through HIPC did not really alter the adverse economic conditions affecting the majority of the people.

Extreme poverty levels for Zambia have fluctuated over the years – currently 68% of Zambians live in poverty. (CSO 2005). The levels have been higher in rural than urban areas and persons living in female-headed households are more likely to be extremely poor than those living in male-headed households – e.g. food poverty was more prevalent in female-headed households (61%) than in male-headed households (52%) (CSO/LCMS 2004). Some other statistics include:

- Zambia ranks 90 in the Human Poverty Index and 166 on the human Development Index (UNAIDS 2006)
- 87.4% of people live on less than US \$2 a day (UNAIDS 2006)
- A decline in life expectancy from 42 years at independence in 1964 down to 37.5 years in 2004 (CSO 2004)
- Zambia's per capita income is US\$609 (IMF 2005)

### 2.2 The National HIV/AIDS Picture

AIDS remains complex and incurable and devastates individuals, communities and nations. Since the start of the epidemic, an estimated 60 million people have been infected with HIV globally, out of which about 20 million people have died (UNAIDS 2005a). The HIV/AIDS prevalence rate in adults aged 15-49 in Zambia is 17% (UNAIDS 2006).

The rising prevalence trends among the 15-19 year-old pregnant women attending antenatal clinics suggests that new infections are still occurring at significant rates in the country (UNAIDS 2005b). Urban residents are twice (23%) as likely to be infected compared with rural residents (11%) with the highest concentration of infection around cities and major towns and along major transport routes (DHS 2001-2002).

HIV/AIDS prevalence is highest in urban areas along the country's main transport routes, such as Kabwe, Livingstone and Ndola (MoH Zambia, 2005). At current levels of HIV prevalence, young persons in Zambia face a 50% life-time risk of dying of AIDS, in the absence of treatment (MoH 2005)

There has been a massive scale-up of treatment services in Zambia over the last 3 years; with more than 75,000 people now on antiretroviral drugs. This is compared with just 3,000 people in 2003, 24,000 in 2004 and 50,000 in 2005. However, this represents only 20% of women and men who need them. Only 13% of orphans and other children made vulnerable by HIV receive free-of-charge, basic external support (UNAIDS, 2006). By 2005, there were over 400 sites offering VCT services nationwide. The percentage of people who have attended for VCT and know their status stood at 30 percent. (ZSBS, 2006).

**Table 1: Numbers of people on ART**

| Year | Numbers on ART      |
|------|---------------------|
| 2003 | 3,000               |
| 2004 | 24,000              |
| 2005 | 50,000              |
| 2006 | 75,000 <sup>4</sup> |

Services are also becoming more widely available for the prevention of mother to child transmission (PMTCT) of HIV, with over 90% of districts having some PMTCT service sites (DfID 2006). Despite this, only 4% of women are actually receiving PMTCT (UNAIDS 2006).

A number of factors in sub-Saharan Africa in general and Zambia in particular contribute to the vulnerability of the population to HIV infection. Amongst these is a decline in the standards of living due to growing deprivation, poverty, unemployment and gender inequality. Under these circumstances, factors increasing the likelihood of a rapid spread of HIV include inadequate knowledge about HIV, cultural factors, high rates of sexually transmitted infections, transactional sex, substance abuse and sexual violence against women and girls.

Data from the 2006 Zambia Sexual Behaviour Survey (ZSBS) on stigma indicators show that among the entire population only 8.5 percent (7.2% males, 9.6% females) were counselled and tested for HIV and only 31.1 percent (33.9% males, 28.5% females) had accepting attitudes of those with HIV. Among men in urban areas, 50 percent used condom at last sexual intercourse with non-regular partners while 44.9 percent among women reported using condom at last sexual intercourse with non-regular partners. The survey also indicates that, among respondents who reported having sex in the last year prior to the survey, 24.5 percent (28.8% in urban, 22.5% in rural) had sex with a high risk partner and only 37.5 percent (50.0% in urban, 29.9% in rural) used a condom at the last high risk episode (ZSBS 2006).

<sup>4</sup>PEPFAR figures show 98,500 people on ART as of March 31 2007 (PEPFAR 2007 Country Profile; Zambia, 2007)

### 3. HIV/AIDS Policies and Legislation

In 2001, Zambia was one of 189 members of United Nations General Assembly Session on HIV/AIDS (UNGASS) who signed a declaration of the commitment to take action on HIV/AIDS in the areas of leadership, treatment, care and support. Government passed legislation that led to the establishment of the National AIDS Council (NAC) in 2002 (see section 4.1 below). Zambia made a commitment to the 2005 UNAIDS "Three Ones Strategy": one National HIV/AIDS Coordinating Agency; one Strategic Framework and one Monitoring and Evaluation System.

Zambia's HIV/AIDS/STI/TB policy (2005) was produced by the Ministry of Health. This policy and the National HIV/AIDS Strategic Framework 2006-2010, define the country's response to the HIV/AIDS epidemic along a continuum of prevention, mitigation and care and treatment. Prevention efforts are designed to help limit the further spread of the virus, while mitigation efforts are intended to address the impact of the epidemic. Treatment and care programmes are intended to support those who are already HIV-infected. The Zambian Government response to HIV/AIDS is guided by the following underlying principles;

- An appropriate legal framework,
- An appropriate national coordination and advocacy framework,
- HIV/AIDS is a serious public health, social and economic problem that requires a multi-sectoral approach,
- Information, education and communication for behaviour change is a cornerstone for prevention and control,
- Providing treatment, care and support is essential in order to minimize the impact of the epidemic,
- The human rights and dignity of all people, regardless of their HIV status, should be respected and stigma and discrimination against people living HIV/AIDS (PLWHA) should be eliminated,
- Gender mainstreaming is a central element in the fight against the epidemic.
- A supportive social and economic environment at all levels of society enhances the response by individuals, families and communities (NAC 2005).

The Framework (2006-2010) like its predecessor (HIV/AIDS Strategic Plan 2002-2004) addresses prevention on a number of fronts, including mother-to-child transmission, reuse of needles, and contaminated blood. On sexual transmission of HIV, the plan adopts a risk reduction strategy that focuses on at-risk groups such as truck drivers, prison populations, children/youth, women, and displaced populations such as seasonal migrant workers and refugees.

