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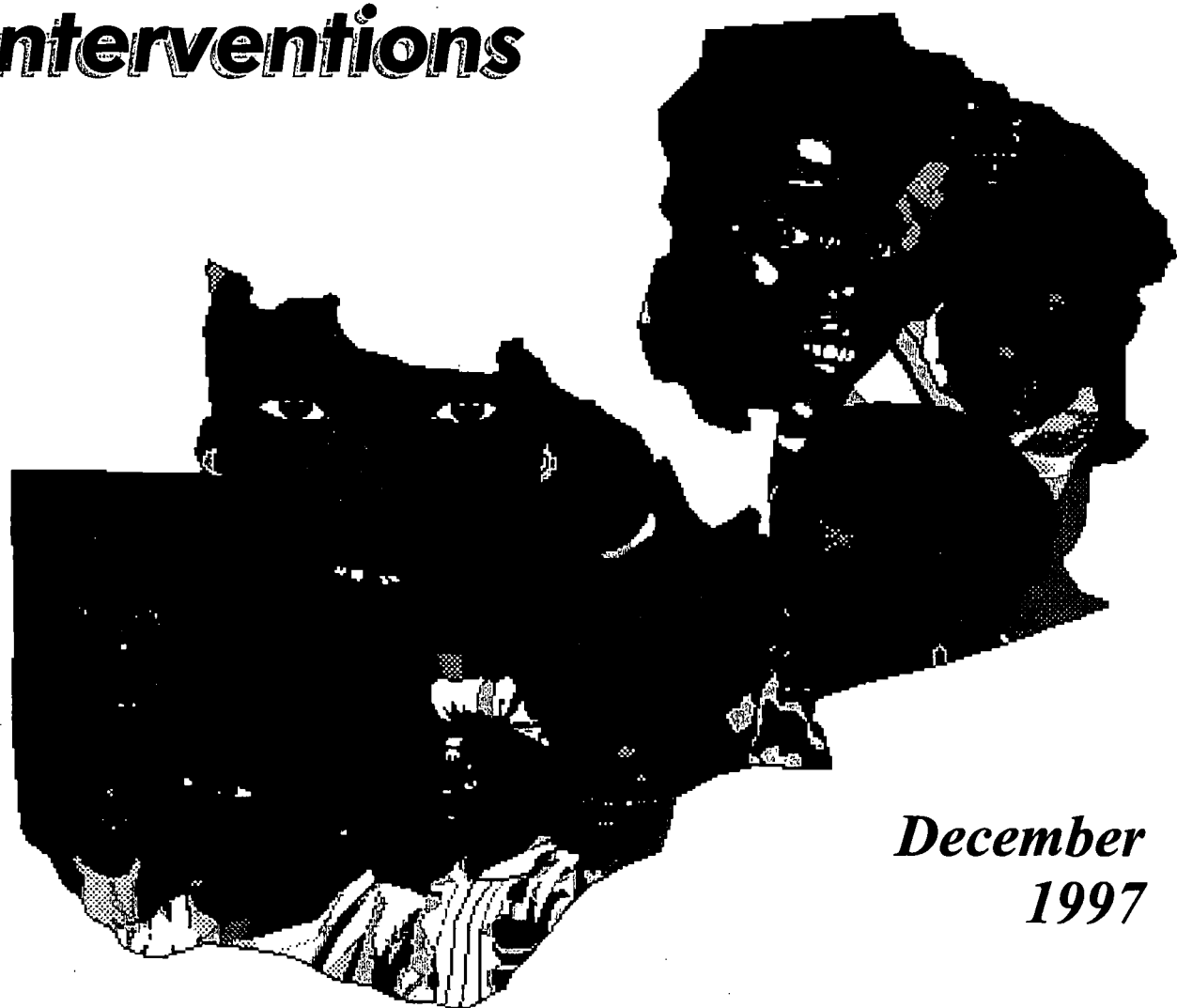
HIV/AIDS in ZAMBIA

Background

Projections

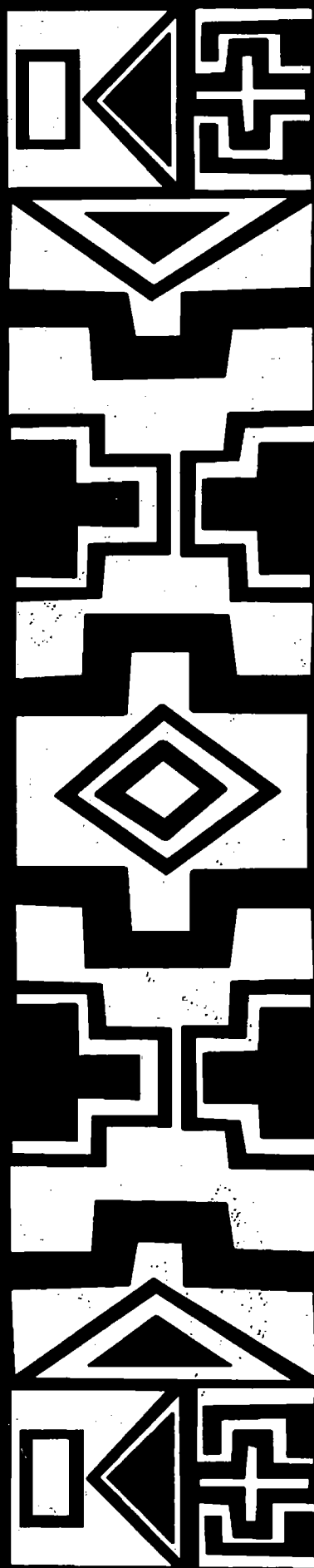
Impacts

Interventions



*December
1997*

***Ministry of Health
Central Board of Health***



ZAMBIA NATIONAL HIV/AIDS/STD/TB INSTITUTIONAL FRAMEWORK

**HIV/AIDS/STD/TB
COUNCIL AND
SECRETARIAT**

AUGUST 1998



Ministry of Health

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Under the guidance of the Honorable Minister of Health Prof. Nkandu Luo, the following groups:

- the HIV/AIDS Task Force,
- the Ministerial team that visited Thailand and Uganda and
- the Central Board of Health

were able to develop a National HIV/AIDS/STD/TB Institutional Framework comprising of a National HIV/AIDS/STD/TB Council and Secretariat which will be responsive to the needs of the Zambian society.

The National HIV/AIDS/STD/TB Council and Secretariat have been structured to ensure the effective coordination of the multisectoral response to HIV/AIDS/STD/TB.

List of Abbreviations

ACP	AIDS Control Programme
Agric.	Agriculture
Allev.	Alleviation
Appr.	Approach
C&S	Care & Support
CBoH	Central Board of Health
CBOs	Community Based Organisations
CDSd	Community Development and Social Development
(D)PS	(Deputy) Permanent Secretary
Dir.	Director
Ed.	Education
FAS	Financial and Administrative Support
H	Health
H/A	HIV/AIDS
IEC	Information, Education, Communication
IM	Impact Mitigation
Info	Information
Int'l	International
MD	Medical Doctor
M&E	Monitoring & Evaluation
MACA	Multisectoral Approach to Control of AIDS (Uganda)
Min.	Ministry/Minister
MLSW	Ministry of Labour & Social Welfare
MoE	Ministry of Education
MOH	Ministry of Health
MoH	Ministry of Health
MoPH	Ministry of Public Health
NASTLP	National AIDS, STD, TB, Leprosy Programme
Nat'l	National
NGOs	Non-Governmental Organisations
NZP+	Network of Zambian People Living with HIV/AIDS
PALS	Positive and Living with HIV/AIDS
PC&S	Prevention, Care & Support
PLWHAs	People Living with HIV/AIDS
SAFAIDS	South Africa AIDS Information Dissemination Service Bulletin
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UAC	Uganda AIDS Commission
UN	United Nations
WHO	World Health Organisation

EXECUTIVE SUMMARY

This report documents the recommendations of the Ministry of Health on the establishment of a National HIV/AIDS/STD/TB Council and Secretariat to coordinate the National response to HIV/AIDS, STD/TB.

Background

Since the first diagnosed case of AIDS in Zambia in 1985, HIV has become endemic. With an estimated adult HIV prevalence rate of 10-15 percent in rural areas and 25-30 percent in urban areas, Zambia is in the throes of a serious HIV/AIDS epidemic. There are 44 000 cumulative reported AIDS cases to date, but this figure is well below the actual figure due to underreporting. The impact of HIV/AIDS is being felt by all sectors of society and the need for a co-ordinated multisectoral response is the key to ensuring a successful response.

The relationship of STDs and tuberculosis to HIV/AIDS has been clearly established worldwide and these conditions have become important public health problems in Zambia. An effective response to HIV/AIDS therefore should also include the effective control of these opportunistic infections.

An effective response to HIV/AIDS/STD/TB requires a *partnership* approach, involving governmental agencies and ministries, local and international NGOs, CBOs (especially PLWHAs), religious organisations, the private sector, UN agencies and bilateral donors.

This partnership approach requires effective *co-ordination* of the policies and activities in each of these different sectors.

HIV/AIDS/STD/TB Institutional framework Development Process

In 1997, under the guidance of the then Deputy Minister of Health, Prof. Nkandu Luo an HIV/AIDS Task Force comprising of members from the Ministry of Health, CBOH, Donors and NGOs began meeting to explore the modalities of putting in place a multisectoral structure at national level to appropriately address the HIV/AIDS epidemic and to move out of the transitional phase created by the formation of the CBOH.

HIV/AIDS/STD/TB Institutional Framework

As a result of these meetings the group proposed the establishment of a National HIV/AIDS/STD/TB Council and Secretariat which would be mandated to coordinate the multisectoral response to HIV/AIDS/STD/TB. It is envisaged that these new structures once approved by cabinet will be in a position to effectively advocate for intersectoral approaches, develop common policies and guidelines and facilitate their implementation.

