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Care and Support Services for People Living with HIV/AIDS (PLHA) in Zambia

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Introduction

With an HIV prevalence of 17 percent (UNAIDS 2006:506), Zambia is one of the countries that are bearing the brunt of HIV/AIDS. Coupled with high poverty levels (Ministry of Finance and National Planning 2002:18-23), the task of providing care, treatment and support services for more than one million PLHA is a major developmental challenge to an economy that is reeling from three decades of economic stagnation. Over the years, HIV/AIDS has produced severe consequences at all levels (POLICY 2001:28). In many cases, it has been observed that older and poor women are left with the task of looking after PLHA (Akintola 2004; Juma et al. 2004). These women lack both the material and technical resources required for the care and support of PLHA. This has implications for prevention as well as treatment programmes as PLHA may not receive the counsel they need. Consequently, adherence to antiretroviral therapy and treatment of opportunistic diseases may also be affected.

After the adoption of the '3 by 5 strategy'¹ in 2004, the Zambian government facilitated the establishment of various HIV/AIDS services and set a target of providing ART to 100,000² people by the end of 2005 (National HIV/AIDS/STI/TB Council [NAC] 2006:4). However, as of 2006, only 65,000 people were on ART (Times of Zambia 2006). There is also anecdotal evidence suggesting that many people have continued to die from AIDS because they are failing to access the much needed antiretroviral (ARV) drugs on time as they tend to rely more on traditional healers than modern health institutions. In many places, including the city centre of Zambia's capital, Lusaka, there is enough evidence of HIV/AIDS patients seeking medical assistance from traditional healers.

Using data from the Zambia HIV Voluntary Counselling and Testing Study (ZHVCTS), this report discusses care and support services for PHWA in Zambia with a view to providing insights into the main challenges facing HIV/AIDS programmes in Zambia.

Data and methods

Data for this report were drawn from the predominantly qualitative ZHVCTS, which was conducted between January and June 2006. Permission to undertake this study was granted by the

¹ An HIV/AIDS programme, which aimed at putting 3 million PLWHA on ART by the end of 2005.

² This figure is half the number of people (200,000) who were estimated to be in need of treatment at that time.

Australian National University (ANU), Ministry of Health (MOH) in Zambia and the Network of Zambian People living with HIV/AIDS (NZP+). This purposive cross-sectional study was conducted in Lusaka and North Western Provinces. Lusaka represented the urban setting while North Western represented the rural areas. Two districts were selected per province; Lusaka and Chongwe in Lusaka Province and Solwezi and Zambezi in North Western Province.

Based on the budget and time, a target sample of 35 health centres was determined. Three specialised data collection instruments were developed and used to elicit information from research participants. These are the in-depth interview schedules, focus group discussion (FGD) schedule and the mini questionnaire. In-depth interviews allow for collection of sensitive information that an individual may not divulge during FGDs. The in-depth interview schedule was used during the one-on-one interviews with various research participants.

The FGD schedule was used to collect information from groups of 10-15 research participants. These schedules were translated into four local languages (Kaonde, Lunda, Luvale and Nyanja) spoken in the study districts. The translations were made by three research assistants and verified by experts in the Department of Literature and Languages at the University of Zambia (UNZA). The mini questionnaire was used to collect information about each health centre. At each health centre, the Officer-in-Charge filled in the questionnaire using administrative records. Information collected included staffing and number of clients for HIV/AIDS services.

Individuals aged 15+ were targeted for interview. These included people living with HIV/AIDS; people who had HIV-negative status and were aware about it; people who did not know their HIV status; voluntary counselling and testing (VCT) service providers, health workers (including home-based-care providers) and traditional healers; health managers; and leaders (including traditional, political and religious leaders). Notes, Dictaphone and mp3 player were used to record some interviews. In many cases there was technological failure or refusal by respondents to be recorded and detailed notes on each conversation were taken.

Selection of research participants, apart from health managers in each district, depended on the inclusion of their nearest health centre as the snow-balling sampling technique, which was used to select respondents was launched from each selected health centre. The health centre was also the main locus for understanding various HIV/AIDS programmes in each community. The health centres were randomly selected from the list of health centres in each selected district. At the end of the study, a total of 25 health centres (14 in Lusaka and 11 in North Western) were covered and 219 people were interviewed.

The data collected were analysed both qualitatively and quantitatively. For qualitative data, I manually used notes taken and recorded discussions during the interviews/discussions to transcribe the information from respondents. Responses from the mini questionnaire were used to obtain some basic frequencies using the Statistical Package for Social Sciences.

Research findings

Three types of health service providers are critical for the welfare of PLHA in Zambia. These are modern health centres, CHBC centres and traditional healers.