The Framework (2006) also recognises the need to fully promote behaviour change that includes abstinence, mutual faithfulness or condom use as priority intervention strategies. In particular, the Framework repeatedly stresses the importance of condoms as a main prevention tool in the national response to the disease, including efforts focused on youths. Emphasis is also placed on the need to increase and improve prevention and control of STDs as well as on reducing high-risk behaviours, including multiple partners and ritual cleansing. The Strategic Framework encourages the use of mass media to provide information, as well as life-skills materials—including those focused on reproductive health and HIV/AIDS/STD—which are increasingly incorporated into the mainstream school curriculum throughout the country (NAC 2002). The HIV/AIDS Policy and the Strategic Framework recognises the need for scaling up the provision of ART. In 2001 the Zambian Government set a target to put 100,000 people on ART by 2005. By September 2006 Zambia had about 75,000 people on ART (UNAIDS 2006) Both the HIV/AIDS policy and the National HIV and Strategic Framework recognise the need to mobilise adequate resources for scaling up HIV/AIDS interventions from Cooperating partners (i.e. donors) including the global HIV/AIDS initiatives.

The Poverty Reduction Strategy Paper (PRSP, 2001) and the Fifth National Development Plan (FNDP 2006) both aim at tackling poverty in the country with a view to quickly addressing the high levels of disease in general and HIV/AIDS in particular. The PRSP, developed through a highly consultative process, represented Zambia's medium term overall policy framework for national planning and interventions for development and poverty

reduction for the period 2002-2004. It is the overarching national development policy on which sector policies are centred for sustainable development, and is, therefore, premised on broad coordination and harmonisation of various economic growth and other development interventions. The FNDP proposes rapid economic development and employment creation, which places emphasis on public institutional capacity building and creation of a conducive environment for participation of other development actors (private sector, NGOs, CBOs, churches and beneficiaries).

# 4. Structures and Mechanisms for HIV/AIDS Policy Implementation

## 4.1 National HIV/AIDS Council

As mentioned above, Government passed legislation that led to the establishment of the National AIDS Council (NAC) in 2002. NAC is the national body mandated to coordinate and support the development of the multi-sectoral national response for the prevention and combating of the spread of HIV, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB.

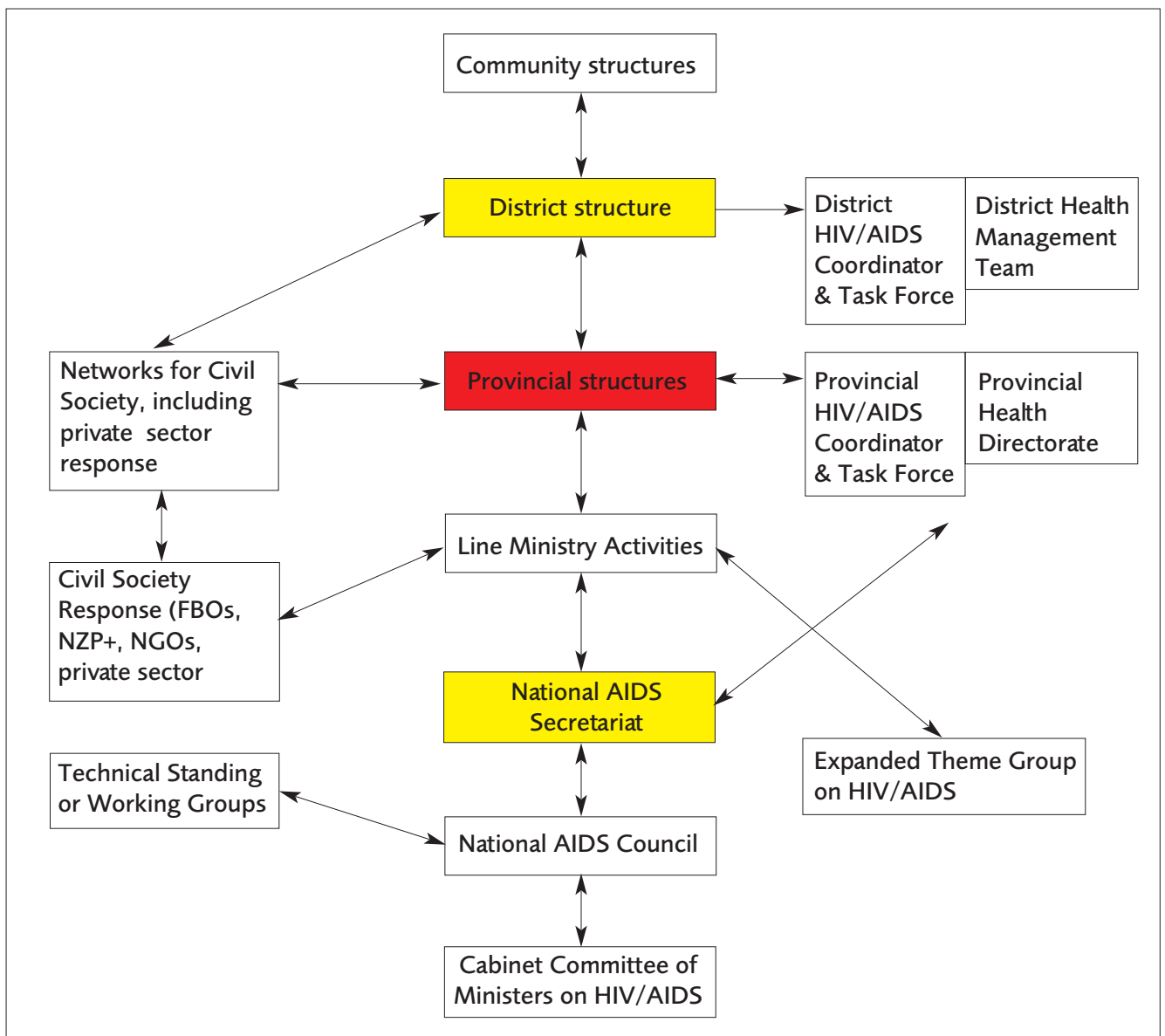
Within the broader vision of the National strategic framework, NAC undertakes the following roles and strategies:

- Support the national response to HIV/AIDS including development and implementation of the strategic plan and work plans;
- Coordination of all HIV/AIDS activities at National, Provincial, District levels, Public, Private Sectors and Civil Society;
- Mobilise resources from various cooperating partners both locally and internationally;
- Management of strategic information on HIV/AIDS;
- Build capacity, plan, track, monitor and evaluate country responses on HIV/AIDS; and
- Facilitate the operations of all Technical Working Groups and the development and revision of various technical documents, such as:
  - Guidelines on the management and care for HIV/AIDS patients,
  - Framework for the introduction and monitoring of antiretroviral therapy,
  - Monitoring and evaluation system, and
  - Home based care guidelines.
- To promote the implementation of multi-sectoral behaviour change communication campaigns
- To decrease the MTCT rate by increasing access to quality prevention of mother-to-child transmission services in all the districts of the country
- Make all blood, blood products & body parts safe for transfusion & promote use of sterile syringes, blades, and needles
- To improve quality of life of HIV/AIDS infected persons by encouraging positive living, good nutrition, prevention of opportunistic infections and avoiding high risk behaviour
- To provide appropriate care, support & treatment to HIV/AIDS infected persons and those affected by HIV/AIDS, TB, STIs and other opportunistic infections
- To provide improved care & support services for OVCs & others affected & at risk such as refugees, prisoners & disabled people.
- To improve HIV/AIDS information management and decision making by developing well coordinated data bases.
- To assure impartial, transparent and effective programme operations by improving the coordination of multi-sectoral implementation of interventions

NAC operates under the principle that HIV interventions should be mainstreamed in the development instruments such as the PRSP, the National Development Plan and the Mid Term Expenditure Framework.