1. Introduction

HIV/AIDS/STD/TB in Zambia

Since the first diagnosed case of AIDS in Zambia in 1985, HIV has become endemic. With an estimated adult HIV prevalence rate of 10-15 percent in rural areas and 25-30 percent in urban, Zambia is in the throes of a serious HIV/AIDS epidemic. There are 44,000 cumulative reported AIDS cases to date, but this figure is well below the actual figure due to underreporting.

The most affected age group is the 15-39 year old group. The epidemic is showing certain signs of stabilisation in urban centres, but rates continue to rise in some rural areas. On average, women are dying of AIDS at a younger age than men.

The increasing number of paediatric AIDS cases may push the under five mortality rate (U5MR) over up to 27 percent, with paediatric AIDS accounting for 60-90 deaths per thousand birth. AIDS mortality rates are still rising and as a result the number of orphans will continue to rise well into the next decade, with the attendant cross-sectional negative socio-economic impact.

Other sexually transmitted diseases are also important health problems in Zambia and these include gonorrhoea, syphilis, chancroid, trichomoniasis and candidiasis. They account for up to ten percent of hospital out patient department attendances in some major hospitals in urban Zambia.

Tuberculosis, an opportunistic infection associated with HIV/AIDS has become one of the leading causes of morbidity and mortality, accounting for 13% of all adult hospital deaths. The total prevalence of tuberculosis cases in the country is estimated to be as high as 100,000, a significant proportion (70%) of which is estimated to be HIV seropositive. These statistics highlight the concern for urgent action to control tuberculosis in Zambia.

The National HIV/AIDS/STD/TB and Leprosy Programme (NASTLP)

The vision of the Programme is to ensure that HIV/AIDS/STD/TB and Leprosy cease to be major public health problems in Zambia, with a reduction in the impact of these diseases on the individual, family and community.

The district health system should be able to reach a level of efficiency that enables it to provide quality health care and a capacity to respond effectively to these and other diseases in a multisectoral way.

The purpose of the programme therefore is to provide leadership to national institutions at various levels (government, private sector) in taking action to prevent the spread of HIV/AIDS/STD/TB, which pose a threat to the wellbeing of the individual, family and community. This supportive role includes advocacy, provision of technical guidelines, facilitation, co-ordination and resource mobilisation.

The mix of strategies and interventions being implemented are as outlined in the Second Medium Term Plan (Strategic Plan MTP-II) for the Prevention and Control of AIDS/STD/TB and Leprosy, from 1994 to 1998, and the targets and indicators derived therefrom.

Developing an effective National HIV/AIDS/STD/TB Response

An effective response to the HIV/AIDS epidemic and the control of STDs and tuberculosis requires a *partnership* approach, involving governmental agencies and ministries, local and international NGOs, CBOs (especially PLWHAs), religious organisations, the private sector, UN agencies and bilateral donors.

This partnership approach requires effective *co-ordination* of the policies and activities in each of these different sectors.

A WHO definition of co-ordination in the area of HIV/AIDS states:

Co-ordination of HIV/AIDS activities is a process (rather than a structure) which promotes information exchange, builds alliances between different organisations, and facilitates the creation of co-operation and programmes which are complementary, collaborative and reinforce one another. It should not be a mechanism of control. The process should build a relationship among partners, for mutually respectful work with jointly accepted goals and targets formulated in national and lower-level strategies and plans (WHO, 1993).

The main goal of co-ordination is to facilitate the collective, multisectoral response to the HIV/AIDS epidemic. This way gaps and unnecessary overlaps, and thus inefficient use or wastage of limited financial and human resources can be avoided.

Currently, NAS TLP's main tasks are advocacy and co-ordination of programme activities aimed at reduction of transmission and mitigation of the impact of HIV/AIDS in all its aspects.

Important issues in developing this co-ordination process include:

- Recognition that all parties involved are equal partners
- Active participation and interest by all parties involved
- Openness to contributions made by all parties
- Flexibility to discuss different approaches

The main characteristics of an effective response are:

- Advocating for and facilitating *intersectoral co-operation*: this means involving all key players in the response to AIDS: ministries, NGOs, CBOs, private sector and donors;
- *Shared responsibility* by all sectors involved, including active *intrasectoral* policy development and budget allocation for HIV/AIDS related activities;
- *Co-ordination* of these sectoral approaches (*intersectorality*);
- *Holistic* approach (deal with AIDS in its sociocultural context, including gender issues, sexuality, reproductive health and culture);
- An *integral* approach, using different strategies (legislation, education, access to facilities) for promotion, prevention, clinical treatment, care and support (positive living);

The Zambian Health Reforms Process and the Fight against HIV/AIDS/STD/TB

The Zambian Health Reforms, designed to "provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible" have had major consequences for the former health programmes, including NASTLP.

Some of the main components of the health reforms include:

- Decentralisation of service delivery to the district level
- Enhancing community involvement and ownership
- Improve infrastructure to support delivery of the essential health care package
- Development of policies, standards and guidelines to facilitate the operations at district, regional and central level

One of the direct consequences for NASTLP of the decentralised provision of an essential health care package, is the shift of responsibilities for clinical services like TB and STD services to the newly formed Central Board of Health (CBOH), and subsequently to the district levels.

Whereas for other, more clinically oriented, former health programmes this often means the total shift of responsibilities for implementation to the district level, for NASTLP it has merely emphasised the demedicalisation of the programme, which had started to take place in an earlier stage already.

At the same time, it was realised that HIV/AIDS is more than a health problem and that discontinuance of NASTLP would not guarantee adequate responses to the many aspects of the HIV/AIDS problem.

Therefore, initiatives were developed to restructure the former NASTLP into a body, which would be in a better position to implement its main responsibility of *co-ordination of the multisectoral response to HIV/AIDS/STD/TB*.

This new structure will facilitate the mobilisation of responses to HIV/AIDS/STD/TB in all sectors, including the health sector.

This includes the creation of intersectoral partnerships among sectors, development of policies and guidelines, advocacy and capacity building, and co-ordination of the strengthened multisectoral response.

These new strategies although accelerated and supported by the implementation of the health reforms, require different structures beyond the health sector, which guarantee the fulfilment of the functions mentioned above.

A new "National AIDS/HIV/STD/TB Programme" should be in a position to strongly advocate for and co-ordinate the necessary multisectoral response.

Organisational Structure

The new HIV/AIDS/STD/TB co-ordinating structure needs to be in a position where it can effectively advocate for intersectoral approaches, develop common policies and guidelines and facilitate their implementation.

2. National HIV/AIDS/STD/TB Institutional Framework Development Process

In 1997, the Ministry of Health identified the existence of a gap in the co-ordination and implementation of HIV/AIDS/STD/TB activities at National level. This coincided with the integration of the previous vertical programmes such as the National AIDS/STD/TB and Leprosy Programme into the newly created Central Board of Health (CBOH).

Under the guidance of the then Deputy Minister of Health, Prof. Nkandu Luo an HIV/AIDS Task Force comprising of members from the Ministry of Health, CBOH, Donors and NGOs began meeting to explore the modalities of putting in place a multisectoral structure at national level to appropriately address the problems of HIV/AIDS/STD/TB to facilitate the move out of the transitional phase created by the formation of the CBOH.

As a result of these meetings the group proposed the establishment of a National HIV/AIDS/STD/TB Council and Secretariat which would be mandated to co-ordinate the multisectoral response to HIV/AIDS/STD/TB.

On a fact finding mission to Thailand and Uganda, important lessons learnt from these two countries were considered and utilised to improve the previously proposed structure (Annex 1).

This report represents the culmination of all the activities to develop the new National HIV/AIDS/STD/TB Institutional Framework.

3. National HIV/AIDS/STD/TB Institutional Framework

3.1 National HIV/AIDS/STD/TB Council

The HIV/AIDS/STD/TB Council will be the highest national body with authority to co-ordinate the national response to HIV/AIDS/STD/TB. It will be an autonomous body within the Ministry of Health.

Active support from the highest governmental level to the Council is crucial to guarantee the government's direct involvement.

In the past, the lack of high level representation in the NASTLP of the different sectors has led to insufficient use of every sector's comparative advantage to address AIDS/HIV/STD/TB in the most efficient manner. The direct involvement of leading national personalities will facilitate the incorporation of all relevant sectors into the response.

The term of office for the Council will be 2 years with the possibility for reappointment. A Committee of senior officials from the Ministries of Health, Community Development and Social Services, Education, Labour, Finance, Science Technology and Vocational Training and some selected NGOs will be appointed to oversee an orderly transition to the new Council and Secretariat.

Responsibilities of the Council

- Co-ordinate the national response to the HIV/AIDS/STD/TB
- Public advocacy for HIV/AIDS/STD/TB in all sectors involved
- Advocate for intersectoral co-operation
- Policy setting and guidance to all sectors involved
- Advising the different sectors on responses according to their comparative advantage
- Resource mobilisation and monitoring for programme activities in all sectors
- Approval of budgets proposed by the Secretariat

Council Membership

The 15 Council members with representation coming from high eminent people in academia, NGOs and Ministries will be appointed by the Minister of Health.

The Council will hold 4 regular meetings in a year (once per quarter), however ad hoc meetings will take place when necessary. The chairperson will be elected by the Council members.

The Secretariat Director will be the secretary to all council meetings. The Secretariat will be responsible for linking up the overall advocacy and policy issues, as formulated by the Council, with programme development as carried out by the various sectors involved.

3.2 National HIV/AIDS/STD/TB Secretariat

The Secretariat will be responsible for developing the technical guidelines for implementation of Council decisions in all matters relating to policy development and co-ordination of the multisectoral response to HIV/AIDS/STD/TB.

The Secretariat will be responsible for linking up general policy as advocated for by the Council, with the various implementing organisations, provide them with guidance and support, and promote co-ordination of programme activities.

