

**WORKSHOP ON URBAN MICRO-FARMING AND HIV-AIDS  
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**INTEGRATED AIDS PROGRAMME, CATHOLIC  
DIOCESE OF NDOLA**

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## INTRODUCTION TO IAP

The Integrated AIDS Programme (IAP) is a Non Governmental Organisation under the Catholic Diocese of Ndola that was created in 1993, with help of Cordaid (then Memisa) after it operated informally in Luangwa – Kitwe and Nkwazi in Ndola from 1991. From its inception, it operates on a non discrimination basis and on interdenominational approach as can be seen from the clients it serves and the staff it recruits.

The overall objective of the Integrated Aids Programme is to address the AIDS epidemic in its widest context for the most vulnerable people in society through the provision -by community based organisations and volunteers- of home and orphan care, prevention and community development activities *in an integrated manner* to people with symptomatic infection and their families and to advocate respect of their rights.

The IAP operates in 32 shanty compounds of five main towns (Ndola, Kitwe, Luanshya, Mufulira & Chingola) in the Copperbelt which is the most urbanised province of Zambia due to the copper mines and industries. As such it high densely populated with a population of 1,600,000.

The target group of people with symptomatic HIV infection and their families is large and has increased over the years. With a population of 350,000 to 400,000 residing in the compounds where IAP operates, the coverage is estimated at 77% of all chronically ill people.

Eleven different managing agencies – of which most are church-related – coordinate the provision of home care -integrating medical and nursing care, psycho-social support and pastoral care- to **patients with chronic illnesses, especially AIDS** by about 750 community volunteers and 38 professional nurses. All patients with symptomatic HIV infection (95% of those chronically ill) are eligible for counselling services.

About 70% of them require immediate medical/nursing care by a trained professional. The latter figure is so high mainly because the majority of the patients join the home care programmes at an advanced stage of their disease. In addition, many of the patients have tuberculosis and they require special medical attention. The number of people receiving home care currently stands at about 9,000 (June, 2005). 80% of these households involved are eligible for welfare support in the form of food or non-food items.

The number of **orphans** that have been identified through the home care programmes is about 15,500. These are all orphaned by the AIDS epidemic. Once a chronically ill patient has died, the programme is obliged to continue supporting the orphans. The emphasis is on supporting children (as far as they are of school-going age) to remain in school; providing their households with welfare support; and assisting orphan guardians and teenage orphans who are no longer in school in setting up income generating activities. Eighty percent of the orphans and their households are eligible for such types of support. Cognisance should be taken, though, of the fact that the needs of some of the orphans will be addressed through the ongoing care of chronically ill component of the home care programmes, which provides for holistic care including welfare support, where appropriate, to the households in their entirety.

**People living positively with HIV/AIDS** (PLHA) form the third target group of the programme. Some of them may already have developed clinical symptoms of AIDS,

but what they have in common is that they all know that they are HIV positive, that they acknowledge this in public and they participate in IAP activities that aim at preventing the further spread of HIV. These are about 1,000 spread among 11 home care programmes. Some groups engage in income generating activities, that the IAP tries to promote in order to strengthen people's income base. In principle, all people living positively with HIV/AIDS are eligible to join groups that engage in income generating activities, but for practical reasons the number of beneficiaries at any point in time has so far been limited.

**Volunteers** form the cornerstone of the IAP programme. They engage in caring for other patients and those affected by the AIDS epidemic, as well as in activities aimed at preventing HIV transmission in their respective communities. The number of volunteers currently stands at 750 (June 2005). The minimum standards put in place by the integrated AIDS Programme to ensure quality home care requires that one volunteer to look after 10 –15 patients, one coordinator for 150 patients and one nurse for every 200 patients.

The **general public** is being targeted through the involvement of volunteers and groups of people living positively with AIDS in a wide variety of activities, in which some of the initial programme beneficiaries have become actors themselves. Counselling and testing services are being offered to the general public at no financial charge by community-based drop-in centres and VCT centres.

#### **Multifunctional centres**

These are centres that are owned by local communities and which draw some limited sponsorship from the IAP. Each centre is run by a coordinator, who receives part of her salary from the IAP programme, in close conjunction with people with HIV/AIDS who have been identified through the home care programmes. There are four such centres, all situated in compounds at the premises of the respective home care programme from which they originated. The participants engage in group meetings to discuss their own situation and what they can do about it, and they organise training in life skills development. They also engage in income generating activities, which, because of their success, have become the mainstay of the MFCs. Further the MFCs serve as a drop-in centre for people who are in search of information about HIV/AIDS, or HIV testing. Iseni MFC in Chingola includes an established centre for Voluntary Counselling and Testing.

