Think Tank Report

Water, Sanitation, Hygiene And HIV/AIDS
1. Summary and Conclusions

In countries where significant numbers of people live with HIV/AIDS, access to safe water supply, sanitation and hygiene promotion (WASH) are key to the prevention of the most common opportunistic infections such as diarrhea and various types of skin disease. Improved WASH access eases the burden of caregiving within communities, and facilitates food security and income generating opportunities near home. In addition the WASH sector has a comparative advantage in reaching communities because of its widespread geographic and social coverage, and long experience with the combination of technology and behavior.

From the water and sanitation management perspective, the epidemic can have a systemic impact on sector performance. It has the potential to both jeopardize the achievement of the MDGs, and the ability of the sector to provide services and maintain quality.

So far the WASH sector has paid little attention to HIV/AIDS and lags behind other sectors such as education and agriculture which have historically been more actively involved in HIV/AIDS. To proactively address the gap, WSP-AF decided to hold a one day think tank meeting to:

- Review WASH-HIV/AIDS linkages and experiences, and how the WASH sector can contribute to HIV/AIDS interventions
- Discuss ideas and determine priorities for action for WSP-AF on HIV/AIDS
- Discuss possible activities in Zambia, chosen as a pilot project because it is a WSP focus country with an expressed interest in doing work on water and HIV/AIDS.

The meeting was attended by 15 WASH and HIV/AIDS specialists from the World Bank, WSP, UNICEF, USAID-HIP, Royal Dutch Institute of Tropical Medicine, National AIDS Council of Zambia, and the Lusaka Water and Sewerage Company (see annex for list of participants).

Presentations and discussions focused on:

- HIV/AIDS and the role of WASH in addressing the pandemic from a public health perspective
  - The linkages between HIV/AIDS and WASH from the WASH consumer and provider perspective
  - The country situation in Zambia with respect to the HIV/AIDS pandemic. Matters covered were strategies of the National AIDS Council, strategies of the water sector, and the strategy and program of the Lusaka Water and Sewerage Company (LWSC).

An overview of the key points of the presentations can be found in the proceedings (section 2.1, 2.2 and 2.3).

The presentations and discussions helped to identify priority actions that the WASH sector can take to mitigate the impact of HIV/AIDS. A list of priorities grouped by partnerships, policy, education and awareness, organizational management, service targeting research and programming is outlined in section 2.4

The immediate priority actions for WSP (full details are given in sections 2.5 and 2.6) are summarized below.

Training

First, manuals have to be developed on options for mainstreaming HIV/AIDS in WASH at policy, service provision, and community levels. This needs to be followed by training programs for WASH staff and WSP partners on the linkages between water and HIV/AIDS, and on HIV/AIDS-responsive programming. At the same time, HIV/AIDS community workers will need to be trained in WASH.
Research

Discussions recognized the need to build evidence on the role of WASH in improving the health of people living with HIV/AIDS (PLWHA). The research should look at safe water supply, and improved sanitation and hygiene. It would also be useful to assess if improved WASH at community level can reduce the burden on the health care system through infected people having less water and sanitation related diseases. In turn, this would mean that patients can be cared for at home for a longer period before turning to the health care system.

Lobby and advocacy

Using results of research, advocacy will have to be carried out to lobby for a greater focus on HIV/AIDS in the water sector. More engagement on WASH activities is needed with other stakeholders and organizations working on HIV/AIDS. In addition, WSP should facilitate dialogue between HIV/AIDS programs and utility staff, and promote workplace policies to be developed in partner organizations.

Utility pilot

Participants agreed that it would be useful to implement a WASH-HIV/AIDS pilot in one utility. For WSP it is important to see evidence that looks at both staff and clients to scale up to other companies/water providers. It was felt that this should concentrate on improving WASH in highly affected rural and peri-urban areas as well as workplace policies and organizational management procedures. Suggestions were made to integrate HIV/AIDS activities in the Lusaka Water and Sewerage Company’s (LWSC) operations in the following ways:

1. Assess linkages between HIV/AIDS and WASH at community level in a peri-urban area for advocacy and improved services. A very important focus area is to develop linkages between HIV/AIDS structures such as the District AIDS Task Force, the health sector, community level organizations, and the LWSC to assess how and where they can work together. Furthermore, an assessment is needed to understand:
   • How people are coping with increased needs for WASH as a result of HIV/AIDS
   • What communities want to see differently in WASH services
   • Whether there are information and knowledge gaps
   • If there is a need for special subsidies and, if so, how could this be done.