NAC is a three tier structure consisting of: the Committee of Ministers; the HIV/AIDS/STD/TB Council and the National AIDS Secretariat.

**Figure 1: Structures and Institutions for Implementing Government HIV/AIDS Programmes**



## 4.2 Health System Response to HIV/AIDS

The Ministry of Health is a key organ in the coordination of HIV/AIDS interventions. It is represented in all the NAC structures from national to district levels. The Minister of Health chairs the Cabinet Committee of Ministers on HIV/AIDS whilst his Permanent Secretary chairs the National HIV/AIDS council.

Delivery of HIV/AIDS treatment and care is being integrated into the existing national health care system and the government aims at integrating ART into the basic health package. The Medical Council of Zambia, in collaboration with the Ministry of Health has defined an accreditation system to ensure that minimum standards are met by health facilities delivering ART. Accreditation specifies type of health personnel to be responsible for care, facilities, including diagnosis facilities, types of drugs that need to be available, dispensing and drug storage facilities and record keeping procedures.

There are currently various parallel ARV drug procurement systems in Zambia. The sourcing of drugs for public health facilities is managed by the Ministry of Health and conforms to national procurement rules, while the

country's Central Pharmacy is responsible for storage and distribution of drugs, including ARVs. In addition, CHAZ (Christian Health Association of Zambia) is managing ARV drugs procurement, storage and distribution procured by PEPFAR, as well as drug stocks distributed by CHAZ that are financed by the GFATM.

This has resulted in a segmented distribution process, with health facilities having to source, store and monitor two different drug flows, leading to additional administrative burden. However the argument made is that CHAZ has been effective in the building of the rapid scale up of ARV distribution, as it does not have to follow cumbersome governmental procurement procedures. The government has been delayed in the procurement of a large volume of drugs financed by the GFATM because of administrative and contractual constraints.

A major constraint to Zambia's health system is the availability of health workers. In 2004, Zambia's output from medical schools produced only 49 doctors, 540 nurses, 20 pharmacists and 38 laboratory technicians, far below the graduation rates required to maintain staff levels (USAID, 2006). There is an acute shortage of skilled human resources in the country. This shortage is aggravated by some of the donor conditionalities. One of the conditionalities that has implication for human resource is the eight percent ceiling on the use of available financial resources for paying and providing incentives to health workers. This creates a situation where the MOH receives less than one percent for human resource related expenditures.

A study carried out by the Zambia HIV/AIDS Workforce (2004) revealed that rates of HIV/AIDS service delivery from individual study sites averaged a low 30 percent annum. For ART services, this represents a continuing need to train replacements and highlights the need to incorporate PMTCT and ART training into the basic (pre-service) training curricula for doctors, pharmacists, laboratory technicians, clinical officers and nurses. The study also showed that, if ART was scaled-up to reach 24,000 individuals, then each of the nine hospitals in the study would require 3.4 doctors, 4 pharmacists and 7 laboratory technicians working full time on ART services. This represents more than 50 percent of the total pharmacy workforce and 19 percent of the total laboratory workforce (The Zambia HIV/AIDS Workforce, 2004).

### **4.3 Multi-Sectoral Approach to the Fight against HIV/AIDS**

In 1999, Zambia declared HIV a national disaster and placed limiting the spread of the virus high on the national health agenda. Since then, political will from the government has been strong, as evidenced by the existence of a Cabinet Committee on HIV/AIDS. The committee, whose mandate is to provide policy direction, political leadership and advocacy, is chaired by the Minister of Health. Through this committee Zambia has developed a policy environment that is conducive for mitigating the impact of HIV (UNDP 2007).

The Zambian Government, cooperating partners and programme implementers agree that HIV/AIDS is more than a health problem and requires a broad based multi-sectoral approach to address the many facets of the epidemic. There is a strong realisation that HIV/AIDS is very much inter-linked with poverty, social and economic inequities between men and women and long standing cultural behaviours and beliefs (NAC 2006).

The national HIV/AIDS/TB/STI Council coordinates the HIV/AIDS activities of line ministries and has sub-structures at provincial and district levels. At the provincial level, the NAC sub-structures include a sub-group of the Provincial Development Coordinating Committee (PDCC) which is referred to as the Provincial AIDS Task Force (PATF). At the district level, NAC is represented by a unit of the District Development Coordinating Committee which is referred to as District AIDS Task Force (DATF). These structures are designed to enhance the multi-sectoral approach of the national response to HIV/AIDS as membership is not only drawn from government line ministries but a wide range of both private and NGO actors.

Because of the Cabinet Committee on HIV, line ministries have embraced HIV/AIDS in their sectoral policies. For instance, the Ministry of Education (MoE) policy has adopted a three pronged approach in responding to HIV: to ensure that the "window of hope" is protected; to help those who are infected lead more protected lives; and to make the teaching of HIV and life skills an integral part of the curriculum at all levels (MoE 1996). The Ministry of

Agriculture and Cooperatives has produced a workplace HIV policy which recognises the need for raising awareness among staff. It also recognises that mitigation interventions such as making antiretroviral drugs and other therapies available to staff could improve the performance of people living with HIV/AIDS (UNDP 2007). All the line ministries have developed a workplace HIV/AIDS policy and the government has appointed HIV/AIDS focal point person (FPPs) in all ministries.

#### **4.4 Bilateral and multi-lateral Partners: Harmonisation**

Multilateral and bilateral partners provide both financial and technical assistance to help implement the National HIV/AIDS Strategic Plan. Through the Expanded Theme Group, international organisations also work with government/NAC to develop strategies to address the epidemic.

The harmonisation program in Zambia was initiated shortly after the Rome High-Level Forum by seven donors in the Like-Minded Donor Group (LMDG): Denmark, Finland, Ireland, The Netherlands, Norway, Sweden, and United Kingdom. In March 2003, Zambia, in collaboration with interested donors, developed a common agreement on the way forward: a Framework for Harmonisation in Practice (HIP) 2003. The Framework builds on the Rome Declaration on Harmonisation (2003).