Health centres

Voluntary counselling and testing (VCT) services

Apart from providing general health services, modern health centres are the leading providers of HIV/AIDS services in Zambia. The most critical services are VCT and ART. VCT services provide counselling and testing for people who want to know their HIV status. VCT is actually the gateway to ART (UNAIDS 2002:9). The number of VCT facilities has increased since the early 1990s making Zambia one of the well-served countries in terms of VCT. However, very

few people are making use of these services largely due to stigma associated with HIV/AIDS (Central Statistical Office 2006:12). The stigma exists because AIDS is seen as a disease for people that have led a perverted sexual lifestyle in the past and is often seen as punishment from God. It is, therefore, difficult for people to accept their HIV-positive status because of this stigma. The following statements by some research participants confirm the problem of stigma:

We have to change our culture and accept that HIV/AIDS is like any other disease like malaria and others. We have to be like Whites and accept that even if you have AIDS you can still live on (male university student, Lusaka).

Awareness has gone everywhere. Everyone knows about HIV/AIDS; it is a household name but we should be able to manage the stigma...To have a young person who gets HIV and it is known that he got it through sex is morally wrong. Those who are going to test and know their status, how are they going to be protected. They can be counselled but what about the village where they come from?...it is acceptable to say that one has malaria, one has a sore-eye but to say one has HIV, it is a problem. But we know that everyone is having sex because people are getting pregnant. It calls for cultural change for people to accept HIV (traditional leader, Solwezi).

The problem of stigma also exists among health workers who are supposed to be an example to the communities that they serve. This problem has also been found elsewhere (Hesketh et al. 2006:111). According to another FGD participant:

Without spilling any beans, the attitude of our nurses is very bad... When my friend had an infection, she was scolded even before they confirmed it was HIV/AIDS. They use words such as "You students do not listen and that is why you will be dying like chickens with bird flu" (Female university student, Lusaka).

Even among health workers, the view that young people are responsible for spreading the virus was evident. This excerpt from an in-depth interview with a health worker at one of the health centres in Zambezi District confirms this assertion:

In elders, transmission is less but in the youth it is high. ...one goes to the Boma [district centre], sleeps with someone positive, acquires it and brings it to me who is here... When you come in the morning you found a lot of young men. Not all, if not none, of them came for treatment. They came to look for women and this is discomfoting us the workers. We are tired of telling them but they don't understand.

The other problem is that testing services are not well distributed across the country. In rural areas, VCT facilities are inadequate, making it difficult for people to access them. According to one District Director of Health:

VCT is not well established. At the moment there is only one VCT centre [in this district]. What about those people in Dipalata, Mpidi, Kucheka, Chitokoloki, who can not easily access the service? They can not easily access the service. We have few staff trained or oriented in providing this service. So many staff are required if the services are to make a meaningful impact in our district...

However, even where the services exist, inadequate staffing was another big problem. Introduction of VCT services in public health centres means that the few staff available have to shoulder more responsibilities. This affects the quality of counselling as little time is allocated for

VCT. Furthermore, most centres have no rooms for VCT thereby compromising the privacy that is critical in the provision of this service. According to one female nurse in Solwezi:

There is no accommodation for VCT. Like today, because there are no antenatal mothers, I am using the antenatal room for VCT clients. When there are antenatal mothers, I use the EHT³ room. I am the only one here. I am the nurse, the in-charge, everything... and because of this my counselling is not good because I would go bla bla bla... because I have to attend to so many other people.

Some participants also complained about the lack of confidentiality among some health workers. This problem has potential to hinder people from seeking VCT given the negative attitudes many people have towards those living with HIV/AIDS. One HIV-positive female in Solwezi expressed the following view concerning the issue of confidentiality:

VCT centres should employ counsellors who are not talkative to ensure privacy [confidentiality]. For instance some of us wouldn't want our parents to know our status. Some counsellors have no privacy [confidentiality]; they release information anyhow. They should change.