2. Work with LWSC on internal management and mainstreaming of HIV/AIDS. LWSC already has a workplace policy and its impact will need to be assessed to identify gaps. Stakeholders can work with the general manager and senior management to find out what will motivate the utility to become committed to address HIV/AIDS both internally and also in its services. For this, a partnership would need to be developed between the National AIDS Council (NAC) establishing linkages, comparative advantage and coordination. LWSC’s core focus is on infrastructure provision and maintenance. Questions that require answers include:
   • What organizational changes would be required to integrate HIV/AIDS?
   • What practices throughout the utility should change?
   • What technological changes are necessary?
   • What would this cost and who would fund this?
   • Is it useful to train all employees to understand linkages between WASH and HIV/AIDS particularly staff in contact with clients such as community development workers and plumbers?
2. Proceedings

2.1 The Health and Public Health Perspective: Reaching a Common Understanding of the HIV/AIDS Pandemic and the Role of WASH

Presentations by: Bert Voetberg, Lead Health Specialist, World Bank Kenya and Kate Tulenko, Public Health Specialist, WSP-HQ

Key points in the presentations and following discussion included:

- The epidemic is still growing. It has a negative impact on the economy, decreases life expectancy, leaves numerous orphans and overwhelms the health system.
- The epidemic is relatively new and is still in a state of flux. Recent advances are new antiretroviral drugs (ARVs), simpler tests and protocols, increased resources and an evolving understanding. Antiretroviral treatment for pregnant and lactating women up till six months after delivery are now available to minimize transmission through breast milk (and therefore reduce the risk of diarrhea in infants due to formula prepared with unsafe water).
- The prevalence of the epidemic differs widely between countries and regions within countries.
- The prevalence is generally higher in urban areas compared to rural areas. Historically the epidemic in Africa started in urban areas (among more affluent males) but then leveled off earlier in these areas. Reasons are higher level of education, access to information, condoms and health services, and a culture of change being more acceptable. In contrast, traditional culture and values may act as a barrier for prevention or turn-around in rural areas.
- The epidemic is mapped out geographically in a fair amount of detail in most countries, but this may be used for political purposes. Social and economic mapping is also possible. Targets could be young people and women for prevention interventions, and treatment or prevention of mother to child transmission (PMTCT).
- HIV/AIDS needs a multi-sectoral approach, rather than a health and treatment oriented approach because HIV/AIDS (in Africa) is predominantly transmitted by sex. The health sector has little influence on sexual behavior of people or on the non-health impact of HIV/AIDS infection on people's lives.
- HIV/AIDS is being addressed differently than other chronic illnesses (such as diabetes) because of its connection with sex, death, fear, and deeply ingrained cultural and social values. For example, physicians still feel uncomfortable discussing HIV/AIDS with patients.
- Despite ARV treatment being increasingly available at affordable prices or at no cost, the epidemic continues to grow because the majority of infections are transmitted within months after a person’s initial infection. This is the stage when the person has a very high viral load and is unaware of being infected.
- ARV treatment is delayed until a minimum viral load is reached to lessen resistance to, and the negative impacts of, the treatment.
- This delay highlights the need to avoid opportunistic infections. The majority of these infections are water, sanitation, and hygiene related which is directly related to the task of the WASH sector.
- Infant formula made with improved water can eliminate the risk of HIV transmission from breast feeding but access to improved water and formula must be guaranteed for at least six months. In Botswana, the promotion of formula feeds for HIV/AIDS positive mothers resulted in a diarrhea outbreak leading to the death of many infants.
- In Africa, HIV/AIDS is dominated by ‘Slim’ disease characterized by chronic diarrhea and weight loss.
- Modeling and scenarios have shown that a comprehensive response of prevention, treatment and mitigation has the most impact both on HIV/AIDS infection and death.
- Stigma is a scourge in itself. It plays an intricate role in preventing people from using services and treatment. For instance the CDC Safe Water System became identified with HIV/AIDS in Uganda and, as a consequence, is no longer being used as before. But stigma differs according to social and economic contexts. It may be less in cohesive communities where all households are affected than in factories, institutions and other workplaces where the social environment is less conducive to openness. The balance between reducing the stigma associated with HIV/AIDS and the need for effectively target those who are infected is precarious and needs to be taken into account at all times. Reinforcing existing stigma has to be avoided. It was recommended that WASH be integrated into existing HIV/AIDS services because of the complexities of working with PLWHA and the risk of exposing people’s HIV status. These services already have staff used to working with the HIV+ community and already have built trusting relationships with PLWHA.
2.2 The Water Sector (Including Sanitation and Hygiene Education) 
Perspective: Understanding the WASH Sector and Linkages to HIV/AIDS