The Wider Harmonisation in Practice (WHIP) Memorandum of Understanding (MoU) was agreed by 70-80% of the donor community in 2004 to address 'coordination and harmonisation of donor practices for aid effectiveness in Zambia' (OECD, 2006). Under this MoU, donors commit themselves to an increased use of the Zambian Auditor General for external audits. Such an increase has been seen in both the health and education Sector Wide Approaches (SWAps)

Almost all development partners active in Zambia (e.g. AfDB, Canada, Denmark, EC, Finland, Germany, Ireland, Japan, the Netherlands, Norway, Sweden, UK, UN family, and WBG) have now signed or indicated interest in participating informally (IMF & USAID) in the HIP initiative along with the government. The MoU focuses on aid effectiveness and includes an annex with specific actions and associated deadlines. These include increased use of direct budget support, establishment of more SWAps, increased reliance on government systems for procurement, fund management and auditing, use of TA pools and preparation of a Joint Assistance Strategy for Zambia (JASZ) with an improved division of labor. These activities are currently being implemented.

#### **4.5 The role of Civil Society in the Fight against HIV/AIDS**

The important contributions that national and international civil society organisations (CSOs) play in the fight against HIV/AIDS have long been recognised. In response to the HIV/AIDS epidemic, a considerable amount of resources are being directed towards CSOs. The CSOs work in partnership with the National AIDS Council (NAC) in the fight against HIV/AIDS. Rather than establish a new grant-making administration for CSOs, existing structures have been developed and are being used to channel new GHI funds to HIV/AIDS control in order to strengthen and promote harmonisation and alignment with prevailing systems.

In order to achieve autonomy and full participation of the CSOs, two fund disbursement mechanisms exist; namely the Zambia National AIDS Network (ZAN) and the Community Response to AIDS (CRAIDS). ZAN was formed in 1994 to promote liaison, collaboration and coordination among all Non-Governmental Organisations (NGOs) dealing with HIV/AIDS. For instance, during the Round 1 GFATM proposal development, the Zambia Country Coordination Mechanism (CCM) selected ZAN to be one of four principal recipients for the HIV/AIDS grant, tasked with channeling funds to CSOs. CRAIDS has been used as a channel for World Bank MAP funds. In Zambia, PEPFAR channels HIV/AIDS funds mainly through international NGOs. One of the organisations that receive funds from PEPFAR is the Centre for Infectious Disease Research in Zambia (CIDERZ), has received most of the funds for scale-up of ART.

Priority areas for funding through ZNAN and CRAIDS include projects that focus, among other things, on:

- prevention through participatory and community-based behaviour change and communication and access to condoms
- mitigation including activities targeted towards orphans and vulnerable children, home-based care, access to treatment and support for people living with HIV/AIDS (PLWHAs), and
- human rights including advocacy and protection and promotion of the rights of vulnerable groups and PLWHAs.

A number of significant questions arise from this section for follow-up at the district level of this study. For instance, how do the implementation structures work together and do they form a coordinated national and district HIV/AIDS response? It will also be important to ascertain which GHIs integrate with one another and with the wider government policies at the district level.

The private sector is also becoming more involved into HIV/AIDS activities. It counts several coordinating networks such as the Business Coalition on HIV/AIDS (ZBCA). Various workplace HIV programmes are also currently being implemented.

# 5. Funding HIV/AIDS Prevention and Treatment

## 5.1 Introduction

Global funding for HIV/AIDS has increased massively during the past five years. The reason for the increase in funding is to achieve the goal of reversing the epidemic by 2015, through the scaling-up of prevention, treatment and care. Globally, levels of funds committed to fighting HIV/AIDS include: US\$1.1 billion since 2000 to the World Bank's Multi-country AIDS Program (MAP), over US\$1.7 billion to HIV/AIDS approved by The Global Fund to Fight AIDS, TB and Malaria (2002-05); and the US Congress' appropriation of US\$3.2 billion in 2006 to the United States President's Emergency Plan for AIDS Relief (PEPFAR). In the high prevalence, low income countries of southern and eastern Africa, the combined commitments from these initiatives frequently amount to over half of the countries' total health budgets (Bennett et al, 2006). This research project focuses on the effects of these three initiatives on Zambia's health system at national and district levels.

In the last five years, Zambia has received large funding from global HIV/AIDS initiatives (GHIs) and other donor agencies to support prevention, treatment and care activities for people living with HIV and AIDS. Resources come from international sources, with the government budget and the private sector also contributing. According to NAC (2007), estimating past expenditures on HIV/AIDS and projecting future needs is difficult. Zambia has not had a National HIV/AIDS Account (NHAA) to track the different financial inflows for HIV/AIDS interventions and the amounts spent on those different interventions. A NHAA would permit better tracking of future financial inflows. (NAC 2007)

Most of the financial support for HIV/AIDS prevention, treatment and care comes from multilateral (including Global Fund) and bilateral funding agencies. The funds approved for Zambia by the GHIs are as follows: Global Fund US\$223,987,560 (Rounds 1 & 4); the World Bank US\$42 million in 2002; PEPFAR US\$59 Million in 2004, US\$47.7 million in 2005 and over US\$100 million in 2006 (WHO 2005).

**Table 2: Overview of the Funding Commitments to HIV and AIDS<sup>5</sup>**

| Source: (Domestic (D) and External (E)) | 2002            | 2003       | 2004         | 2005       |
|---|-----------------|------------|--------------|------------|
|   | (US\$ '000,000) |            |              |            |
| Government (D)                          | -               | -          | 41.4         | 41.4       |
| Out of Pocket (D)                       | 22.3            | -          | 24.2         | 27.9       |
| Global Fund (E)                         | 41.9            | -          | 26.8         | -          |
| PEPFAR (E)                              | -               | 61         | 57.9         | 84.7       |
| ZANARA (E) (WB MAP)                     | -               | 42         | -            | -          |
| <b>TOTAL (D,E)</b>                      | <b>64.2</b>     | <b>103</b> | <b>150.3</b> | <b>154</b> |

The total amount allocated for HIV and AIDS programmes by the Government accounted for 1.53 percent of the national budget.

<sup>5</sup> NAC, 2005, "Source of Funds for 2005"

**Table 3: Overview of the Funds Disbursed to HIV and AIDS, as % of Funds Committed to HIV and AIDS Specifically**

| Source: (Domestic (D) and External (E)) | 2002 | 2003 | 2004   | 2005        |
|---|------|------|--------|-------------|
|   | (%)  |      |        |             |
| Government (D)                          | -    | -    | 34.3%  | 39.4%       |
| Out of Pocket (D)                       | 100% | -    | 100%   | 100%        |
| Global Fund (E) <sup>6</sup>            | -    | 6.0% | 30.0%  | 2.8% + 3.4% |
| PEPFAR (E)                              | -    | -    | 141.3% | 164.1%      |
| ZANARA (E) (WB MAP)                     |      | 3.1% | 16.9%  | 34.5%       |
| JFA (D,E)                               |      |      |        |             |

In April 2006, the IMF approved Zambia's \$4 billion debt relief package after the country met conditions for sustained good economic management under the initiative for highly indebted poor countries (HIPC), a global plan to cancel debts owed by some poor nations. Zambia projected it would receive an additional \$2.5 billion in debt relief after the Group of Eight (G8) nations cancelled 100 percent debts owed to multilateral lending institutions by 18 poor nations, including Zambia. In June 2006, the Zambian government announced the intention to use some of the funds from debt relief to provide AIDS drugs for 100,000 people by the end of the year.