Thus, the Secretariat will play a facilitating and co-ordinating role through technical support without specific implementing tasks. This is a major shift from the role of the current NASTLP.

The staffing of the Secretariat will comprise various technical fields to effectively help translate policies into concrete strategies and action plans by providing guidance and support to the different sectors.

The composition of the Secretariat will include a full-time director, two specialised units, staffed by full-time technical officers, and a financial-administrative support department. PLWHAs will be explicitly invited to apply for these functions. The total workforce will be twelve members of staff (Annex 2 and 3).

3.2.1 Positioning of the Secretariat

To guarantee the appropriate position to co-ordinate the multisectoral response to HIV/AIDS/STD/TB with all sectors, the Secretariat will have an autonomous status while being resident within the Ministry of Health.

3.2.2 Resource Mobilisation and Allocation of Funds

a) Own budgets and funding of implementing sectors

An important role of the Council will be to advocate for funding for HIV/AIDS/STD/TB activities within all sectors. It is essential that all sectors involved, both governmental and

non-governmental, systematically assign their own budgets to core activities related to HIV/AIDS/STD/TB, on a yearly basis. Proper funding for HIV/AIDS/STD/TB activities *within* and *by* the different organisations and sectors, show their real involvement and commitment to an adequate response to HIV/AIDS/STD/TB, and guarantees sustainability.

b) Catalytic funds handled by the Council

Although the Council's and Secretariat's tasks do not include direct implementation or funding, experience has shown that the availability and easy access to catalytic funds ("*seed money*") for specific activities is necessary for flexibility in responding to emerging needs.

Therefore, the Council and Secretariat will have a small budget available to directly fund the kinds of activities:

c) Funds for functioning of Council and Secretariat

The Council and Secretariat will receive adequate budget for fulfilling their own tasks.

3.2.3 Functions of the Secretariat

The Secretariat will have the following main functions:

- Dissemination of HIV/AIDS/STD/TB related information.
- Development of policy and guidelines
- Support collaboration at international and regional levels
- Advocacy for HIV/AIDS/STD/TB at decision making levels
- Partnership development among all sectors involved
- Coordination of multisectoral response
- Capacity building in all sectors
- Technical assistance to council and other partners
- Support to monitoring & evaluation
- Identification of priority areas for research
- Support resource mobilisation for implementing partners
- Preparation of budget for allocation of catalytic/donor funds to be approved by the Council
- Administrative support to the Council
- Tracking of resource allocation and expenditure, accountability
- Developing partnership models for financial sustainability

The Secretariat will consist of two specialised Units, and a Financial & Administrative Support Department. The Secretariat will be led by a Director (see Figure 3).

The two technical units will be responsible for Prevention, Care & Support and Impact Mitigation, whereas the Financial and Administrative Support Department will provide administrative support to Council and Secretariat and support resource mobilisation by the two Secretariat units and other sectors.

The unit will be staffed by specialised full-time technical officers whose main task it will be to coordinate a truly multisectoral response at all levels, from the national down to the community level.

3.2.4 Specific Tasks and Responsibilities of Secretariat Staff

DIRECTOR

The Secretariat Director will have the following tasks and responsibilities:

- Setting the national agenda for the HIV/AIDS response
- Policy development
- Advocacy at international and national levels
- Partnership development (at international & national levels)
- Formation of international and regional networks of collaboration
- Co-ordination of the multisectoral response
- Resource mobilisation
- Research prioritisation
- Information dissemination

The Director will be directly responsible for the general functioning of the Secretariat and its staff. He/she will liaise Secretariat tasks with the Council and all other partners

His/her responsibilities and linkages will be at the national and international level. He/she will forge intersectoral partnerships at the higher political level and with major national and international organisations. These include CBOH Directors, Permanent Secretaries of the various key Ministries, international donors and umbrella organisations.

The Director will supervise and give guidance to all the units and co-ordinate their activities

As such he/she will be actively involved in resource mobilisation, identification of research priorities, information dissemination to all levels, development of policies and guidelines, and advocate for their implementation through the sectors and organisations involved. He/she will ensure continuous monitoring and evaluation of HIV/AIDS/STD/TB programme activities to identify the most cost-effective interventions and promote their implementation at the national level.

Profile: (Public Health Specialist/Social Scientist with an extensive knowledge of, and experience in (inter)national responses to HIV/AIDS. He/she possesses strong communication and programme management skills; he/she has strong leadership skills, and knows how to motivate a multisectoral team.)

Secretariat Units & Department

The two technical units and the financial & administrative support department of the Secretariat will be responsible for the specific tasks derived from the general ones, which fall under the Director's responsibility. They will work closely together under the Director's supervision.

The technical units will support the attainment of the two main goals of Prevention, Care & Support (PC&S) and Impact Mitigation (IM).

The Financial & Administrative Support Department will have a supportive function in administration, as well as for the development of partnerships with health and non-health sectors for sustainable, cost-effective responses and resource mobilisation.

In their respective fields, both technical units will be responsible for Policy Development and Guidance, Advocacy, Partnership Development, Co-ordination of the Multisectoral Response, Technical Support and Assistance, Support Resource Mobilisation, Prioritisation of Research, and Monitoring and Evaluation.

In addition to its general functions, the PC&S Unit will be responsible for enhancing and co-ordinating the flow of information between all actors in the field.

Where the Director is responsible for the higher national and international level, the two technical units will be responsible for specific follow up activities at the lower national, regional/provincial and district levels. They will co-operate directly with smaller organisations, like NGOs and CBOs in their respective areas.

They will support the different implementing organisations in translating (inter)national policy issues into concrete national, district and community programmes and activities.

All three units/departments will work closely together, especially regarding Partnership Development, Resource Mobilisation and Co-ordination of the Multisectoral Response.

Their role will be to facilitate and create favourable conditions for the implementing partners at governmental and non-governmental level.

Prevention, Care and Support Unit

The Prevention, Care & Support (PC&S) Unit will deal with all aspects of the continuum of HIV/AIDS/STD/TB prevention, care and support.

HIV/AIDS/STD/TB prevention does not end where Care & Support to people affected by HIV/AIDS starts, it is a continuum in which active care and support to the different layers of society affected by the epidemic are not only supportive of HIV/AIDS prevention, but are in fact essential elements.

In a similar way, prevention is part of care and support activities, e.g. prevention and control of opportunistic infections, STDs, tuberculosis and mental support to PLWHAs.

The PC&S Unit will accommodate technical officers with extensive knowledge and experience in the technical areas supporting prevention and care & support activities, such as health education, information and communication, anthropology, sociology, psychology, community organisation, medicine, nursing sciences, health systems and research.

This team of officers will co-operate with each other and all sectors involved, under the general guidance and supervision of the Director.

Their main task lies in the following fields:

- Developing PC&S Policy & Guidelines for HIV/AIDS/STD/TB

- Advocacy for PC&S
- Development of Partnerships for PC&S
- Facilitate Communication Between All Sectors Involved
- Co-ordination of Multisectoral Response
- Capacity Building for PC&S
- Technical Support on PC&S
- Resource Mobilisation for PC&S
- Recommend PC&S Research Priorities to the appropriate bodies
- Monitoring & Evaluation of PC&S Activities

The team will consist of a Unit Head, a Health Education, Information & Communication Officer, a Prevention Officer, and a Care & Support Officer.

PREVENTION, CARE AND SUPPORT UNIT HEAD

The Head of the PC&S Unit will have the following tasks and responsibilities:

- Co-ordination of PC&S Unit Activities
- PC&S Policy Development
- Advocacy for PC&S at National Level
- Resource Mobilisation for PC&S Programmes
- Partnership Development for PC&S
- Co-ordination of Multisectoral Response at Regional, Provincial and District levels

The Head of the PC&S Unit will be responsible for the overall co-ordination of the PC&S Unit activities. He/she will provide strong leadership regarding PC&S initiatives, and initiate general policy development on PC&S issues.

The Head of the PC&S Unit will be responsible for advocacy at decision making levels, and resource mobilisation for PC&S related activities. He/she will do so in close collaboration with the Finance and Administration Department.

The Unit head will develop partnerships at the national and international level, with a special focus on district and community levels. The development of these partnerships is instrumental for effective co-ordination of activities by all partner organisations.

Profile: (Social Scientist/Public Health Specialist)

HEALTH EDUCATION, INFORMATION & COMMUNICATIONS OFFICER

The Health Education, Information & Communications Officer will have the following tasks and responsibilities:

- Development of communication systems
- Information dissemination
- Research facilitation and co-ordination
- Health education & IEC policies & guidelines
- Monitoring & evaluation

This technical officer will be responsible for establishing efficient communication systems, dissemination of information guidance and technical support for health education and IEC, research facilitation and monitoring and evaluation of PC&S activities.

a) Communication Systems and Information Dissemination

Availability of, access to, and systematic dissemination of information among all levels and sectors is indispensable for effective co-ordination and intersectoral co-operation, as well as the development of up to date programme activities.

Therefore, this officer will establish and constantly update a national HIV/AIDS/STD/TB database and information system.

HIV/AIDS/STD/TB information will be made widely available and accessible to all stakeholders at national and international level, through traditional and electronic channels.

The HIV/AIDS/STD/TB information system includes the creation of a national HIV/AIDS/STD/TB Newsletter, a national HIV/AIDS/STD/TB website, maintain a national HIV/AIDS/STD/TB e-mail listserv, support to the development of regional or African electronic information services on HIV/AIDS/STD/TB, establishment of easily accessible resource centres at district and national levels, and dissemination of information in the form of books, journals, newsletters, health education materials and others.