Presentations by: Madeleen Wegelin, Senior Advisor HIV/AIDS, Royal Tropical Institute, the Netherlands and Dennis Mwanza, Senior Water and Sanitation Specialist, WSP-AF

Key points in the presentations and following discussion are detailed below.

Links between HIV/AIDS and the Water Sector from a Consumer Perspective

- The links include staying healthy (avoidance of opportunistic infections), home-based care, infant feeding and water for productive use. Of specific relevance are:
  - The amount of water needed to care for an HIV/AIDS patient which is greater than that required for non infected consumers
  - Knowledge gaps on water and sanitation related diseases not only with HIV+ people but also with their caregivers and home-based care volunteers
  - Evidence from research in Kibera, Nairobi shows that 30% of water in affected households is safe but 66% is safe at source. This indicates a huge need for appropriate hygiene education, especially safe water storage.
  - Water quantity (patient care, environmental hygiene and productive use) and water quality (safe drinking water, food hygiene, and utensils) need to be addressed separately.
  - Latrines need to be able to accommodate both patient and caregiver.
  - Water for productive use is essential to increase food security (home vegetable production) and for income generating purposes (livestock, crops, commercial food and drink preparation).
  - HIV/AIDS threatens the sustainability of WASH systems due to decreased availability of qualified technical staff and volunteers who can complete Operations and Maintenance requirements (training, time, cost recovery, maintenance funding, and participatory planning to included affected households or orphans). Therefore there is a need to review the existing community management paradigm.
  - Gender issues need to be addressed with urgency because vulnerabilities and responsibilities of men and women in HIV/AIDS prevention, care and mitigation are very different. In most African countries, a larger number of women than men are infected, and women and girls traditionally are responsible for care giving within the family.
  - PLWHA and/or their families need to be involved in all stages of the programme cycle to ensure the special needs of HIV/AIDS affected households are taken into account.

Links between HIV/AIDS and the Water Sector from a Provider Perspective

- A decrease in productive staff will result in lower construction capacity and quality. Another consequence will be a decrease in technical support for maintenance and quality monitoring.
- Organizational management will be affected by a variety of factors, including loss of knowledge and capacity. In addition the ability to provide existing or institute new services will be affected by reduced budgets. This would result from decreased water utility cost recovery due to the reduced ability of clients to pay.
- The water sector needs to double the effort for water and triple the effort for sanitation to achieve the MDGs on water supply and sanitation. Barriers are:
  - Institutional arrangements
  - Financial constraints by institutions that lack autonomy
  - Low tariff levels to cover the cost of providing the services
  - Low payment levels by users
  - Operational inefficiencies by many public utilities
  - Inadequate involvement of stakeholders.
  - Some of these barriers become higher as a result of HIV/AIDS and hence jeopardize the achievement of the MDG.
  - Utilities investment approaches in urban areas are oriented towards the 20% of the population that provide them with 80% of the revenue. This ‘population’ lives in formal residential areas with house connections. They receive a bill and pay. The utility
generally does not give any additional services (such as hygiene education or community management training) towards this population segment, and therefore is unlikely to educate them on the links between HIV/AIDS and WASH.