The government has abolished a 40,000 Zambian Kwacha (\$9) fee which people receiving ARVs were previously required to pay each month in order to raise the number of people receiving free drugs to 100,000 by the end 2006 (Shacinda 2005).

This research will look at scale up of HIV/AIDS services at the district and facility levels and in particular to assess trends over time. Other questions to be asked include the role of GHIs in service scale-up. Where it is found out that scale-up is occurring, how and in what ways, in terms of types of services delivered and providers. How has the scale-up of HIV/AIDS interventions affected the provision of non-HIV/AIDS services?

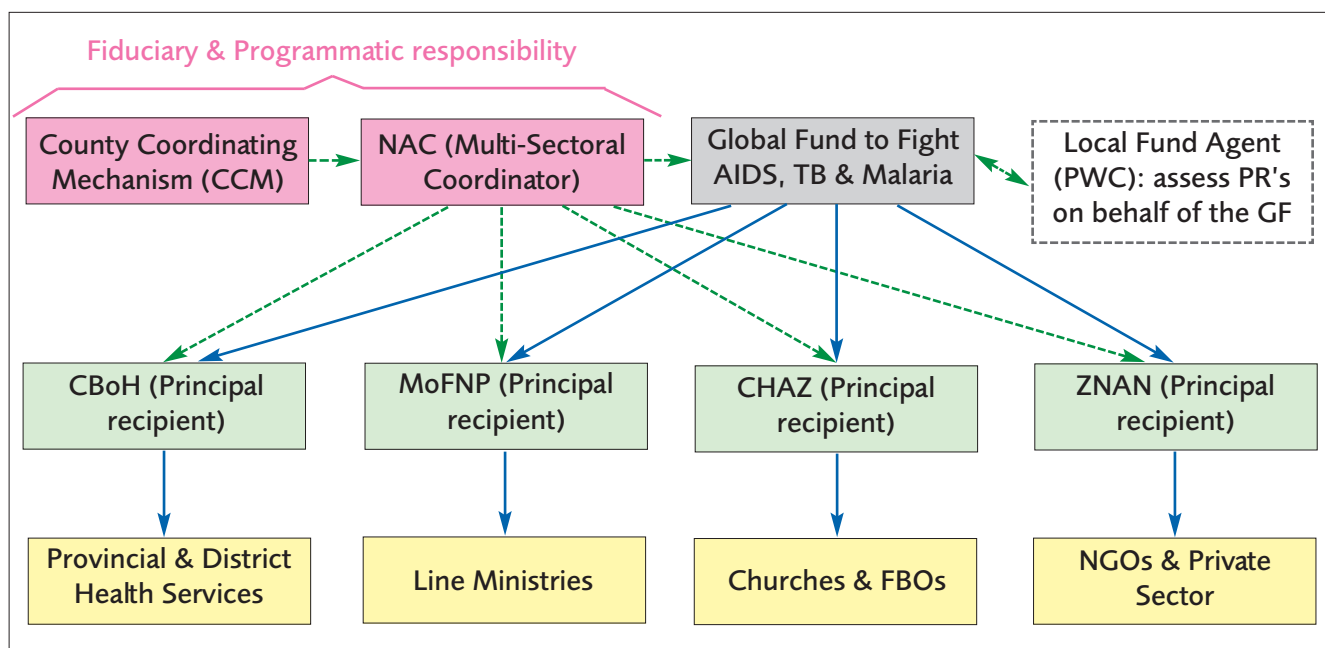
## 5.2 Global Fund to fight AIDS, TB and Malaria (GFATM)

GFATM is an initiative that has aimed to radically change the way assistance flows from rich to poor countries. The fund has been viewed as necessary because existing financing mechanisms were not getting funds quickly to where they were needed. The Global Fund aimed to create mechanisms for making aid flows more performance-related; by expecting countries to apply for aid; by broadening levels of participation in the application and delivery process; and by making grant disbursement conditional on the achievement of progress and disbursement milestones. In so doing, GFATM has contributed to introducing new roles and relationships – between government, civil society and donors – at the country level (Brugha et al, 2004). A Government-led process through the Country Coordination Mechanism (CCM) resulted in a successful Round 1 application in March 2002 and again in Round 4, April 2004. In both rounds, Zambia received large awards, which between them covered the three diseases. Zambia did not receive grants for Round 5 and 6. The view of most national level respondents in a 2003-04 study was that the appropriate constituencies were represented on the CCM (Brugha et al, 2004; Donoghue et al 2005).

<sup>6</sup>Note that the two entries under 2005 for the Global Funds indicate that two disbursements were made for the two separate Rounds (Rounds 1 and 4, respectively) of the Global Fund

The Round 1 success received much national publicity and was a cause of national pride (Brugha et al, 2004) Soon after grant approval in June 2002, Zambia selected four Principal Recipients (PRs) to receive, channel and account for Global Fund resources: Ministry of Finance (MoF), Central Board of Health (CBoH), Churches Health Association of Zambia (CHAZ) and the Zambia National AIDS Network (ZNAN). Government's support for civil society to control the funds that would come to it demonstrated its commitment to partnership. ZNAN and CHAZ disburse the funds through Lead Agencies.

**Figure 2: Global Fund Model Structure of Financing<sup>7</sup>**



**Table 4: Global Fund Round 1 (HIV/AIDS)**

| Principal Recipient                          | Grant Amount (USD) | Amount disbursed (USD) |
|--|--------------------|------------------------|
| Ministry of Health                           | 40,884,928         | 21,442,636             |
| Churches Health Association of Zambia (CHAZ) | 22,840,611         | 19,894,115             |
| Ministry of Finance and National Planning    | 6,395 758          | 3,057,134              |
| Zambia National AIDS Network (ZNAN)          | 20,204,481         | 17,780,634             |

<sup>7</sup>NAC Annual Review Report (2005)

**Table 5: Global Fund Round 4 (HIV/AIDS)**

| Principal Recipient                          | Grant Amount (USD) | Amount disbursed (USD) |
|--|--------------------|------------------------|
| Ministry of Health                           | 11,091,640         | 10,698,939             |
| Churches Health Association of Zambia (CHAZ) | 8,487,920          | 8,487,919              |
| Ministry of Finance and National Planning    | 2,376,376          | 912,162                |
| Zambia National AIDS Network (ZANAN)         | 4,814,840          | 4,424,196              |

### 5.2.1 Zambia National AIDS Network (ZANAN)

In April 2003, the GFATM and ZANAN signed a grant agreement for the fight against HIV/AIDS. The task of ZANAN under the GFATM agreement was to mobilize non-faith-based NGOs, community-based organisations (CBOs), people living with HIV/AIDS and the private sector organisations in order to effectively disperse the GF money and enable them to scale-up their HIV/AIDS prevention activities as outlined in the national HIV/AIDS Strategic Plan. ZANAN has two modes of disbursement of funds; i) direct disbursement to sub recipients applying for funds, ii) disbursements through lead agencies for further sub granting to other NGOs, CBOs, and private sector organisations. Drawing on the successful Round One grant from the GF, the total amount committed for 2 years was US\$8,073,013 for implementation during the period August 2003 to June 2005. About 118 organisations were funded. In the Round 4, US\$4,814,840 was committed for implementation from July 2005 to June 2007.