The officer will link up with existing regional and international information networks such as SAIMDS and others.

b) Research Facilitation

An integral part of information services is research. Therefore, the officer will identify priority areas for PC&S related research, such as epidemiological monitoring, socio-behavioural and care research. Vulnerable groups will have special attention. He/she will facilitate this priority research by linking up with international and national research bodies for implementation, and help disseminate the information collected to all stakeholders. He/she will ensure active participation and access to information by the stakeholders involved.

c) Guidance and Support for Health Education & IEC

Health education can only be effective if it is based on systematic use of information and planning. Therefore it is indispensable that the secretariat will develop health education policies and guidelines regarding specific target groups and messages, based upon up-to-date information and research. The officer will assist the different partner organisations in developing appropriate health education programmes and materials. He/she will give technical support regarding the prioritisation of target groups, development of appropriate messages and selection of media channels.

d) Monitoring & Evaluation

Monitoring and evaluation of PC&S programme activities are an integral part of a comprehensive information system. Therefore, the officer will advise and support partner organisations in the systematic monitoring and evaluation of programme activities and their

outcomes. This information will help improve the effectiveness of the national response to HIV/AIDS/STD/TB, and help build a collection of national best practices.

Profile: (Health Education/Communications Specialist, with a good knowledge of, and experience in establishing (traditional & electronic) information systems, participatory research methods and techniques, esp. evaluation research.)

PREVENTION OFFICER

The Prevention Officer will have the following tasks and responsibilities:

- Link up research with prevention practice
- Development of prevention policies & guidelines
- Support development of plans of action
- Technical support to prevention activities
- Capacity building in all sectors
- Co-ordination multisectoral response
- Monitoring & evaluation

a) Link up Research with Prevention Practice - Development of Policies & Guidelines

The Prevention Officer will be responsible for the translation of research findings and evaluation studies into prevention policies and guidelines, involving major stakeholders in a participatory process.

He/she will integrate and harmonise these prevention policies with related field programmes and reproductive health, family planning and population issues, access to safe sex choices, reduction of mother-to-child transmission and vaccine development efforts.

Special attention will be given to topics threatening girls' autonomy, such as limited access to education, early marriage and other traditions, sexual violence.

b) Support Development of Plans of Action

He/she will assist the different sectors at the national, provincial and district levels in translating these policies and guidelines into concrete plans of action for prevention with special attention for vulnerable groups, such as in- and out-of-school youth, street children, adolescents, (pregnant) girls and women, refugees, commercial sex workers and other high risk groups.

He/she will also deal with legislative and ethical issues regarding prevention, such as HIV testing, sexual violence and incest, and employment related legislation. On these issues, he/she will work closely together with the Counselling Officer and organisations providing services in these areas.

c) Technical Support & Capacity Building

The Prevention Officer will give technical support to the various partners and support capacity building in prevention related areas.

d) Co-ordination Multisectoral Response

Furthermore, he/she will facilitate a co-ordinated multisectoral response by bringing different stakeholders together and advocate for intersectoral collaboration. He/she will actively mobilise the different sectors to contribute to programmes targeting the various priority areas.

e) Monitoring & Evaluation

The Prevention Officer will work closely together with the health education, information & communication officer on the systematic monitoring and evaluation of prevention related programme components. This includes capacity building for M&E with partner organisations, development of indicators, and advocacy for systematic M&E of programme activities. This will allow for identification of national best practice models for prevention.

The Prevention Officer will work closely together with the Health Education/Information and Communication Officer in information dissemination, research prioritisation, linking information to programme development, health education and monitoring & evaluation.

Profile: (Social Scientist/Public Health Specialist)

CARE & SUPPORT OFFICER

The Care & Support Officer will have the following tasks and responsibilities:

- Link up research with C&S practice
- Development of C&S policies & guidelines on HIV/AIDS/STD/TB
- Support development of plans of action
- Support sustainable models for community based care
- Support availability of counselling services
- Strengthen organisation and development of national networks of PLWHAs
- Technical support to C&S activities
- Capacity building for C&S for all sectors
- Co-ordination of multisectoral response
- Monitoring & evaluation of C&S programmes

As already observed, HIV/AIDS prevention does not end where care & support to people affected by HIV/AIDS starts; prevention is a *continuum* including active care and support (C&S) to PLWHAs and their families.

The Care & Support Officer will focus specifically on the development of cost-effective and sustainable models for comprehensive community based care, psychosocial support, including counselling services and the management of infections such as STDs and tuberculosis for people living with HIV/AIDS (PLWHAs).

He/she will work in close collaboration with PLWHA organisations such as NZP+ and PALS, organisations involved in home based care, local governmental organisations, community based organisations (CBOs), churches, and traditional healers and birth attendants and their organisations.

a) Link up Research with Care & Support Practice - Development of Policies & Guidelines

Based on national and international best practice models, the C&S Officer will be responsible for the translation of research findings and evaluation studies into national C&S policies and guidelines, involving major stakeholders in a participatory process.

Special areas of concern are the developments in treatment of opportunistic infections, and increasing the availability and access to new drugs for treatment of AIDS, as well as for the prevention of vertical transmission.

b) Support Development of Plans of Action - Community Based Care, Counselling Services

The C&S Officer will assist the different sectors at the national, district and community levels in translating these policies and guidelines into concrete plans of action for community based care for people living with AIDS, and availability of professional psychosocial counselling services for PLWHAs and their relatives.

In close collaboration with the CBoH, the officer will maximise equity of access to basic medical care. This includes access to drugs for treatment of STDs and TB and other common opportunistic infections. The development of an efficient two-way referral system is vital to guarantee cost-effectiveness of interventions.

c) Technical Support & Capacity Building

The Care & Support Officer will provide technical support to the various partners and support capacity building in counselling and home based care. Emphasis will be placed on the district and community level.

He/she will build on existing resources and mechanisms for training, such as the counselling curriculum, and home based care programmes, STD and TB training curriculum and stimulate the development of new ways of providing better services, with special attention to better coverage, availability and access.

d) Co-ordination of Multisectoral Response

Furthermore, the C&S Officer will facilitate a co-ordinated multisectoral response by bringing different stakeholders together and advocate for intersectoral collaboration. Especially, PLWHA organisations will have to be directly involved in programmes, and supported in their organisation, thus strengthening their capacity to advocate for the needs of PLWHAs.

e) Monitoring & Evaluation

The C&S Officer will develop mechanisms for systematic *monitoring* of community and home based care programmes, counselling services, and other aspects of care and support activities, as well as *evaluation* of their impact and outcome. He/she will ensure that this information will be used to improve the key aspects of care & support, with a special focus on their sustainability and cost-effectiveness.

The C&S Officer will work closely together with the Health Education/Information and Communication Officer in information dissemination, research prioritisation, linking information to programme development, health education and monitoring & evaluation.

Profile: (Community Development/Public Health Specialist or MD/Clinical Officer with extensive knowledge and practical experience in Home Based Care and Counselling for PLWHs)

Impact Mitigation Unit

The Impact Mitigation (IM) Unit will complement the tasks and responsibilities of the Prevention, Care & Support Unit, by focusing on mitigation of the impact the HIV/AIDS epidemic has on many sectors of Zambian society.

beyond the direct impact on the personal lives of many Zambians, HIV/AIDS has enormous effects on economic, social, educational, demographic and health indicators.

The studies that have been conducted on the impact of HIV/AIDS on various sectors of Zambian society, have not yet been translated into effective mitigation policies and strategies.

Whereas HIV/AIDS clearly places an enormous burden on the health system, the impact on other sectors is yet to be fully understood.

Though the short-term impact of HIV/AIDS on economy is masked by factors such as the abundance of cheap labour force, the high HIV prevalence rates will certainly have severe mid- and long-term effects on the economy.

The loss of skilled human resources is already having a serious effect on the public and private sector. Increased AIDS related illness such as Tuberculosis, STDs, chronic diarrhoea, Kaposi's sarcoma leads to high expenses for employers and families.

More research is needed to determine the impact on areas such as educational and agricultural systems, social security as well as the demographic effects of the epidemic.

The IM Unit will deal with the assessment of the impact HIV/AIDS has on all these systems, in order to be able to formulate adequate responses.

The unit's main tasks lie in the following areas:

- Systematic assessment of the impact of HIV/AIDS/STD/TB on various sectors
- Developing IM policies & guidelines accordingly
- Advocacy for implementation of adequate coping strategies by the different sectors
- Development of partnerships for impact mitigation
- Co-ordination of multisectoral response
- Capacity Building and technical support for impact mitigation activities
- Resource mobilisation for impact mitigation
- Monitoring & Evaluation of IM activities

The IM team will consist of a Unit Head, and an Impact Mitigation Officer.

IMPACT MITIGATION UNIT HEAD

The Head of the IM Unit will have the following tasks and responsibilities:

- Co-ordination of IM Unit activities
- IM policy development
- Advocacy for IM activities at national level
- Resource mobilisation for IM programmes
- Partnership development for IM
- Co-ordination of multisectoral response at regional, provincial and district levels

The Head of the IM Unit will be responsible for the overall co-ordination of the unit's activities. He/she will develop general policies on IM issues, and provide leadership for developing specific IM responses.

He/she will be responsible for advocacy at decision-making levels, and resource mobilisation for sustainable IM related activities. He/she will do so in close collaboration with the Financial and Administration Support Department.

The Unit head will develop partnerships at the national and international level, with a special focus on district and community levels. The development of these partnerships is instrumental for effective co-ordination of activities by all partner organisations. All activities will be co-ordinated closely with the PC&S Unit.

Profile: (Economist/Social Scientist/Public Health Specialist)

IMPACT MITIGATION OFFICER

The Impact Mitigation (IM) Officer will have the following tasks and responsibilities:

- Overall support to the IM Unit Head
- Identify research priorities for assessing the impact of HIV/AIDS/STD/TB on various sectors
- Provide technical support to implementation of impact studies
- Information dissemination to all sectors involved
- Translation of research findings into policies, strategies and guidelines
- Technical support to development of response strategies by all sectors involved
- Develop specific support strategies for people directly affected by the effects of HIV/AIDS/STD/TB.