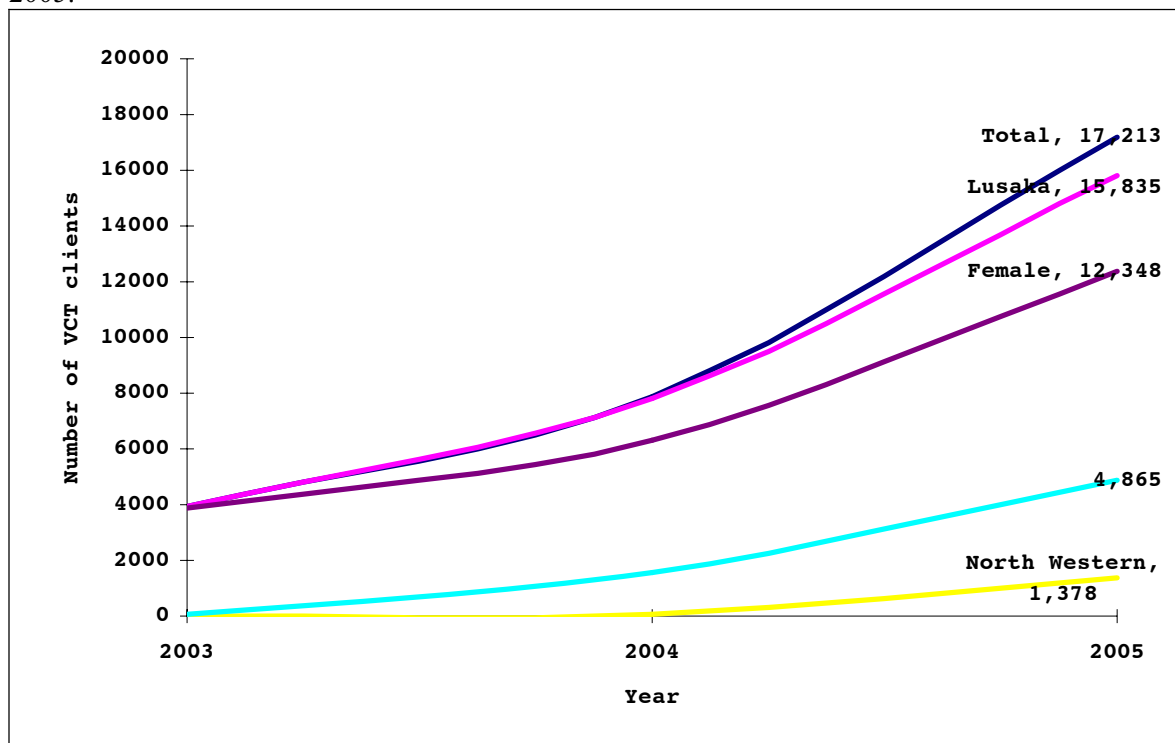
The referral system between VCT and ART centres was further seen as another factor compromising confidentiality. VCT clients wanted ART services wherever there is a VCT centre and preferred that the same staff who counselled them for VCT be the ones to administer ARV drugs. This ensures that information about their status is known by few people. In the case of a referral to another health centre, it means that staff at the other centre will also know about their status. The referral system emphasises the concept of “shared confidentiality” in order to ensure that those in need of ART access them but the public have little confidence in this arrangement.

Despite these problems, administrative records showed that the number of people seeking VCT services increased between 2003 and 2005 (see Figure 1). However, much of this progress is in Lusaka Province which has better health facilities than North Western Province. It is also clear from Figure 1 that majority of people seeking VCT services are women. This is because of the prevention of mother-to-child transmission of HIV programmes, which target women and leave out men.

As a result of increased access to VCT, the number of people on ART has also risen. In 2002, there were 4,000 ART clients throughout the country and this rose to 65,000 in 2006 (Times of Zambia 2006). This figure represents about six (6) percent of the estimated number of PLHA in Zambia in 2006, hence the need to scale up VCT and ART services. As of 2006, 44 and 10 percent of health facilities in Zambia were offering VCT and ART services, respectively (MOH et al. 2006:17).

³ Abbreviation for environmental health technician.

Figure 1. Number of VCT clients in selected health centres by sex and region, Zambia: 2003-2005.



Source: 2006 ZHVCTS data.

Antiretroviral therapy (ART) services

MOH developed an ART framework to guide the provision of ART MOH (2005b). There are two types of patients into ART: the ‘new on HIV care’ and the ‘transfer-in with records’. New-in-HIV care, are patients, coming into HIV care without prior records of being in HIV care or on ART. Transfer-Ins are patients already on ART programme, transferred from another facility. They are Transfer-ins only if they have official records from the source facility.

These patients are then assessed based on World Health Organisation (WHO) staging (WHO 2004:33-34) and laboratory assessment. The CD4 count⁴ is the main indicator used by health personnel in Zambia to determine a person’s eligibility to be on ART and the kind of therapy regimens. Generally, an HIV-positive person is eligible to be on antiretroviral (ARV) drugs if he/she meets any of the following criteria: Stage 1 with less than 200 cells; (ii) Stage 2 with less than 200 cells; (iii) Stage 3 with less than 350 cells; and (vi) Stage 4 (regardless of CD4 count).

Those who are not eligible are still kept in the Pre-ART Register and fresh appointments dates are given for reassessment. Not every eligible patient will be ready to commence on ART. Those ‘eligible but not-ready’ may include patients still being prepared for adherence. ART adherence refers to the strict observance of conditions on the use of ARV drugs. This may entail changing

⁴ In advancing HIV infection, declining CD4 count and/or reduced CD4/CD8 ratios indicate increased immune damage by HIV and the progression to AIDS (CD stands for cluster of differentiation, with the different clusters marked by a number. These clusters are T4 lymphocytes, T4 cells and critical cells in activating the cellular immune response, targeted by HIV).

some lifestyle aspects of the client such as work schedule and nutrition, depending on the therapy combination. Clients are also told not to share drugs with anybody [no evidence was available to show that some clients had shared ARV drugs with family members]. Non-adherence to ART instructions can lead to severe consequences including drug failure (Schönnesson et al. 2006:246-247). The 'eligible-and-ready' patients are those who are prepared to adhere to take ARV drugs.