The Lead agencies for ZANAN and their service/intervention areas are presented in the table below.

**Table 6: The Lead agencies for ZANAN and their service/intervention areas**

| District | Name of NGO/CSO  | Service  |
|----------|--|--|
| Ndola    | Development AID from People to People                          | Workplace, Condom distribution, VCT, PMTCT, PLWHA                  |
| Lusaka   | Family Health Trust  | Youths, Condom Distribution, HBC, OVC                              |
| Lusaka   | KARA counselling and Training Trust                            | Condom Distribution, VCT, PLWHA, HBC                               |
| Lusaka   | Zambia Business Coalition for HIV/AIDS (ZBCA)                  | Workplace, VCT   |
| Lusaka   | Africare   | Youths   |
| Kitwe    | Copperbelt Health Education Project (CHEP)                     | Workplace, High Risk, VCT, HBC, OVC, PLWHA                         |
| Lusaka   | Traditional Health Practitioners Association of Zambia (THPAZ) | STI Programme, Specific Groups                                     |
| Lusaka   | International HIV/AIDS Alliance                                | Youth, High Risk, VCT, PLWHA, PMTCT, HBC, OVC,                     |
| Lusaka   | Thandizani Community Based HIV/AIDS Prevention and Care        | Youth, Workplace, Condom Distribution, VCT, PMTCT, PLWHA, HBC, OVC |

ZANAN was chosen by the CCM during Round 1 to serve as Principal Recipient (PR) for the GFATM on behalf of CSOs, based on its potential capacity to manage and disburse large sums of money.

### **5.2.2 Churches Health Association of Zambia (CHAZ)**

Churches Health Association of Zambia (CHAZ) was established in 1970 as an umbrella organisation for church health institutions and church administered Community Based Organisations (CBO) in the country. There are 129 member institutions affiliated to CHAZ. Altogether these account for 59 percent of health care coverage in rural areas of Zambia. Due to CHAZ's extensive infrastructure and local experience, in March 2003, the CCM chose CHAZ as one of the four Principal Recipients to disburse Global Fund money to Faith Based Organisations (FBO) for the control of HIV/AIDS, TB and malaria. CHAZ receives financial support from a number of cooperating partners including PEPFAR. The Global Fund and CHAZ signed HIV/AIDS, TB and Malaria grants amounting to US\$50,905,608 for disbursement up to 2008. Since January 2005, CHAZ has disbursed close to US\$29 million to FBO for HIV/AIDS, TB and Malaria. With support from the Global Fund, the provision of Anti-Retroviral Therapy (ART) has been scaled up to 14 church health institutions. (CHAZ Fact Sheet 2006).

### **5.3 World Bank Multi-Country Programme (MAP)**

The World Bank Multi-County AIDS Program in Africa (Africa MAP) is one of main World Bank programs for HIV/AIDS assistance and specifically aims to provide long-term support (10-15 years) to combat HIV/AIDS and mitigate its impact in African countries. Designed to be demand-driven, multi-sectoral and often community oriented, the Africa MAP is clearly different from traditional World Bank lending, although projects are intended to fit within the country's development strategy and the Bank's strategy for overall lending in that country.

Launched in 2000, the Africa MAP was the first major donor initiative focusing on HIV/AIDS in African countries. The World Bank program has grown to be the largest funder for HIV/AIDS within the United Nations system. However, the World Bank's funding for HIV/AIDS is small in comparison to new and larger donor initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund for AIDS, TB and Malaria.

The objective of the first phase of \$500 million (MAP I), approved in September 2000, was to increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (such as youth, women of childbearing age, and other groups at high risk). MAP II, approved in February 2002, had, in addition, the objectives of: (i) pilot testing antiretroviral therapy (ART); and (ii) supporting cross-border initiatives (Oomman 2005).

An IDA loan of 42 million was committed in 2002 for 5 years to support the Zambia National Response to HIV/AIDS Project (ZANARA). This MAP project aims to reduce the spread of HIV/AIDS, to mitigate the socio-economic impact of the disease, and to increase access to care and support for people infected or affected by the HIV/AIDS epidemic in Zambia. The project characterizes itself as a financing mechanism for high priority interventions for which significant funding gaps exist. Its funds are divided across four areas:

- 1) Community-Based Organisations (CBOs); for community-level responses
- 2) National AIDS Council and Secretariat;
- 3) Line ministries, to mainstream HIV/AIDS related activities into their work programs and the Health Ministry, for implementation activities; and
- 4) Program administration.

There is an agreement between the Governments of the Republic of Zambia and the World Bank for a period of five years starting in 2003 ending in 2008. The funds totalling US\$42 million were already agreed upon. ZANARA draws the funds based on requests and evidence of utilisation. The more funds are spent the more requests are made. ZANARA disperses the funds to all the line ministries. Yearly activity plans exist which are worked jointly by individual ministries, ZANARA and NAC. These are circulated to all the partners and once they are satisfied, they are then sent to the World Bank for scrutiny and approval. When the World Bank has completed this, they are then sent to the ministries as approved action plan. The procedures for requesting funds are those that exist in the government. The ministries submit their activity plans that are then reviewed by both technical and financial staff at ZANARA and approval is then made for payment.

### **5.3.1 Zambia National Response to HIV/AIDS (ZANARA)**

The World Bank funds are channeled through ZANARA which is housed in the Ministry of Finance and National Planning (MFNP). The centre for coordination is the National AIDS Council. ZANARA has also received money from the Global Funds and together with NAC and the line ministries come up with specific activity plans and the modalities of how to implement the activities. ZANARA ensures that the line ministries implement workplace programme of HIV/AIDS activities. It also mainstreams the funding and implementation of HIV/AIDS control activities across the government's line ministries,

ZANARA also has care and support components where line ministries are given food supplements for PLWHA. The ministries are also given support and information to help them fight stigma. In as far as monitoring and evaluation is concerned, a joint group of M&E specialists from ZANARA and the ministries work together and use one framework. A joint database assists with joint planning of HIV/AIDS activities for the line ministries. Line ministries have appointed Focal Point persons who coordinate HIV/AIDS activities. These are also charged with the responsibilities of ensuring that HIV/AIDS workplace committees function optimally. ZANARA facilitates the training of peer educators within the ministries.