The Impact Mitigation (IM) Officer will support the Unit Head in all his/her tasks. Where the Unit Head will be mainly responsible for policy development and co-ordination of inter-sectoral responses to the impact on different sectors, the IM Officer will be responsible for identification of research priorities and facilitating systematic data collection.

For this purpose, he/she will mobilise resources within the sectors affected, and provide them with the necessary technical support. The IM Officer will disseminate this information to the sectors involved, and support the Unit Head and the different sectors involved in formulating adequate response strategies.

Apart from the impact in the various sectors of society, the IM Officer will also specifically focus on the development of programmes that support and empower people directly affected by HIV/AIDS/STD/TB. He/she will do so in close collaboration with sectors like the Ministry of Health, the Ministry of Labour and Social Security, and the Ministry of Community Development and Social Services.

Profile: (Economist/Social Scientist/Public Health Specialist)

Financial & Administrative Support Department

The Financial & Administrative Support (FAS) Department will give technical support to the Director and technical officers of both units on financial matters, as well as administrative support to all programme activities. The Department will consist of two financial officers and two secretaries/administrative assistants.

This unit will be supported by a Budget Committee consisting of the following: the Secretariat Director, the Financial and Resource Manager, the Prevention, Care and Support Unit Head and the Impact Mitigation Unit Head.

FINANCIAL & RESOURCE MANAGER

The Financial & Resource Manager will have the following tasks and responsibilities:

- Support Resource mobilisation
- Resource allocation of catalytic/donor funds to sectors
- Ensure accountability and tracking of resources
- Monitor cost-effectiveness of programme activities
- Sustainability of programme activities
- Resource sharing
- Donor co-ordination
- Funding

This officer will support the members of Council and Secretariat staff in resource mobilisation, allocation and all financial aspects of their policies and activities, such as cost-effectiveness of proposed activities, sustainability, budgeting and financial administration.

Furthermore, he/she will give technical advice and support to all sectors involved in developing cost-effective and sustainable strategies that support prevention and impact mitigation. This includes providing advice on prioritisation of resource allocation to specific sectors.

Thus, he/she will play a key role in building the capacity in all sectors to come up with programmes sound in terms of financial sustainability and available resources.

The officer will also support Government, Non-governmental organizations and donor community in developing models for resource sharing and donor co-ordination.

Profile: (Certified Accountant/Economist/Financial Specialist)

ACCOUNTANT

The Accountant will have the following tasks and responsibilities:

- Accountability and tracking of resources
- Financial administration of Council & Secretariat expenditures

He/she will mainly look at resource allocation and expenditure within Council and Secretariat. He/she will guarantee accountability of all expenditures of Council and Secretariat in securing continued financial support from various sources.

He/she will also assist the Financial & Resource Manager in specific capacity building activities to sectors involved.

Profile: (Certified Accountant/Controller/Economist/Financial Specialist)

Annex 1

Comparative Matrix of National HIV/AIDS Councils and Secretaries

	Uganda (initial)	Uganda (new)	Thailand	Zambia, proposal	Zm. recom. changes
Multisectoral approach	Yes, for 1990. Multisec. Appr. to Control of AIDS (MACA)	Yes, even more emphasised 1994-98. Nat. Oper. Plan	Yes, priority 1997-01 AIDS Prev. & Allev. Plan	Yes, even more emphasised 1994-98. Strategic Plan 1999-03, Strategic Plan	As proposed
Organisation	• UAC (AIDS Com) - high profile commis • AIDS Secretariat	• UAC + Secr. • Joint nat. planning team (headed by diff. (D)PS)	• Nat. AIDS Committee •	• Nat. AIDS Council • Nat. AIDS Secretariat	As proposed
Placing of AIDS Commis./Commit./Council	Office of the President	MoH, inter-ministerial consultations	Min. of Public Health	MoH (with "latitude and flexibility" to interact with other sectors)	As proposed
Composition of Commis./Commit./Council	23 members (11 cabinet ministers, NGO rep., relig. org.)	13 members (full time chair, 11 board members, Min. of Health = vice-chair, 2 ex. Legislators, academics/research., relig. Leaders, NGO and youth)	35 members (PS's of MoPH and 6 other Min., NGOs, nat. planners, Dir. Budget Bureau)	Appointed by President in their personal capacity: Dep. Min. of key Min., MP, relig. org., priv. sector, UN Theme Group, donor, NGO Secr. Dir. is secr. to Council	Appointed by President while ensuring that key ministries and stakeholders are represented. The Secretariat Director will be the Secretary to the Council.
Roles of AIDS Commis./Commit./Council	• coordin. partners ('galvanize thinking') • dev. policy environment • advocacy • resourcing	• advice • harmonize policies • harmonize planning (not plan) • monitor and review together with implementing sectors • harmonize/share	• approve budget proposals • look at annual action plans • sets rules and determines national policy → meets 2-4 times a year	• Public advocacy for H/A in all sectors involved • Advocate intersectoral approach • Dev. policies and guidelines • Advice sectors' compar. advantage	Same as proposed! Meet quarterly

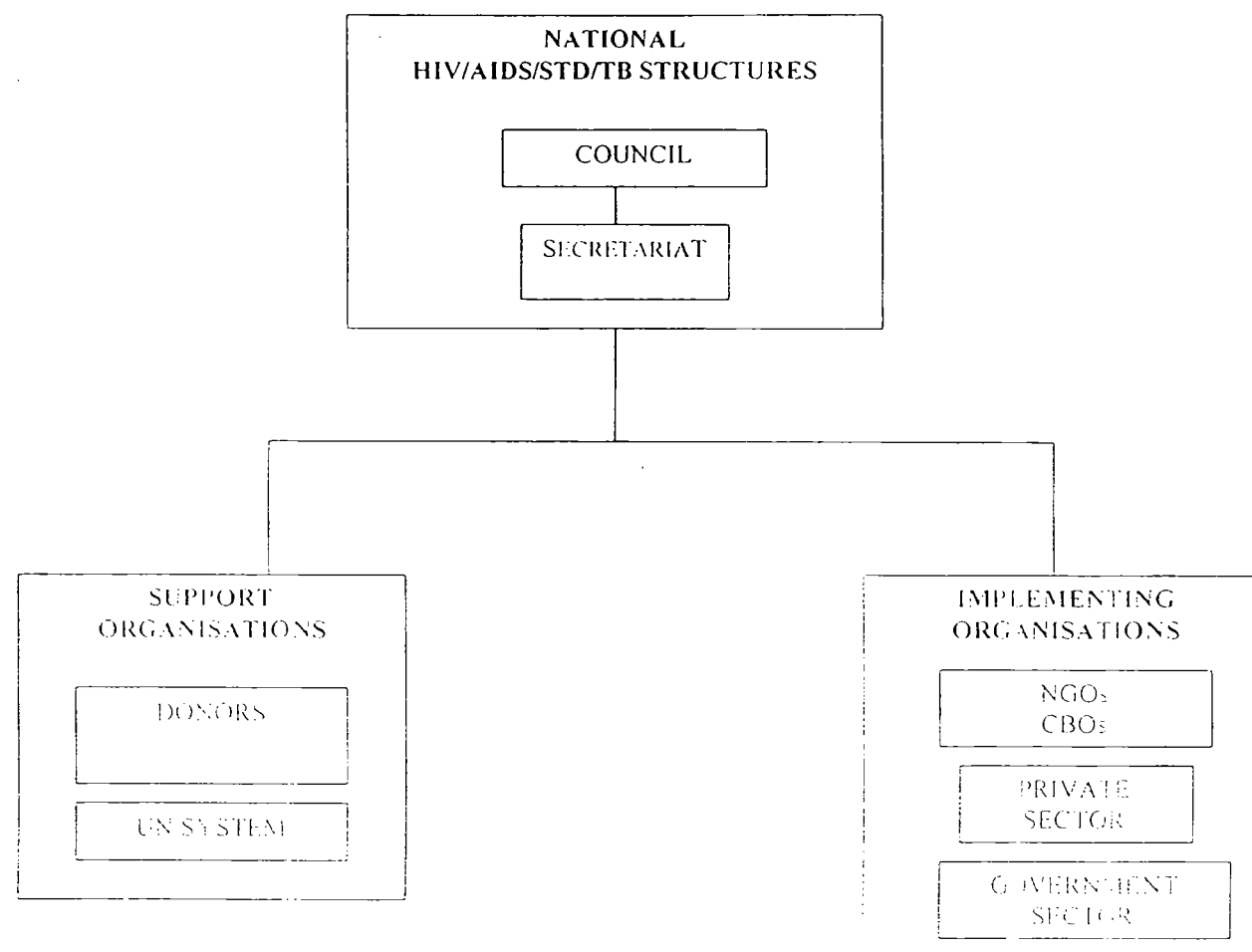
	Uganda (initial)	Uganda (new)	Thailand	Zambia, proposal	Zm, recom. changes
		information		response Resource mobiliz.all sectors	
Structure of AIDS Commis.		- Advisory Committee (ACP managers in 13 ministries) - Technical Committees (implementation) - Research & Dev. - Prev. & Control - Care & Support - Traditional practices - Policy & Planning - Task Force/Steer.Com. - Women - Youth - Law	- Executive Board 3 Sub-committees - AIDS Vaccine Dev. - Foreign Collabor. - Private & NGO Collaboration 6 technical Sub-com. - Public relations - Education - Health promotion - Community promotion - Socio-ec. Infrastructure - Research		
Roles of AIDS Secretariat		- Operational arm of UAC - Dir. Gen. secretary to Board 7 funct. units & support staff	AIDS Division of MoPH acts as secretariat	- Linking overall advocacy & pol. issues with progr. dev. carried out by sectors - Not specific involvement - Director and 3 units - Prev. Care and Support - Comm. Mitigation - Finance & Adm.	As proposed Regarding the placing of the Secretariat it was proposed that it shall have an autonomous status, while residential of MoH.