After commencement of treatment, a patient can either remain on the first line regimen or may be substituted to an alternative first line drug or be switched to second line or higher drugs. The 'transfer-in with records' can either continue with drugs they were on at the previous health facility or may be substituted or switched according to the results of the assessment. Monitoring tests may be carried out at intervals during treatment. The frequency of revisit to the facilities depends on the number of months of supply of their drugs, which is often 3 months unless the patient experiences severe side effects. On these visits adherence checking is conducted at pharmacy as a way of monitoring patients. At both pre-ART and ART stages, there are possibilities of death, withdrawals, transfer out and defaulters. In case of defaulters, they may be restarted depending on the time lapse and the judgement of the medical officer. Clients continue receiving treatment until there is complete treatment failure.

In Zambia, the common first line treatment ARV drugs include Zidovudine and Lamivudine. The second line drugs are Nevirapine and Efavirenz. The third line drugs mentioned by ART service providers are Epavir, Lopinavir and Kelatrar. These are essentially protease inhibitors. Epavir is a type of Lamivudine, which is also used for treatment of Hepatitis B (Schiff 2005:33). Combination of these drugs depends on the individual patient. For example a person whose haemoglobin level is less than 10 grams per decilitre is not supposed to be put on first line drugs and anybody on TB treatment is not supposed to be on Nevirapine because of severe side effects that could be fatal. The third line of drugs is used if there is drug failure.

However, the ART programme in Zambia is still in infancy and only 10 percent of health facilities are offering ART services (MOH et al. 2006:17). Only six out of my 25 study health centres had ART services and four of these were in Lusaka City. In these centres, the main problem facing ART programmes was poor adherence by some clients. Providers complained that some clients stopped taking the drugs when they started feeling better, indicating lack of adequate information at initiation of ART. This could lead to drug failure and consequently death.

Other problems were lack of necessary test kits and lack of skilled human resources to run these centres. Most ART centres lacked the CD4 counting machines, which are very critical for ART programmes. For example, Solwezi General Hospital was the only health facility with a CD4 counting machine throughout North Western Province. This means that most people in need of ART have to travel for hundreds of kilometres for CD4 before they can access ART. This is a big problem for the rural poor. The poor state of the roads also makes it more difficult to transport people who are already vulnerable due to HIV/AIDS. Similarly, even in the highly urbanised Lusaka Province, certain areas still have problems accessing ART services. For example, the ART centre at Chongwe Health Centre in Lusaka Province also relied on health centres in Lusaka City (45 kilometres away) for CD4 count.

This problem is worse in many parts of North Western Province, where most people have no access to modern transport. Even though the media and the nearest health centres provide information on ART for people in remote areas, getting these services is a big challenge. One woman in Zambezi District narrated her experience before she started receiving her ARV drugs:

I had been perpetually sick despite taking various drugs. Then in November 2004, I went to be tested. I was told that I was HIV-positive and was given a paper to show this. I stayed for one year after testing; then in 2005 I heard an announcement on radio that drugs for treating HIV-positive people were now available. The announcement made me to go to the Boma [district centre] for medical attention. At the hospital I was told that I was HIV-positive but they could not give me ARV drugs because I had not yet reached the

treatment stage. I went back in January and February and was told that my status was still the same and they could not give me ARV drugs because they said that they were too strong. I went back in April and was told that the machine was not working properly, so I was told to go back after two weeks. I complained about transport problems and asked if I could go back after one month but they insisted I go back after two weeks.

A health service provider in Solwezi also shared her experiences concerning transport problems facing ART clients:

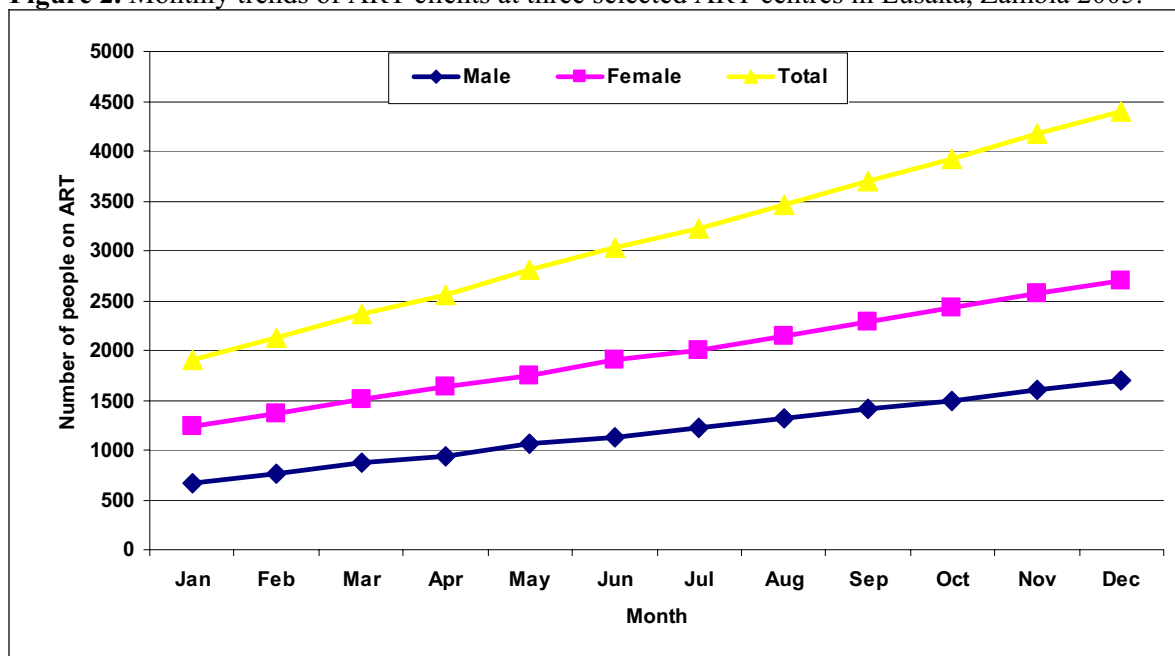
I referred 4 clients to Solwezi General Hospital for CD4 count and HIV viral load but out of 4 only one managed to go. Others failed to go due to lack of transport money. The one who went I gave him K20,000.00 [US\$6.00 equivalent at the time of the interview] from my pocket.

Figure 2 shows monthly trends for the year 2005 obtained from three ART centres (Bauleni, George and Kanyama) in Lusaka, which had complete data for the whole year. According to Figure 2, the use of ART services was increasing for both males and females in 2005.

According to statistics obtained from five ART centres included in this study, 4,632 people were on ART in 2005, which represented 6 percent of HIV-positive individuals in the total catchment population for the five centres. Most of these people (95%) obtained this service from centres within Lusaka District. Two out of three ART recipients were female, suggesting that ART programmes are more successful among females than males.

PLHA raised some concern about what would happen to them in case the ART centres ran out of ARV drugs. These fears were particularly due to their knowledge that these drugs are not manufactured locally, hence the perceived unreliability of constant supply of ARV drugs. Nevertheless, staff at ART centres bragged about having enough stocks of ARV drugs and that government would always ensure that these drugs are available.

Figure 2. Monthly trends of ART clients at three selected ART centres in Lusaka, Zambia 2005.



Source: 2006 ZHVCTS data.

Community Home Based Care (CHBC) services

A rise in the number of HIV/AIDS cases increases the burden of care of PLHA at the household level as well. Families respond differently to issues of care for members with HIV/AIDS, hence CHBC is an important component of a comprehensive continuum of services for people with HIV infection (Fleishma 1997:170). Due to inability by most families to cope with needs of HIV/AIDS patients, the CHBC concept has been adopted in many countries in Africa including Zambia (Juma et al. 2004). Under this programme, relatives of the PLHA are given technical and material assistance on how to look after those infected with HIV.

Zambia has one of the most famous and one of the first CHBC programmes in Africa, dating back to 1987 when The Family Health Trust HBC Project was started by a British professor who was working with one of the clinics in Lusaka (Nsutebu et al. 2001:240-241). In 1991, the Catholic Church formed the Ndola Catholic Diocese HBC Programme, which started as a Catholic Church group that visited and treated sick church members or their friends and family members at home (Nsutebu et al. 2001:240). Over the years and with increased funding from institutions such as the Catholic Relief Service and United States Agency for International Development, the Catholic Church has become the main provider of these services. The main services and goods offered through this programme include the following: (i) direct observation treatment system for TB patients; (ii) HIV testing; (iii) pre-ART adherence and spiritual counselling; (iv) anti-fungal and STI drug provision; (v) food supplements; (vi) shelter rehabilitation; (vii) HIV/AIDS and nutrition education; and (viii) blankets and clothes.