- Provision in informal settlements (80% of population) is the most difficult. Services are poor or non-existent as are payment mechanisms. The situation is exacerbated by HIV/AIDS and an increasing demand for services.
- The main focus of provision in rural areas is on community participation, Participatory Rural Assessment (PRA), and financing and payment mechanisms that take into account the vulnerability of communities. All of these issues are affected by HIV/AIDS.
- In relation to HIV/AIDS, utilities are interested in the impact on their own employees. This includes HR costs to the company and cost of care for employees. The gravity of the negative impact of the HIV/AIDS pandemic on consumers still needs to be fully grasped.
- Utilities do not have clear information on the relationship between water and sanitation (their services) and the (changed) needs for these services as a consequence of HIV/AIDS. They calculate social tariffs on the basis of 6,000 liters/capita per month (which is too low for HIV/AIDS affected households), and does not include water for productive use.

Role and Strategies For the Water Sector

Community Level

- Increase access to sufficient water and sanitation. Improved water can reduce the number and severity of episodes of diarrhea of PLWHA. It increases productive time and improved WASH eases the burden of family caregiving, especially at the end of life.
- Integrate HIV/AIDS concerns in community mobilization and link up across sectors. An example is school based activities of the education sector that are already multi-sectoral.
- Create mechanisms for poor people (in general), and PLWHA and women (in particular) to establish their needs, and to influence water and sanitation decisions.
- Ensure hygiene education incorporates linkages to HIV/AIDS, and is also given to home-based caregivers.
- Facilitate communities to develop HIV/AIDS responsive O&M systems.
- Train more water operators.
- Adapt PRA tools used in the water sector to include issues on HIV/AIDS.

Provider Level

- Assess the impact of HIV/AIDS within the organization:
  - What can be done about the impact of existing staff infections?
  - How can staff infections be prevented?
  - How can we improve the understanding of staff about the links between WASH and HIV/AIDS?
- Assess the impact of HIV/AIDS on the organization’s business objectives:
  - How is the epidemic likely to affect the sector goals, objectives and programmes?
  - How is the spread of HIV/AIDS caused or contributed to by the sector?
- Address the question of the sector’s comparative advantage to respond to the epidemic.
- Lobby for water and sanitation in the political arena and create commitment at the highest level. Focal points or HIV/AIDS committees within the organization need time, a budget, authority, and capacity.
- Educate staff about prevention.
- Raise awareness with clients and suppliers.
- Look at scope for innovative interventions, partnerships and delivery mechanisms.
- Develop strategies to inform and educate care givers, PLWHA and their families on how to reduce exposure to water, sanitation, and hygiene related diseases.
- Identify how this can be done most efficiently using hygiene educators, plumbers, and other staff operational at consumer level.
- Establish water and sanitation standards that take HIV/AIDS into account. An example is to redefine domestic water supply to include both water for basic needs and small scale production.
- Develop and offer technologies that require minimum effort for operation and maintenance, home-based water treatment,
and sanitation. This is especially important for child-headed and grandmother-headed households, and those weakened by HIV/AIDS.

- Speed up funding for water and sanitation coverage in rural areas and low-income urban settlements, especially those areas most affected by the epidemic.
- Develop partnerships with relevant sectors and service organizations in the public and private sector based on comparative advantage (health and education sectors, HIV/AIDS service organizations, and NGOs).
- Use existing guidelines for the development of workplace policies and on mainstreaming HIV/AIDS in different sectors.

**Comparative Advantage of the Water Sector**

- Long and extensive experience with matching technology and behavior.
- Long and extensive experience in going beyond “delivering the message”.
- Geographic and social coverage.
- Decentralized arrangements.
- Demand for safe drinking water in treatment, home-based care (HBC) and PMTCT programs.
- Able to use readily available WASH methods.

**Questions For Which We Need Evidence**

- How can access to safe water be ensured away from home? Research shows that PLWHA who have clean water at home, continue to contract diarrhea from contaminated water sources outside the home.
- Can sanitation alone or hygiene alone reduce diarrhea in PLWHA? All of the research conducted has concentrated on the effects of clean water on diarrhea in PLWHA.
- Can improved WASH reduce the number of respiratory infections in PLWHA?
- Can improved WASH help maintain weight and nutritional status?
- Can improved WASH provided at onset of symptoms delay the need for ARV initiation?
- Can improved WASH prolong lifespan?
- What has the water sector done internally to mitigate HIV/AIDS?