In working with line ministries, ZANARA faces some challenges. The level of commitment among ministry focal point staff differs from ministry to ministry. In many cases HIV focal point staff are not operating at their full capacity because they undertake this role in addition to their full time public sector positions (UNDP 2007).

According to some of the key informants interviewed s part of the context mapping exercise, the other challenge is the issue of reporting. Although ZANARA has devised a joint reporting format, reports from some ministries are not submitted; or are only submitted when the ministries want to make requests for materials and other requisites, because they know that they will not receive them if they have not submitted reports for the previous activities. In some situations, it is difficult to ensure financial accountability, as the interest of some ministries appears to be limited to getting the money and once the activities have ended ministry staff delay in submitting financial accounts. In order to tackle some of these problems, a cadre of staff called United Nations Volunteers (UNVs) was employed with the support of the UN to work on HIV/AIDS issues in the workplace in all government ministries. There are currently 19 UNVs for line ministries. Focal point persons from all the line ministries have been trained on HIV/AIDS mainstreaming in the workplaces.

### **5.4 President's Emergency Plan for AIDS Relief (PEPFAR)**

Under the President's Emergency Plan for AIDS Relief (PEPFAR), the United States Government (USG) is providing funding for HIV/AIDS-related prevention, treatment, and care programs in 15 focus countries, including Zambia. The overall funding includes money for programs that seek to prevent mother-to-child transmission, blood and injection safety programs, and other prevention initiatives targeting high-risk groups. Prevention funds also support programs promoting abstinence and faithfulness to young people as well as the general public.

PEPFAR resources are distributed through a number of government agencies which include the U.S. Agency for International Development (USAID), the U.S. Department of Health and Human Services (HHS), the U.S. Department of Defense, the Department of Labor, the Peace Corps and the Census Bureau. The most active recipient of funds in Zambia is USAID.

The PEPFAR funding is therefore meant to indirectly support Ministry of Health, National AIDS Council, Private Sector Workshop Programs, Youth Organisations and the Ministry of Sport, Youth and Child Development, FBOs and NGOs in response to HIV/AIDS. The implementing agencies mainly include international NGOs and FBOs who access funds directory from PEPFAR.

**Table 7: PEPFAR Funds to Zambia**

|  |              |
|--|--------------|
| Total PEPFAR funds received in FY04  | \$57,933,801 |
| PEPFAR funds for prevention programming in FY04                                    | NA           |
| PEPFAR funds for abstinence/faithfulness programming in FY04                       | NA           |
| Planned allocation of PEPFAR funds in FY05   | \$83,462,896 |
| Planned allocation of PEPFAR funds for prevention programming in FY05              | \$19,938,600 |
| Planned allocation of PEPFAR funds for abstinence/faithfulness programming in FY05 | \$5,115,000  |

Some of the organisations that received PEPFAR funding to promote abstinence and faithfulness in Zambia are: the Academy for Educational Development (AED); American Institute for Research; Boston University; Catholic Relief Services; Children's AIDS Fund; Family Health International; National Arts Council of Zambia; Population Services International; Project Concern International; University of Zambia; and Zambia's University Teaching Hospital.

## 6. Conclusion

Zambia obtains financial support from three GHIs – The Global Fund to Fight AIDS, TB and Malaria, PEPFAR and the World Bank. Although these initiatives focus on HIV/AIDS, they are quite diverse in scope and scale. For instance, the GFATM is purely a funder and has no permanent presence on the ground, and does not get involved in programme implementation but merely partners with local institutions. Its conditions are that GFATM resources should focus on prevention, treatment, advocacy, coordination and resource mobilisation. PEPFAR preferentially supports programmes promoting abstinence while the World Bank focuses on building capacity of institutions such as the Ministry of Finance and CBOs.

There is no doubt that the unprecedented levels of external funding that the GHIs have provided to Zambia have helped in scaling-up HIV/AIDS prevention, treatment and care activities. However, we don't yet know the nature of the scale up. The project will explore how these services are being scaled up and in what way. Are there differences in the GHIs? The performance of non-HIVAIDS priority services will also be explored.

Most funds from the GHIs are being channeled towards programme implementation, especially purchase of commodities, while areas such as human resources, supply systems, service management (i.e. quality of care) and monitoring and evaluation are receiving limited funding. These areas are very critical to health system strengthening in Zambia.

The introduction of the GHIs has heightened the Zambian Government's political commitment due to increased availability of funds; but the level of commitment across the different ministries/sectors (mainstreaming) is quite uneven (UNDP 2007). The GHIs have helped in strengthening institutions dealing with HIV, as well as enlisting the support of community-based organisations. However, at the community level, building capacity particularly in handling donor funds is seen by those at the national level as a major challenge. Therefore, district level data are needed to determine how – and how well – districts and community level providers are managing this challenge; and, indeed, to confirm that significant funds are reaching and being used at this level.

This report generates some important research questions which will be pursued at the district levels during 2007 and 2008 and for follow-up at the national level in 2008.

### **A: Scale up**

Whilst it is clear that scale up is indeed occurring, it is not yet clear how and in what way. In the district level field work, we will collect data on which services are being provided on the ground and the different providers that are engaged in these services. What are the different models of care being provided and what is the (patient-perceived) quality of the services provided by these providers? It will also be useful to look at other priority non-HIVAIDS services? Are they scaling up? Are some being neglected because they lack GHI funds?

### **B: Human Resource Capacity**

The report states that increased training is taking place. This poses questions to follow up regarding issues such as types of training and is it appropriate to health worker needs. The informants interviewed for this report mention lack of motivation as a problem; issues around motivation, incentives, time spent on HIV control versus other services will need to be explored in more detail at the district level.

### **C: Coordination, Harmonisation and Alignment**

The findings from this report mention that coordination is occurring in varying degrees. What is the capacity of the districts to coordinate HIV/AIDS control? How do the different GHIs integrate with one another and with the wider government policies, both at national and district level? What coordinating structures exist? What is the coordination of services at provider level?

#### **D: Access and Equity**

While the findings show that there has been some improvement of access to HIV/AIDS related services, there are still many barriers to access for some groups. The district level research will need to assess the effects of GHIs on equity of access to HIV/AIDS interventions and services at district level, focusing on barriers to access for key target groups: for example the poor, the young, rural dwellers, women. Models of delivery that help increase/overcome these barriers will also be explored.