The CHBC services in Zambia are NGO-driven and rely on foreign donors but are somewhat interlinked with government health institutions. There is no direct government funding to CHBC institutions to supplement resources provided by other donors but there is an arrangement for these centres to access food supplements for their clients, which the government provides through public health centres. In 2006, MOH et al. (2006:38) found a higher proportion of NGO health facilities (18%) offering care for advanced HIV/AIDS cases than government health facilities (16%). NGOs are often seen as institutions that engage in development activities that governments are unable to or are not willing to do (Mooney and Sarangi 2005:276). However, these programmes are often linked with the nearest health centre for VCT/ART services and a lot of PLHA are benefiting from this arrangement. According to one CHBC Co-ordinator:

Most of the time the rural health centres do the testing. We do the counselling and the tests are done by the rural health centres. We have our own test kits but we still send our clients for testing to the rural health centres to confirm the results...we also assist the rural health centres to have drugs, especially STI drugs. We ensure that our clients are not subjected to walking long distances in search of health services. We are able to buy a few drugs for those who are HIV-positive. These are expensive drugs and most health centres can not afford them; so we subsidise.

Even though no estimates are available, providers reported that a lot of people were accessing CHBC services. CHBC providers interviewed also mentioned that most providers were female, indicating the gendered burden of care for the PLHA in Zambia. It was also common for PLHA to report more than one CHBC programme as a source of material and financial support. CHBC services were also one of the entry points for clients into VCT and ART. Due to material expectations from this service, a lot of people opted to approach CHBC providers who arranged for VCT services for them in order to assess their various needs. In outlying areas, CHBC providers also collect samples for various tests thereby averting the transport problems that PLHA often face.

CHBC programmes are monitored monthly. The provincial coordinator visits all the clients and their families, other community members and the care givers, to assess how the programmes were performing. Data gathered through M&E activities are fed into national data systems through umbrella organisations. However, it is difficult to attribute outcomes to one institution/intervention in cases where PLHA are receiving support from more than one institution. Furthermore, most of these institutions are not reflected in the strategic plans of government data collection agencies, implying that they are not budgeted for by the government and their implementation depend on the good will of cooperating partners who also use the information from these agencies for their reporting purposes. According to NAC (2005) data from NGO-driven programmes are not provided to government in good time, coupled with lack of standardised data quality. In addition, reporting requirements by donors are not harmonized. This makes it difficult for government to carry out effective M&E on HIV/AIDS programmes.

A number of problems also characterise CHBC programmes in Zambia. Most CHBC workers are not trained by or supervised by government clinics and/or hospices; hence their typical lack of clinical know-how required to effectively interface with hospices and clinics. Furthermore, most of these workers are volunteers who work part-time and lack incentives to continue working for CHBC programmes. This means that they spend less time on CHBC work because they have to fend for themselves as well.

CHBC providers also complained about the stigma attached with HIV/AIDS and inadequate resources for all the needy people given the vast areas they have to cover coupled with poor roads. High poverty level in the communities was another problem as a lot of other services are expected from the programme. One provider observed:

People may think we have to build a house because they are too poor to support themselves...when we talk of material support, some families neglect their relatives and think that we are going to take over all the social requirements of their relatives.

Due to high poverty, there is inadequate support from the communities. As one provider observed:

Support from the community becomes difficult. For example, when there is communal cultivation meant for clients, the same community ends up consuming the crop instead of the clients.

High illiteracy is also another impediment to the success of these programmes. As a result, a lot of time and resources are required to carry out education programmes to ensure client compliance with various CHBC programmes, particularly adherence to treatment regimens.

There is also a lot of competition among organisations providing HIV/AIDS services and this affects the implementation of treatment programmes. Because clients are desperate for material benefits as well, they have a tendency to abandon important programmes in preference for new providers. As one male participant in Solwezi explained:

There are too many players in the field of HIV/AIDS and we do not have a single organisation that seems to be co-ordinating everybody. Every organisation has its own approach. Interventions are fragmented...some communities have too many organisations implementing the same programmes. Other communities are left unattended to.

Traditional healers

Alongside modern health services, traditional healers also play a role in the provision of health services in many parts of Africa, including Zambia. According to Stekelenburg et al. (2005:68), a traditional healer is a person who is recognised by the community in which he/she lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social wellbeing and the causation of disease and disability, thereby constituting a junction of beliefs, practices and stories of ancestral origin within a given population. Furthermore, Green (1994:18) noted that specialists in treating locally recognised STDs are found throughout Africa and they fall into four main categories: (i) the diviner–medium healers; (ii) the herbalists; (iii) the alternative healers; and (iv) the religious faith healers.

In 1978, WHO recognised the existence of two health care systems: traditional and modern health care systems (Stekelenburg et al. 2005:67; Kaboru et al. 2005:2). Bakx (1991:27) argues that the existence of this system is due to the evolution of “cultural pluralism” during colonialism. Colonialism brought modern medicine but failed to eradicate use of traditional medicine. Even among the highly educated people, I have made some observations among Zambians that there is a point (i.e. when modern medicine fails) in their search for good health when they resort to use of traditional medicine. Furthermore, some traditional healers also believe in the modern religion (Ndubani and Höjer 1999:18), making it more difficult for people to regard them as unorthodox practitioners.