**2.3 Zambia: Country Situation (HIV/AIDS and Water Sector) and Needs**

Presentations by: Ben Chirwa, Director General, National Aids Council, Zambia; Kennedy Mayumbelo, Peri-Urban Manager, Lusaka Water and Sewerage Company; Barbara Mwila Kazimbaya-Senkwe, Water and Sanitation Specialist, WSP Zambia

The Zambia country presentation looked at the epidemic in Zambia. Areas covered were:

- Goals, principles and themes of the National AIDS Council (NAC)
- Policies and strategies of the water and sanitation sub-sector
- Strategy and program of the Lusaka Water and Sewerage Company (LWSC).

The latest statistics (2001) show an HIV/AIDS prevalence rate of 16%. Prevalence in urban areas was 25% compared to 11% in rural areas. There was a prevalence difference between men and women of 13% versus 18% in the adult population (aged 15-49).

The multi-sectoral response which is coordinated by the NAC is committed to controlling HIV/AIDS. The intention is to integrate HIV/AIDS into the work of every ministry and partner, and into the development agenda. Rapid and responsive prioritized actions geared to the needs of the local communities to be served will be scaled up. Within the NAC, themes of operation relevant for the water sector are the mitigation of the socio-economic impact, strengthening the decentralized response, and mainstreaming HIV/AIDS in all sectors.

This means NAC has the mandate to coordinate the responses of stakeholders and sectors. So far, the water sector (or LWSC) is not involved, but new technical working groups are being formed under the NAC, and this is an opportunity for the water sector. However, evidence must be gathered to show for advocacy purposes to both sectors that WASH improves the lives of PLWHA. This can then be followed by integration of WASH services into ongoing programs for PLWHA and mainstreaming of HIV/AIDS in all water sector operations.
The water sector is guided by the Water Supply and Sanitation Act, 1997. The Act incorporates the establishment of Commercial Utilities as well as the National Water and Sanitation Committee (2000) as the regulator for WASH. Further strategies are laid down in the Institutional Framework for Rural WATSAN (2004), the National Rural Water Supply and Sanitation Program (2005/2006), the Water Resources Master Plan (1995-2015), and the Environmental and Sanitation Strategy (1998). None of these strategies takes HIV/AIDS into account, but there is ongoing reform and the Devolution Trust Fund (DTF) is focusing on WASH provision in peri-urban communities. It would be possible to start a pilot project on integration of HIV/AIDS and WASH using the DTF. Expected World Bank funding could subsequently be used to scale up the resources.

The LWSC, established in 1988, serves 1.8m people in Lusaka of which 60% live in peri-urban areas. It covers 70-80 percent of water and 30-40 percent of sewerage needs. Service provision to the poor is done in partnership with other organizations/providers such as NGOs. The Peri-Urban Department is operational in 33 areas, and aims to serve the poor while ensuring commercial sustainability. However, it has low coverage resulting in inadequate access. This, in turn, leads to inequity with resale at higher prices.

Internal reform is ongoing to enhance operational management and service provision. LWSC has an HIV/AIDS policy for its employees that covers prevention (condoms, peer educators, and awareness raising) and benefits. It does not cover awareness on the linkages between their services and HIV/AIDS, or an assessment of comparative advantage of the water sector to address HIV/AIDS. Also internal management procedures have not been adapted to include policies on HIV/AIDS.

### 2.4 Priority Action For WASH Sector To Mitigate Impact of HIV/AIDS

After the presentations and discussions, participants were asked to list priority actions that should be taken by the WASH sector. These priorities were grouped into actions pertaining to partnerships, policy, education and awareness, organizational management, and service targeting research and programming.

#### Partnerships
- Develop global partnerships between WASH and HIV/AIDS service organizations.
- Advocacy with sector partners as the reach of the water sector to consumers is high.
- Create partnerships with other sectors especially health and education in designing policy.
- Establish more formal links with HIV/AIDS organizations (UNAIDS, ICASO, National AIDS Councils, and national HIV/AIDS service organizations).
- Establish clear guidelines for National AIDS Councils to work with the water sector (cooperation between WASH and NAC).