	Uganda (initial)	Uganda (new)	Thailand	Zambia proposal Support:	Zim. recom. changes
Link with other ministries Link with other ministries, cont'd	One Focal Point Person in each ministry (found to be too limiting)	Part of daily activities of min. and dept. – each ministry responsible for integration H/A in own policies. A team, rather than a person. UAC strengthens MoH to harmonize pol, standards and training. Implementation to districts.	MoPH: treatment and care MoPH/Univ.: early detection MoH: prim. prevention, youth MoPH/Univ./NGO: follow up MLSW: 2 dept. with Sub-com. 14 ministries in Ed. Sub-com.	⇒ Links between MoH and other Ministries not outlined	
Decentralisation		Strong focus on decentralization Implementation responsibility of the districts (inst. under Distr. H Boards) Tried out: District, sub-county, parish and village AIDS Coord. Committees, but problems with funct., thus diff. approach adopted recently: To fit H/A issues in existing structures (Distr. Techn. Planning Committees)	• HIV/AIDS down to provincial level • H Reform focus on PHC and dev. of family practice • Issue specific sector involvement (compar. advant.)	• At the core of the health reforms: - service delivery to the district level - community involvement and ownership • Needs develop guidelines for all levels The two technical units (1&2) responsible for specific follow up of activities at lower national, reg./prov. and district levels. Cooperate with CBOs and NGOs.	As proposed. In addition: Propose that MoH and M. of Local Govt. become key Ministries for coordination at district level.
Funds and funding		• UAC autonomous body with financial	Financial independence, i.e.	• Funds for Council/Secret. from	As proposed. Emphasize more Govt.

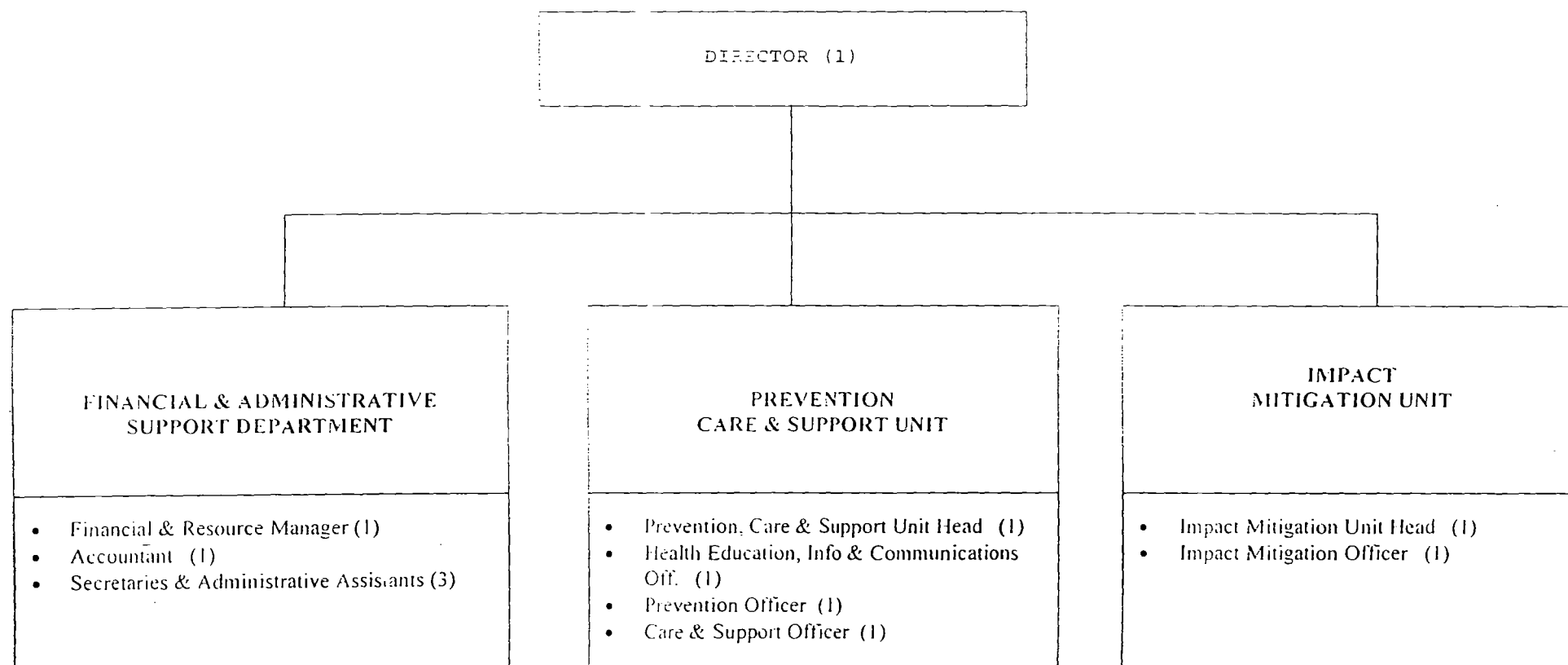
	Uganda (initial)	Uganda (new)	Thailand	Zambia, proposal	Zm, recom. changes
Funds and funding, Cont'd		indep. - Govt. and donors mainly - Other Min than MoH handle 2/3 of H/A funds - Revenues at district level	Govt. 90%	MoH & donors - Council advocate H/A funding within all sectors - All sectors assign H/A budgets on yearly basis - Additional donor funding - Allocation by indep. <i>Funding Advisory Committee</i> (donor, govt. and non-govt. impl. org., Council and Secr. memb.) - Catalytic funds by the Council	funding
Relevance for Zambia?	Experience useful, but model not relevant	Relevant	- Not very relevant - Learn from priv. sector involvement		
Challenges		- Coord.: local resource mobiliz.; community particip.; info.exchange; internat. collaboration - Multisect. coop Govt and private sector; involve PLWHA, priv / commercial enterprises, vulnerable	Difficult to involve civil/ private sector into real intersectoral approach	- Linkages - interministerial - intersectoral - between levels - Funding (donor reliance) - Capacity build district - Uneven degree of decentralization in different Ministries	

Uganda (initial)	Uganda (new)	Pharland	Zambia, proposal	Zm, recom. changes
	groups • Implement: awareness into behavioural change • Strengthen research			

Figure 1. National HIV/AIDS/STD/TB Council and Secretariat and their Partnerships



NATIONAL HIV/AIDS STD/TB SECRETARIAT ORGANOGRAM



The New York Times

NEW YORK, FRIDAY, SEPTEMBER 18, 1998



A few of the thousands of Zambian children orphaned by AIDS in Lusaka are fed at a church

In Zambia, the Abandoned Generation

By SUZANNE DALEY

DEAD ZONES

Children of the Plague

LUSAKA, Zambia -- It was only two weeks after their mother died from AIDS that their aunt took them to the bus station. She said she did not want to take care of them anymore. She told them to go to Lusaka, find a police station and ask for an orphanage.

The children, Calvin Katoya and Jackson Kabaso, who would like to be soccer stars someday, did as they were told, riding the bus an hour from the small town of Kabwe, then asking strangers where to go. But the police could not help them. As the days went by, the boys, 12 and 15, slept in the rusting, abandoned cars nearby. They had no money or food.

Edith and Khuzini Banda lived with their aunt for about year after their mother died in 1994. But then the aunt said her home was too crowded. She sent the girls -- then only 13 and 14 -- to live alone in their mother's house.

The girls make do by renting out half the two-room house for \$15 a month, and begging from the neighbors when food runs out.

The two keep their cinder-block room tidy, decorated with magazine layouts of models and Hollywood stars. They hope the headmaster will be lenient about their school fees, which are eight months over due.

Sometimes, said Edith Banda, she is jealous of those who still have parents. "It would be nice to have someone who cares about us," she said.

The AIDS epidemic has been raging in Zambia for nearly two decades, and as the deaths pile up, so do the orphaned children. It is much the same in many other parts of Africa. In rural areas of East Africa, four of every 10 children who have lost one parent by age 15 have lost that parent to AIDS, according to U.N. figures. In 1997 alone, the disease orphaned 1.7 million children, more than 90 percent of them in Africa south of the Sahara.

But it is Zambia, a landlocked county in southern Africa that has

never embraced birth control, that has the highest proportion of orphaned children in the world, according to the United Nations. Here, an estimated 23 percent of all children under 15 are missing one or both parents, many of them dead from AIDS, and the numbers are expected to keep rising.

For now, most of the children have been absorbed into extended families. Almost 75 percent of all households are taking care of at least one orphan. But in this country, where half of all households are living in extreme poverty, the strain of caring for extra children is beginning to take its toll. Many children are being squeezed out. In 1991 Lusaka had 35,000 children living on the street. Today there are more than 90,000.

Zambian officials believe the number of adults infected with HIV, the virus that causes AIDS, will not decline before 2010, which means that the orphan population will not peak until 2020. Recent U.N. reports estimate that there are now nearly half a million orphaned by the disease in Zambia. That number is expected at least to double in the coming decade, further straining the country's meager resources.

The Orphans

Even Within Families, Many Are Outcasts

Experts say that already the orphans are suffering. When there is not enough to eat, orphans often get less than the other children in the household. They are also often the last to get shoes and the last to go to school. In the rural areas, girls are being married off at 12 or 13, far younger than the usual age of 18. The reason: the family no longer has to feed the girl and, in keeping with local custom, can claim a bride price.

Advocates for the children say the orphans are more likely to be forced to work long hours, to suffer from beatings and to experience sexual abuse.