The failure to find a cure for AIDS using modern medicine has led to a renewed interest in traditional herbal remedies. Recent findings about strong similarities in plant selection criteria among the African great apes in response to parasite infection and gastrointestinal upset, and the common use of some plants by chimpanzees and humans to treat such illnesses provide a strong argument for traditional medicine (Huffman 2001:659). Other studies have also demonstrated that herbal medicines have the potential to provide vaccines that can cure HIV/AIDS (Huang-Lee et al. 1995; Sancho et al. 2004). Huffman (2001:659) also acknowledged the on-going campaign aimed at integrating effective traditional medicines into the modern health care programs in Africa. The Zambian government also recognises the existence of traditional healers and has since commenced scientific trials of various vaccines/herbs being used by some of these healers. These healers have a national association, known as the Traditional Healers’ and Practitioners Association of Zambia (THAPAZ), which is the link between traditional healers and government. THAPAZ also plays a regulatory role on these healers to ensure that their practices are in tandem with national guidelines on health provision. However, THAPAZ is more of an urban institution as many rural healers especially those in remote areas, are practising without certification.

Traditional healers are certified to practice traditional healing after passing anthroposcopy-related tests. Traditional health practitioners and faith healers even advertise themselves in newspapers claiming that they can cure all forms of STIs including AIDS. Advertisements such as the one below are common:

ATTENTION: International traditional Doctor T. Kola from Tanzania specialised in treatment for all chronic disease by using herbal made tablets for stomach problems, CD4 improvement, HIV/AIDS, swollen and pain body/feet, Asthma, BP, TB, Diabetes, Diarrhoea, etc. also helps court cases, Bewitched, promotion, bad luck, customers attraction, NGEME is special herbs to call bring back quick a lost lover and to make faithful to you. NG’OMA is special tablets for all sexual transmitted disease, Lupi is herbal tablets to enlarge in men those who got small organ may lead not to satisfy a partner and if you erection weak or when make love you release quickly as a chicken; get right service on the right time; we are in Kanyama, Check sign post at Los-Angeles BP Filling Station or call: 097-617233 in Kitwe ask Dr. Limbu Kola on 097-121821 (The Post 2006).

Traditional healers interviewed claimed that they could cure HIV/AIDS. Most healers, especially those found around Lusaka, acknowledged the importance of VCT with some of them claiming that they ask their clients to have HIV test results before attending to them. However, most healers interviewed relied on anthroposcopy, a technique where a healer is able to tell the health condition and other aspects of a client including names and place of residence without asking about them (Vontress 1991:246). They argued that in the absence of an HIV test, they could still diagnose HIV/AIDS cases using traditional X-rays, locally known as *ngombo* amongst the Luvale of North Western Province. The *ngombo* can be in the form of a mirror or idol (an artefact in the image of a human being or other objects). The mirror is able to show the cause of illness/death but is often used to identify witches after someone has died. The human idol can either make some movements or produce a voice. These movements (which only the healer understands) or voice will itemise the symptoms that the client has. Based on that, the traditional healer is able to judge whether it is HIV/AIDS-related or not. As White (1948: 14) noted earlier, there are numerous types of divining apparatus and the term *ngombo* is a general one, which means divining apparatus. Vontress (1991:70) also noted that there are different forms of divination across Africa. These include crystal-gazing, shell-listening, the flight of birds, bibliomancy or tuning randomly to passages in sacred books, botanomancy or the reading of leaves, cartomancy or the reading of cards, clairaudience or hearing things inaudible to normal hearing, and clairvoyance or seeing things invisible to normal sight.

One female healer at Lusaka's Soweto Market revealed how she diagnoses her patients:

My spirits will let me know the kind of problem the person has. Once I greet the patient, the pain he has will be transferred [temporarily] to me and I will feel it. From that I am able to know what the patient is suffering from (female traditional healer, Lusaka).

A popularly known healer in Lusaka expressed confidence that he can cure HIV but lamented that government was not doing enough to make use of traditional healers' talents in the fight against HIV/AIDS:

I can cure AIDS but it is difficult for me to tell that a person has got HIV and that is why I ask my clients to test for HIV before they come to me...we are willing to work with government but government has failed to put a system where we the healers can have valid referral forms that we can give to our clients so that they can go for testing (male traditional healer, Lusaka).

Similar claims were made by another healer from Zambezi East Bank who also stated that some of his herbs were from Angola, a country bordering Zambia on the West:

The government should give us [healers] the right to bring a patient for HIV test in person and then go back and treat him [or her] with herbal medicine. If...healers are visited, we can enlighten people on which medicine can cure what diseases, not just meeting on streets [workshops/meetings] we cannot disclose anything at all.