#### Advocacy
- Advocacy within the sector and with HIV/AIDS policy makers such as UNAIDS.
- Set up a global moderated list server, including people from different stakeholder groups.
- Submit papers and propose sessions on WASH and HIV/AIDS to the Global Health Council Annual Conference and other similar meetings.
- Submit a proposal to make a presentation on WASH and HIV/AIDS to the UNAIDS Board meeting to be held in Zambia.
- Present evidence on what we know now.
- Ensure time in meetings is allocated to home based care.
- Ensure representation of PLWHA in all meetings such as above.
- Adhere to GIPA (Greater Involvement of People living with AIDS) principle.
- Make use of existing contacts (Richard Feachem, Sandy Cairncross, Madeleen Wegelin).
- Prepare a short pamphlet on the status of WASH and AIDS for advocacy purposes.

#### Policy
- Review applicability of WASH policies for HIV/AIDS.
- Recommend policy review for WASH needs to cater for HBC.
Mainstream WASH into ongoing programs for PLWHA and their caregivers.

**Education awareness**

- Give hygiene education to home-based caregivers.
- Build awareness on sector knowledge hubs about the link between WASH and HIV.
- Pilot the integration of HIV/AIDS life skills training into water, sanitation and health education programs.
- Create awareness of the impact of HIV/AIDS on water users.
- Develop behavior change programs.

**Financing**

- Apply for HIV/AIDS funding via global HIV/AIDS funding mechanisms (GFATM, WHO’s 3 x 5, PEPFAR, etc).

**Organizational management**

- Develop workplace policies and adapt organizational management procedures.
- Train water sector staff on the relationship between HIV/AIDS, water, sanitation, and hygiene.

**Service targeting**

- Provide potable water for the poor peri-urban communities to target the affected.
- Provide rural water to target affected PLWHA.

**Research**

- Conduct studies on improved household sanitation and hand washing on HIV/AIDS related illnesses. This is the highest priority research. If we do not have stronger evidence that WASH actually improves the health of PLWHA, no one will invest in it.
- Review technology usability.
- Research investment and charging mechanisms that recognize special needs for HIV/AIDS.
- Conduct a gender analysis of HIV/AIDS responsiveness of the water sector.
- Conduct advocacy and analytical work to create WASH leadership commitment.
- Factor HBC WASH needs/requirements in sector investment plan (SIP).

**Programming**

- Integrate WASH into support programs for PLWHA.
- Incorporate HIV/AIDS education programs in all water and sanitation projects.
- Develop gender-responsive programs about HIV and AIDS for the water sector.
- Lobby water sector planners to take HIV/AIDS related water needs in account.
- Include HIV/AIDS affected households in the strategy for targeting WASH interventions.
- Take into account HIV/AIDS issues based on comparative advantage in program design.
- Integrate (mainstream) HIV/AIDS into community level planning and implementation.
- Ensure a forward looking angle as HIV/AIDS responses and needs change continuously.
- Give consideration to aspects that do not change such as reducing vulnerability factors, facilitating context, and gender issues.

During the discussion it was pointed out that the education sector has had success in integrating other sector activities in its operations and programs (such as life skills, hygiene behavior, and health sciences). It was felt that doing this through schools is easier than in communities as many children can be reached in a single classroom. Children also are instrumental in their acceptance of new behaviors. It was also understood that integration of sector services, from a community perspective, into a holistic development approach is common sense.
As improved water and sanitation provision will reduce the burden on the health care services such as hospitals, these facts should be included in any advocacy action. Other facts that can be covered are less need for treatment and prolonging the period where ARV treatment is not necessary. This reduces costs and the risk for ARV resistance.

2.5 Priority Actions for WSP

Participants indicated priority actions for WSP if it had $100,000 as start-up funding. These priorities were grouped into actions pertaining to training, pilot programs, research and mapping, lobbying and advocacy.

Training
- Develop manual of options for mainstreaming HIV/AIDS in WASH at policy, service provision and community levels.
- Develop training programs for WASH staff and WSP partners in HIV/AIDS.
- Train water sector staff on HIV/AIDS-responsive programming such as planning and budgeting.
- Train HIV/AIDS community workers in WASH.

Utility pilot
- Develop a behavior change marketing program led by a utility in one city.
- Make safe water available for people living with HIV/AIDS in rural and peri-urban areas, including community/household level water treatment.
- Work with one utility to pilot internal and external mainstreaming.

Research and mapping
- Conduct detailed HIV/AIDS and WASH linkage research.
- Finance a pilot study and disseminate the results.
- Demonstrate impact of improved WASH for home-based care in high prevalence region/area.
- Conduct impact study on HIV/AIDS and the WASH sector, focusing on employees as well as clients.
- Map WHO/areas needing specific attention, considering capacity of sector.
- Community diagnosis of water and HIV/AIDS related needs.