Chisilano MFC at Nkwazi compound of the Ndola home care programme is the oldest centre, where several groups of people living with HIV/AIDS have participated in various activities. Some of the income generating activities of the centre are highly successful, such as the production and sale of greeting cards, doormats, school uniforms and gardening. While there is a steady attrition from the groups of people living positively with HIV/AIDS (PLHA), due to death, it is a deliberate policy of the centre to renew the membership of the groups every 6-12 months so as to make room for new members.

**The Clinical and Pastoral Care Centre (CPCC)** located at Kitwe Central Hospital, is an interdenominational centre that provides information, counselling and testing services and pastoral care. The centre plays an important role in ensuring continuity of care between the various home care programmes in Kitwe and the hospital. It receives both patients that are referred from home care programmes to the hospital, as well as patients that are referred by the hospital back to the home care programmes. The Centre is run in partnership between the Counselling and Testing Unit of Kitwe Central Hospital, the Hospital Chaplain Office (with a Catholic priest and a reverend of the United Church of Zambia) and the Integrated AIDS Programme. The

IAP has a coordinator, Counsellor/nurse and a Secretary/Receptionist based at the CPCC, who provide VCT services to patients referred by the home care programmes. The coordinator is also involved in training activities, especially for home care volunteers and counsellors from the community and for nurse counsellors. The CPCC has in phase iv taken up a new role of a training centre/resource centre.

### ***AIDS department of Ndola Diocese***

The AIDS department provides technical support to the above implementing agencies – the agencies implementing home care, the multifunctional centres and the CPCC – and ensures proper coordination and exchange of experiences between them. The department has no implementing role and always works through the above implementing agencies, or through other organisations and programmes that have similar objectives. The AIDS Department is responsible for planning of the activities conducted under the IAP, monitoring, reporting (on a half-yearly basis) and accounting towards the donor agencies that provide financial assistance to the IAP.

### ***Income generating activities***

Through the four Multi-functional Centres, IAP has some bit of experience in Income Generating Activities (IGAs) including urban agriculture. The People Living with HIV/AIDS have been involved in IAGs such as knitting, weaving, gardening, poultry, production of high energy protein supplements (HEPS) and running of grinding mills. All these activities are meant to provide an income to the PLWHA who have lost their jobs due to their poor health and are not strong enough to engage in labour intensive activities to earn a living.

## **LESSONS LEARNT**

### ***Access to resources***

Small scale farming is very difficult on the Copperbelt because access to land is very difficult since most of the land is owned by the Copper mines, industries and the state. The people are confined to lands around the big cities where they live in 'shanty compounds' or slums. Some compounds have over 45,000 people while the smallest are those with over 10,000 people. Unfortunately, these are the areas which are highly affected by HIV/AIDS. Some Positive Living groups have small communal gardens near the centres where they have access to water and a bit of space. Those who grow their crops around the compounds usually fail to harvest as the crops are stolen before it is even ready.

However, since the privatisation wave and the massive job losses due to the closure of the mines and most supporting industries, the government is seriously considering to degazet part of the state own land and give it to jobless people in the form of small farming blocks. This may offer a chance to the PLWHA who may want to engage in micro-farming in the near future.

The Integrated AIDS Programme intends to lobby with the government through the bishop to get a large piece of Land where some of the beneficiaries may access the land for micro-farming.

### ***Other challenges***

The development of the gardening, poultry and other production activities has encountered many difficulties. Some being:

- a. Lack of technical competence in the staff at IAP level to enhance the technical capacity of the various support groups involved in IGAs as almost all the IAP staff are health biased and lack production or marketing skills.

- b. Limited access to finance: Most donors refuse to fund farming as a way of supporting and empowering PLWHA. Most partners advise IAP to leave farming to those involved in agriculture as IAP's expertise is health and social work.
- c. Access to water for irrigation is very difficult and simple irrigation technology is absent.

***Increasing need for urban agriculture***

With a lot of PLWHA accessing ARVs in Zambia, the challenge of socio-economic rehabilitation becomes even more relevant if the quality of life for PLWHA has to improve. As experienced so far, the 270 PLWHA who were put on the ARVs five months ago are now up and running. Five months ago they were bed ridden; today they are strong and engaged in gardening to sustain themselves. The demand for economical empowerment from the PLWHA on ARVs is increasing every day. If PLWHA are rehabilitated with ARVs, without economic empowerment, prevention of the further spread of HIV in Zambia and on the Copperbelt in particular, is a pipe dream. It is time donors funded initiatives such as urban micro-farming as tools for economic empowerment for the PLWHA after they access ARVs.

Integrated AIDS Programme is therefore interested to learn from all those organisations already involved in the economic empowerment of the PLWHA through Urban Micro-farming.