According to one Principal at a Teacher Training College, traditional healers are critical people in the fight against HIV/AIDS and advised that it is important for people to identify the kind of problems that various healers are able to attend to because not all of them have the same ability:

We must bring them on board. If they can cure opportunistic diseases, we can find our own formula as Zambians...some claim they have found the cure...they can play a role in VCT, you have to go to them with vision. There are different categories, some are

spiritual and will tell you your status, and others will look at symptoms (College Principal, Chongwe).

However, discussions with some health workers revealed that it is very difficult for the modern medical system to work with traditional healers because traditional healers are not transparent. Some workers accused healers of making financial gains by misleading people that they could cure HIV/AIDS. One health worker in Lusaka made the following comment:

It is very difficult to work with traditional healers because we do not understand their methods. Even amongst themselves, they fail to work together...they seem to be more interested in generating money than help those with HIV/AIDS because we all know that there is no cure for AIDS.

During the ZHVCTS, it was evident from the number of clients found at traditional healers' clinics that demand for traditional healers, is high. This has brought traditional healers under intense scrutiny from the public and has also introduced some form of rivalry between modern and traditional service providers. Even though traditional healers deny that they engage in risky practices, they are perceived as obstacles to the improvement of reproductive health in communities because of their unorthodox methods such as telling HIV-positive clients to have sex with minors as a way of curing HIV/AIDS. These healers are also alleged to be charging exorbitant prices for their services and threatening their clients who fail to pay. According to one informant in Zambezi, some male healers also demand sex from their female clients who often give in due to the following or similar threats:

I will go and touch the shrub which I used to prepare the medicine to cure you and once I do so, the disease will recur and you will never be cured.

The following discussion with a Catholic Priest also highlights more problems associated with traditional healers:

Interviewer: *What are your views on traditional healers in their fight against HIV/AIDS? What role can they play or have they played in the utilisation of voluntary counselling and testing services?*

Respondent: *It is difficult to speak on their behalf [poses and laughs]...but looking at what we are made to understand, to some extent they are frustrating the policy of reducing HIV/AIDS...use of razor blades...to them every disease is curable. For them they target the symptoms other than the root cause of the disease. I do not think they are doing a good job. Unfortunately, even when they know that they can not cure AIDS they do not want to admit it and people have a lot of interest and faith in them. They are still going in numbers.*

A Provincial Health Director also observed that traditional healers have a tendency of using the same blade on their clients, making these clients vulnerable to HIV infection. He further observed that this could be avoided if MOH came up with written unsafe cultural practices, which should be written in local languages and distributed to various community groups. However, given the number of people who visit these healers, he was of the view that these healers can also be used as agents for condom distribution as well as VCT referral.

Conclusion

Traditional healers, CHBC and modern health centres are the main providers of care and support services for PLHA in Zambia. However, provision of these services is complex and should involve all stakeholders as use of these services also depends on what people know or think about the services and HIV/AIDS in general. Even though this report has not examined people's knowledge and attitudes about HIV/AIDS, it has established that HIV/AIDS stigma is still a serious problem in Zambia. Even though many people have heard about HIV/AIDS, most of them have not accepted it as a health problem and this is affecting the use of care and support services for those living with the virus.

ART is the most reliable treatment for PLHA and its introduction has encouraged many people to seek HIV testing so that they can eventually access ARV drugs if needed. Nevertheless, there are very few ART centres in Zambia, making the process of acquiring ARV drugs costly, especially for people in remote areas of the country. Even in urban areas where these centres are common, the problem of inadequate laboratory facilities, particularly the CD4 count machines, which are critical in determining the type and initiation of ART treatment regimens, still persists. Therefore, acquisition of more CD4 counting machines or the introduction of manual CD4 counting techniques would improve the use of ART services especially in the remote parts of the country.

CHBC programmes are making some positive contribution towards the welfare of PLHA but there is still need to strengthen synergies between government health centres and the CHBC programmes. Most CHBC providers have no medical qualifications hence the need to provide special training through established government medical training centres. The funding problems CHBC programmes could also be reduced if there is a deliberate attempt by government to avail some supplementary funding to CHBC institutions through the Welfare Department in the Ministry of Community Development and Social Welfare. In addition, there is need to establish a national coordinating unit for CHBC programmes in order to avoid duplication of interventions as well as enabling effective monitoring and evaluation of these programmes.

As for traditional healers, there are still some irregularities about some of their practices in spite of earlier observations that Zambian healers are enlightened about HIV/AIDS (Burnett et al. 1999). Given that many people still depend on these healers for their health including HIV/AIDS related problems, there is need to strengthen THAPAZ in order for it to effectively play its regulatory role including providing more education about HIV/AIDS to traditional healers in very remote areas. The on-going government supported clinical trials on herbal concoctions used by traditional healers to treat HIV/AIDS patients should be supported and speeded up so that the public can make informed decisions about HIV/AIDS services. In the meantime, traditional healers can also be used as referral points HIV testing once they are educated on the importance of VCT. This arrangement could be more effective if these healers are linked with CHBC and modern health centres.

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