Lobbying and advocacy
- Combine HIV/AIDS advocacy with WASH advocacy.
- Facilitate dialogue between HIV/AIDS programs and utility staff.
- Lobby for world class HIV/AIDS related HR procedures (access to ARVs, improved confidentiality systems) internally within the Work Bank.
- Disseminate model to others.
- Demonstrate requirements of productive use of water/waste in all WSP rural/peri-urban programs.
- Prioritize schools as key water points in the community.

2.6 Possible Activities with LWSC for Integration of HIV/AIDS In Operations

1. Assess linkages between HIV/AIDS and WASH at community level (especially peri-urban) for advocacy and improved services. A specific area could be Kanyama.

Suggestions on how this can be done included:
- Work with District HIV/AIDS Task Force and LWSC to see where they can work together and identify stakeholders that are working in HIV/AIDS and/or WASH.
- Use regular outreach work of the Peri-urban Unit (records and household survey) to make research linkage between
WASH and HIV/AIDS.

- Use records of the health sector to assess links between HIV/AIDS and WASH diseases.
- Find out how people are coping with increased needs for WASH as a result of HIV/AIDS (baseline).
- Assess what communities want to see in WASH services (especially the link with WASH diseases and home based care).
- Find out if there is a market research group in LWSC.
- Assess whether people would be more willing to pay if WASH services include HIV/AIDS concerns. (Note: lack of payment of bills is not restricted to HIV/AIDS and has always been an issue, so this angle may not be attractive to the community).
- Assess whether special subsidies are needed for AIDS affected families.
- Assess information needs (HIV/AIDS and WASH) at community level.
- Find out whether there are gaps and which stakeholders are already involved.
- Use existing information from Zambia and elsewhere (such as Kibera research, CARE International’s experience, and the Network for Water and Sanitation (NETWAS).

2. Work with LWSC on internal management and mainstreaming of HIV/AIDS.

Suggestions on how this can be done included:

- Work with NAC on partnership.
- Establish linkages.
- Assess comparative advantage and coordinate initiatives.
- Ensure stakeholder participation.
- Assess impact of current HIV/AIDS workplace policy and identify gaps.
- Get commitment by advocacy with general manager and senior management.
- Work out what may trigger interest.
- Be seen to be the first utility addressing this issue.
- Build a profile of social responsibility.
- Focus on the responsibilities of the utility as duty bearers that have to fulfill the rights of clients (users) to access to safe water and sanitation (rights based approach).
- Assess whether a rallying slogan can be developed.
- Assess how the issue of quality of water is being addressed.
- Get an advisor with expertise in HIV/AIDS, WASH sector, and utility management to assist in the process.
- Understand what LWSC has to do to integrate HIV/AIDS into its vision and mandate.
- Assess what practices in the whole utility should change including any technological change.
- Determine costs and funding.
- Train all employees to understand linkages between WASH and HIV/AIDS.
- Train community development workers and plumbers (and other staff that are in touch with communities) on the links between WASH and AIDS (education/awareness).
### Annex 1. List of Participants

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<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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</tbody>
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### Annex 2. Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti retroviral drugs</td>
</tr>
<tr>
<td>CDC</td>
<td>Center of Disease Control</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV/AIDS</td>
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<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, TB and Malaria</td>
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<tr>
<td>HBC</td>
<td>Home-based care</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HIV+</td>
<td>HIV positive</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>ICASI</td>
<td>International Council of AIDS Service Organizations</td>
</tr>
<tr>
<td>LWSC</td>
<td>Lusaka Water and Sewerage Company</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council (Zambia)</td>
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<tr>
<td>NETWAS</td>
<td>Network for Water and Sanitation</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>O&amp;M</td>
<td>Operation and Maintenance</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PRA</td>
<td>Participatory Rural Appraisal</td>
</tr>
<tr>
<td>UAFW</td>
<td>Unaccounted for water</td>
</tr>
<tr>
<td>WASH</td>
<td>Water supply, sanitation, and hygiene promotion</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WSP</td>
<td>The Water and Sanitation Program</td>
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</tbody>
</table>