"When you start talking about the rising number of orphans, you are quickly talking about a rise in all these related issues -- child labor, child abuse and sexual abuse," said Stephan Dahlgren, a project officer with Unicef based in Zambia. "The more vulnerable children you have, the more the problems escalate."

Despite the huge number of people infected with HIV in Zambia, there is little planning for death. Most people are never tested for AIDS and would not admit to it even if they did find out they are infected. Only among the educated elite is this beginning to change.

The Shelters

Help for Children Hardened by Life

Zambian health authorities believe that the prevalence of HIV here will peak this year because recent surveys report significant behavioral changes. But even that seems like bitter news: The infection rate in urban areas is expected to plateau at 28 percent. In rural areas, experts calculate, it will be 22 percent, giving Zambia one of the world's highest infection rates.

As is the case elsewhere in Africa, the vast majority of infected Zambians are between 15 and 40, meaning that they are dying when they should be in their most productive years. This, combined with wide-scale layoffs as the government tries to retool a socialist economy by selling off state-owned businesses, has made it all the more difficult for families to absorb the growing number of orphans. Children, orphaned or not, have hard lives in Zambia. Nearly half are stunted from a lack of food, about 20 percent severely so.

"Everybody knows about AIDS," Dahlgren said. "If you go into a small village and ask a chief about AIDS, he knows all about it. But when it comes down to 'What is this disease that so and so died from?' then it's tuberculosis or malaria."

Many orphans are losing both their parents and all their inheritance at the same time. Relatives quickly swoop in and grab property, be it cooking pots or farm land, and the children have little to say about it. In theory, they

could appeal to the courts, but few Zambians have the wherewithal and the money to do so.

Florence and Veronica Phiri once lived comfortably with their parents in the modest house they owned. Their father was an electrician. But in 1994 both parents died within months of each other. The girls were 8 and 6.

Within weeks, their father's family took over the house and sent the girls to live with an aunt in a rural village. There, the girls said, they were beaten and had to work long hours fetching water and collecting wood.

Two years later, their mother's relatives intervened and brought the girls back to Lusaka to live with their maternal grandmother, who sells vegetables in the market. Florence and Veronica and four cousins who are also orphans spend most days playing in the dusty streets in front of their grandmother's dilapidated house.

Florence and Veronica have nothing that ever belonged to their parents and do not expect they ever will. At her grandmother's, Florence said, some days there is no food.

But she is still glad to be there. "It is much better than before," she said, shyly adjusting her ragged clothes.

families settle in for the night on the sidewalks. Scattered among them are the ragged street children, many of whom make money as prostitutes and look for any means to get high.

Workers at the Fountain of Hope, a nonprofit organization that works with the street children, say the children have even found a way of getting a powerful high from fermented human feces, a substance known as jekem.

In the daylight, many idle the hours away kicking a soccer ball around outside the Fountain of Hope headquarters. The organization is trying to offer them a special four-year education program that will ready them for school exams. But the street children here are like street children everywhere -- hardened and focused on immediate survival.

The stories the children tell of fear, rejection and loneliness are numbingly similar. Simon Phiri, who is 14 but looks about 10, can not even remember when his parents died. Slumped in a chair, he peels the dirt from his palms as he talks sullenly about his short life. For a while, he said, he stayed with his mother's best friend. But after a while, he left.

"They were always insulting me," he



THOSE LEFT BEHIND Children orphaned by AIDS say a prayer before a meal at the Catholic church in Matero. More than 2,000 orphans have been admitted in Matero, a neighborhood in the Zambian capital, but the church, aided by local volunteers, can only feed 60.

This year a community group donated money for her school fees, a school uniform and shoes. But Veronica will have to wait; there was not enough money for her.

Elsewhere in this city, as the sun sets, casting shadows over the modern government-sponsored high rises, entire

said. "They always ate when I went out and never saved me anything."

He said he has spent many nights sleeping in the aisles of the local market place. But now he sleeps on the floor of a friend's older brother's house. He must get his own food, though, and he has no money for soap.

He earns money doing odd jobs in the market, he said. The counselors said that he has a sexually transmitted disease. Nearly half the boys do.

wives of the brothers because the brothers tend to behave similarly."

put outside when it is bedtime. "I am not alone like this," she said, pointing across the dirt road at another house. "Right over there, it is the same."

While the grandmothers struggle with the burden of feeding and clothing the children, some child advocates are more worried about those who are growing up in the households run by siblings, where chaos sometimes reigns.

Like the Banda girls, the Zulu siblings survive on the rent they receive from their parents' house in a neighborhood called Kuanda Square. The seven children live in the back in a tumbledown two-room structure. But recently the oldest boy got married and set up his own household, leaving less money for the rest of the children, who range in age from 19 to 11. The 19-year-old is known in the neighborhood as a drinker who regularly beats the younger ones.

On a recent visit, there was no food in the dank-smelling house. Shoes and dirty clothes were strewn about. With the 19-year-old sitting silently nearby, no one complained of any difficulties. All but the youngest appeared to have found some way of making money, from working as a maid to selling sugar cane in the market. But each keeps that money for himself or herself, the children said. The 11-year-old appears to survive on the generosity of the others, but it was clear they expected her to do most of the housework.

"Sometimes the laundry is difficult," the girl admitted, twisting the hem of her skirt nervously.

By 1991 the needs of the orphans in the Matero neighborhood had become so apparent that some local women banded together to try to help. They have registered 2,047 orphans in the neighborhood and assigned someone to look in on each household and help solve problems that crop up. To raise money for school fees, they make doormats, bake bread, sew and batik fabrics. Six days a week, they also give about 60 of the children a free meal, with the help of the local Catholic church.

So far this year the group, called Kwasha Mukwena, has promised to pay the school fees for 279 children -- fees that range from less than \$10 for the younger children to about \$30 for the oldest. But they have only raised



THE VICTIMS OF AIDS A distressingly familiar sight in Zambia, a supplier of coffins waits on a roadside in Lusaka, the capital, for customers. AIDS deaths are most common in Africa, and because society is slow to change, the epidemic is expected to persist

Simon has not been to school in at least four years, though he hopes to be an accountant when he grows up. "I would like to work in an office," he said, suddenly brightening.

Finding homes for the street children is not really a possibility, say center employees. There are only a handful of very small orphanages in Zambia, including the Kabwata Orphanage, where Calvin and Jackson ended up after three days without food. Eventually the police contacted Lorraine Miyanda, who runs the place, and she bent the rules to admit the boys. Usually the orphanage will not take children over the age of 10.

But Ms. Miyanda said she has little hope that anyone will ever take the boys into a new home. In many African countries there is little tradition of taking in children who are not blood relatives and formal adoption is extremely rare. Child advocates say that this may be a particular problem in the future because of the way AIDS tends to devastate whole families, particularly in villages.

"The extended family in Africa is far better than in the West about taking in relatives," said Mark Loudon, a South African who is writing a book on AIDS orphans. "There is no formality about taking care of cousins. They slip right into saying 'Mom.' In Africa you have 30 Moms. The problem is that AIDS doesn't usually take just one woman in a family; it tends to take all the

The Caring Adults

Grandmothers Help, but When They Go ...

In the last few years, dozens of fledgling organizations have sprung up in Zambia to try to help the children. But there is virtually no government money available and many of the organizations are staffed only by volunteers.

"It's not that the government in unsympathetic," said Louis Mwewa, the coordinator of Children in Need, an umbrella organization that tried to represent the groups. "But we are a poor country and they do not have money."

In Matero, one of Lusaka's poorer neighborhoods, where small houses with tin roofs stretch for miles, overwhelmed grandmothers and households that are a collection of siblings living on their own are easy to find. In one house, Brenda Tembo, 52, cares for 14 of her grandchildren.

On a recent afternoon, no one in her household had eaten yet; there was no food in the house. Mrs. Tembo was waiting for someone to buy tomatoes from her vegetable stand before buying corn meal, which would feed more of them for less. Five children in the household should be in school, but there is no money for tuition.

There is barely enough room for all the children to lie down on the floor at night. The homemade plywood table and the three rickety chairs must be

the money to pay fees for 132.

As the lunch hour drew near recently, orphans began arriving in the carefully swept church yard. In the back, over an open fire, the women had made a vegetable and peanut stew to be eaten with a corn porridge. The children, in tattered clothing, were painfully obedient. Some, as young as five, care-

fully carried full plates to the room where even the toddlers ate without spilling a drop.

A dozen children also carried plastic boxes -- a signal to the workers that they were having a particularly hard time. Before eating, these children put half their food in their boxes. Either they knew they would get no supper

and were saving for later, or they had been told to bring food home for other children in the household or face punishment.

"It is not that people are so cruel," said Patricia Ngoma, who volunteers with the program. "But they have nothing themselves."

AT ISSUE

Swept Aside By An Epidemic

The U.N. estimates that in rural areas of East Africa, 40 percent of orphans have lost one or both parents to AIDS. The number of children who have become orphans as a result of AIDS since the beginning of the epidemic:

NUMBER OF ORPHANS

Children under 15 who have lost their mother or both parents to AIDS between 1970 and 1997

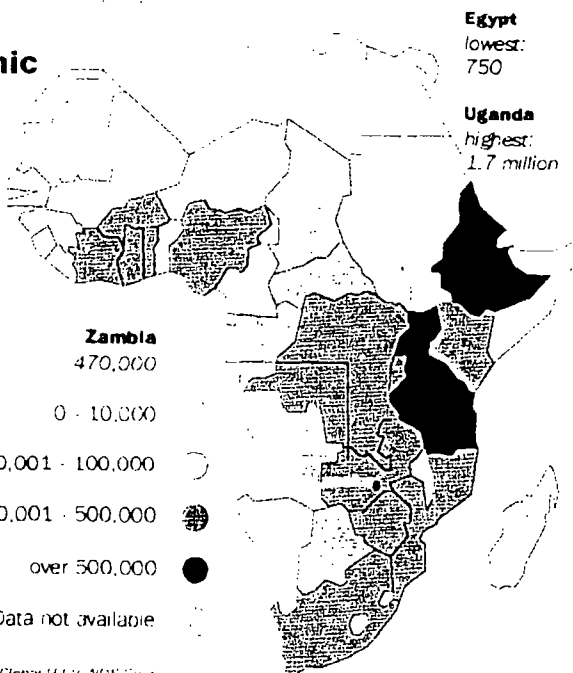
0 - 10,000

10,001 - 100,000

100,001 - 500,000

over 500,000

Data not available



Source: UNAIDS "Report on the Global HIV/AIDS Epidemic"

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Trendsetters

Edition # 8

December 1997

Setting Trends for a Wise and Proud Generation...