# Appendix 1: General Views from the Key Informants

This section presents the views and perspectives of the five key informants interviewed during the context mapping exercise with regard to key dimensions of HIV/AIDS related GHIs that are being explored in this study. Further national level research will take place early 2008, including further interviews with national stakeholders. These dimensions and associated questions are:

- (How and how well) is GHI-funded scale-up of HIV/AIDS services happening in Zambia?
- Given the huge increase in GHI funding to HIV/AIDS, how well coordinated and aligned is scale-up with national structures: policy (with NAC), strategic alignment (with ZANARA), management and monitoring and evaluation (with MoH)
- What are the effects of increased resources and scale up of HIV/AIDS activities on patterns of mobility, deployment & motivation of health and other key staff at district level?
- What are the effects of GHIs on equity of access to HIV/AIDS interventions at district levels with particular focus on marginalised groups?

These views summarised below reflect both organisational as well as personal positions with regards to the effects of the GHIs on these processes and the "Three Ones" principles.

## A: GHI role in scale-up of HIV/AIDS Services

The general view of the key informants was that the GHIs had a positive impact on the fight against the HIV/AIDS epidemic in particular and the Zambian health care systems in general. It was pointed out that there were now additional resources for scaling-up HIV/AIDS related activities. With the GF, there has been a great acceleration of interventions in the areas of HIV/AIDS, TB and malaria specifically through human capacity building. As mentioned elsewhere in the report, ART has increased significantly in Zambia since 2003.

This raises important questions for the study at the district level such as what types of HIV/AIDS services are being delivered and scaled-up? What types of services are not being scaled-up and why not? What are the roles of different GHIs in the scale-up and what is happening to non-HIV/AIDS priority services as a result of scale-up?

## B: Coordination and Harmonisation

### *B(i) National level*

Some of the key informants observed that, despite considerable efforts to have all the HIV/AIDS activities well coordinated at the national level, through the NAC and the CCM, there remain considerable challenges. One of the biggest is at implementation level. It was indicated by different stakeholders that there were a number of mechanisms put in place to try and help with the coordination and harmonisation of HIV/AIDS activities. This has been due to the efforts of government through NAC as well as the efforts of the Civil Society Organisations and other stakeholders. In particular, the National AIDS Council has played a key role in terms of trying to coordinate the HIV/AIDS activities.

It was indicated by some of the stakeholders that there is a sharing of resources based on cooperative advantage to avoid duplication. Some key informants cautioned that there was lack of effective consultations between the GHIs and the local stakeholders. This was echoed by other key informants who felt that the GHIs had a tendency to come with prescriptive strategies, and therefore much more needs to be done by them to plan, strategise and implement in a coordinated way.

## **B (ii) District level**

Some of the informants observed that as much as the PATFs and DATFs are trying their best, due to increased funding, there are many small projects that have been established, some of which are funded directly outside of pooled or coordinated funding mechanisms. They further reported that knowing which CBOs were implementing what activities at the community level, to ensure that there is no duplication, was quite difficult and posed a challenge. Even though the plan was to spread the role of the PATFs and DATFs, whose main mandate is HIV/AIDS activities, there are many health related donor funded activities which do not directly focus on but overlaps with or underpin HIV/AIDS control activities. It was also suggested that it might be a good idea to revisit the mandate of these coordinating organs to incorporate all donor funded programmes, in order to ensure that there is a synergy in the implementation of all health related programmes.

There were also concerns from some informants about the ability of NAC to effectively coordinate the various GHIs and the activities they were funding, while recognising that the NAC had become a stronger institution in recent years. It was noted that, in addition to the GHI funded activities there were other non-GHI funded activities and this had resulted in an increased amount of coordination work. There was the view that, due to rapid increase in HIV/AIDS activities, NAC did not seem to be able to keep pace and was somewhat short in capacity to effectively coordinate, monitor and evaluate the aggregated HIV/AIDS activities supported by the GHIs and other donors. It will be important to explore in more detail the efforts of the various stakeholders in terms of coordination and harmonisation, both at the national and district levels.

It was viewed by one informant that stronger coordination mechanisms from the national level to the province and the district are required to ensure that stakeholders at various levels are regularly communicating and therefore able to address specific operational problems as they arise.

It was viewed by one informant that the national development planning processes present a timely opportunity to address this institutional arrangement issue, and to reflect on the different mechanisms through which response coordination, financing and wider stakeholder participation could be achieved. This needs to include broad mechanisms for integrating HIV/AIDS with all the other development efforts including the coordination of workplace programmes, community responses and for establishing coordination of interventions for orphans and other vulnerable groups.

Responses from the key informants show that coordination is taking place in varying degrees. Key questions for follow up include; How do the different GHIs integrate with one another and with the wider government policies (both at national and district level)? How well are coordinating structures functioning? What are the mechanisms and how well is coordination of services and providers / organisations taking place at the district level?

## **C: Human Resources**

Human resources were indicated by the interviewees as a big problem facing the health sector. The inadequate numbers of core health staff was cited as problem that is yet to be resolved by the government in consultation with the international funding organisations. It was viewed that the GHIs should now focus more on system wide funding including human resources, infrastructure, transport and communication. It was suggested that one of the areas that would be strengthened by investment and improvement in human resources is monitoring and evaluation. The staff levels in the health sector are so low relative to the amount of work to the extent that they are finding it hard to cope and as such there is high burn-out. A funding system that includes investment in human resources was preferred by some of the respondents because the task of scaling-up HIV/AIDS, TB and Malaria interventions was a mammoth one.

Some of the interviewees suggested that increased training is taking place within the limited pool of health staff. This poses questions for follow up at district level regarding issues such as recruitment, types of training and appropriateness to the needs of the health staff. Informants mentioned lack of motivation among health workers as a problem; described by one interviewee as "they work as they are walking in the mud". Follow up questions to address this issue need to be asked around motivation, incentives, time spent on HIV control versus other services at the district level

## D: Equity and Access

There was optimism amongst some of the respondents that the GHIs design programmes in such a way that they include all the marginalised groups of people. However, there were also some concerns that PLWHA were not fully benefiting from the services supported by the GHIs mainly because of the lapses in the health service delivery system. In order for people living with HIV/AIDS to fully benefit from the support given by the GHIs, it was noted that advocacy and lobbying were key, particularly with those who are seen to be 'the gatekeepers' and the donors.

Failure to reach most people in need, particularly those requiring Antiretroviral Therapy (ART), was indicated as one factor that has reduced the impact of assistance from the GHIs. These issues raise important questions around why people living with HIV/AIDS have not fully benefited from services. This will be explored in more detail at district level: for example, what are the individual, community and institutional factors that act as barriers to people accessing services? Do GHIs differ in terms of ensuring equity of access to services?

## Appendix 2: References

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