K300

CHILDREN LIVING IN A WORLD WITH AIDS

Editorial

THIS month, Trendsetters, with the world, commemorates World AIDS Day by focusing this edition on AIDS and how it affects our lives. This year's World AIDS Day theme is "Children Living in a World With AIDS."

With the number of people dying and dead from AIDS, we think it's about time everyone wakes up and smells the coffee. AIDS is real and the figures are there to prove it, the figures also scarily show that they aren't going down, which means that more and more people are getting AIDS. In fact the ZDHS states that one in every four Zambians is HIV positive. We don't mean to preach or depress you by writing these articles, all we are doing is giving you a reality check and showing you that you have to start taking responsibility of your own life. We also take this time out to remember all those who have died of AIDS and to their families who were there with the love, care and support all AIDS patients need. Don't shun AIDS victims. They need the support, too. Meanwhile, positive or negative, we wish you a Merry Christmas and a healthy and prosperous New Year!

Play it safe: abstain or use a condom.

EVERYBODY'S CONCERN

By Ndashe Phiri

HIV/AIDS concerns everybody, but not everyone acknowledges this.

HIV, the virus that leads to AIDS, is commonly transmitted through sexual intercourse. This is widely known, as reported in the Zambia Demographic and Health Survey (ZDHS), in which 80 percent of women and 94 percent of men reported to have changed their sexual behaviour by restricting themselves to one sexual partner. However, the question which we should now be asking is do these women and men use condoms with their partners?

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HIV acts by gradually destroying the immune system of the infected person until they can no longer fight off illnesses.

ACKNOWLEDGMENT: BBC "Surviving AIDS"



THE fabulous singing trio, Salt 'N' Pepa, have now gone into singing for AIDS, as part of the international awareness campaign on HIV/AIDS.

Salt 'N' AIDS

RAP divas in their own right, Salt 'N' Pepa are strong black career women as well as mother. These female rappers are notorious for their feminist approach.

Salt 'N' Pepa are among of the few artistes still around from the original rap era, including LL Cool J.

Salt 'N' Pepa deals with issues that are real and it shows through their music. They were among the first artistes to deal with AIDS when they released "Let's Talk About AIDS," whose proceeds went towards AIDS work. The song was a cover of their "Let's Talk About Sex" single. The song dealt with AIDS within the community, as well as within in a relationship.

'The Last Time I Was Seeing My Beloved Mother'

By Evans Banda

IT was about 3 o'clock in the morning. Land it was time to go. Everybody came to say bye to Mother.

I can still hear her last words echo in my mind. "Bye my son. You take care of your sisters." I could not hold back my tears. The bravest thing I thought I could do then was not to see her being driven away. So I just turned away, went back into the house and cried. I didn't even see her wave good-bye.

I knew deep down that it was the last time I was seeing my beloved mother. I could tell from the look in her eyes that the words she was saying were the last words, and they meant forever. It was the saddest day of my life.

Mum was being taken for medical treatment to Zimbabwe, for she had been terminally ill for a larger part of 1989 and the early months of 1990. It was hoped that the advanced medical facilities in Zimbabwe would provide the solution to her long illness.

Mother, who had been a healthy, vibrant and successful young woman of 38 years, had deteriorated to almost baby-like form. The last six months before she went to Zimbabwe had been very hard for her to pull through, even from one day to another. The six months had virtually been spent in a hospital bed.

It was even harder for everyone in the family to see Mum deteriorate into such a state, and there was nothing that anybody could do to reverse the situation. The only thing that the oldest people in the family could do was to make empty assurances about signs of improvement in Mum's health to the ignorant, helpless and innocent but ever inquiring young family members.

TRUE STORY

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HEALTH

Mr Speaker

In the health sector, the Government's vision is to ensure that every citizen has access to quality health care and to bring such services as close to the family as possible. In order to realise this vision, Government embarked on health reforms to improve the quality of health care, through cost sharing schemes which exempt vulnerable groups from paying user charges in a decentralised management system. Government, however, has encountered some difficulties in implementing the programme. It is for this reason that the following measures are being taken:

A) Amendment of the National Health Services Act (1950) to strengthen management boards;

B) Restructuring of the Central Board of Health to make it lean, cost-effective and efficient;

C) Re-establishing the provincial health offices;

D) Reviewing and finalising the national health care financing policy;

E) Revisiting the policy on public employed doctors engaging in private practice;

F) Finalising the draft national food and nutrition policy with a view to harmonising and integrating the activities of various stakeholders to improve the health status of all Zambians; and

G) Ensuring that the health sector focuses more on service provision as opposed to administrative matters.

The health status of most Zambians has generally remained poor. This has largely been due to the shortage of drugs, failing quality of care in our health institutions and an increase in malnutrition, all of which have to a large extent been brought about by the poor performance of the economy.

In spite of these difficulties, our commitment to the health reforms has remained steadfast. It is in recognition of this by the international community that Zambia has been chosen to host the 11th International Conference on AIDS and STDs in Africa (ICASA) in September 1999. The conference, which will attract 3,000 foreign and 2,000 local participants, is the most important forum for Africa to discuss progress and constraints in the response to the HIV/AIDS pandemic, which is threatening the socio-economic development of the African continent. The conference is increasingly becoming a platform for dialogue resource mobilisation and generating the required

To be continued tomorrow

Continued from yesterday.

political will to respond to HIV/AIDS. Hosting of the ICASA conference, therefore, will help reinforce our efforts respond effectively to the HIV/AIDS pandemic by benefiting from the varied experiences that will be presented at the conference.

We cannot hope to eradicate the HIV/AIDS pandemic and other communicable diseases unless we as people can change our attitudes and lifestyles. As the saying goes, charity begins at home, and so does cleanliness. It is, therefore, incumbent upon each and every one of us to ensure that our immediate surroundings are kept clean and habitable and to impart a culture of cleanliness to our children. In this connection, I would like to encourage local authorities, chiefs and headmen to launch campaigns for healthy cities and clean villages in 1999 and the years beyond.

Equally, let us strengthen our family values and adopt clean lifestyles. I am sure honourable members of the House know what I mean by clean lifestyles!

**"New Orphan Prevalence Estimates for Zambia." By Douglas Webb
Health-L, October 12, 1998**

Just in case network readers had not seen these new estimates, I think they are worth having. They are taken from Susan Hunter and John Williamson's document 'Children on the Brink: strategies to support children isolated by HIV/AIDS' produced for USAID. They used the latest modelling techniques to come up with figures. further info can be got from Susan Hunter.

Zambia: for year 2000:

- population of children aged under 15: 4,828,272
- maternal and double orphans from all causes: 745,492
- maternal/double orphans as % of children aged under 15: 15.44%
- % of maternal/double orphans from AIDS: 78.4%
- paternal orphans from AIDS: 911,157
- paternal orphans as % of children aged under 15: 18.87%
- total orphans from all causes: 1,656,649
- total orphans as % of children aged under 15: 34.31%

This figure of 34.3% of children orphaned by the year 2000 is the highest estimate out of the 23 countries in the study! Sobering statistics.

**"AIDS Victims Must Live Positively, Says Activist." By George Malunga
The Daily Mail, October 12, 1998**

A Livingstone man on Friday disclosed he was HIV positive and declared his intention to use his life as a living testimony when educating others about the dangers of AIDS. Mr Ronnie Chibweza made the declaration during a workshop on the formation of AIDS support groups in the Southern Province held at Tunya Lodge in Livingstone.

Mr Chibweza said it was pointless to continue living in a husk for the rest of his life, saying his life could be more meaningful if it was used to save others. Mr Chibweza, 40, has three children and is currently on separation with his wife. He said being HIV positive did not mean that one had committed a crime but that misfortunes came in one's life. He added that there was nothing which HIV victims did that other people did not do.

He discovered that he was HIV-positive in 1996 but said his life had improved because he now knows what the problems is and he has learnt to accept it. "I have accepted the condition that I am in, and it has helped me to lead a more positive life." Mr Chibweza commended the Roman Catholic Sisters whom he said had been giving him a lot of encouragement and material support since he is unemployed.

He believes there is nothing wrong about belonging to the group of AIDS victims. Mr Chibweza now belongs to SETC AIDS Centre in Livingstone which has eight active members and he is currently the only one who has gone public at the centre. The workshop organised by Network of Zambia People living with HIV/AIDS was meant to develop self-confidence in victims and give them courage to reach-out to others. The Workshop, conducted by Mr David Chipanta and Mr Winstone Zulu, both HIV-positive activists, had 30

they are far advanced and treatment is difficult.

- Females often suffer different medical and social consequences of certain illnesses. For example, women often become infertile after STDs and this infertility can ruin their lives. Although men can also become infertile after STDs, it is easier for a man to hide his infertility or to put the blame elsewhere.

The Programme of Action that Zambia committed itself to at the Cairo International Conference on Population and Development, called on all societies to end discrimination against women and to promote gender equality. We can't do anything about the physiological reasons that cause women to suffer more. But we can recognise the factors above and try to compensate for them by encouraging prevention as well as early diagnosis and treatment of reproductive illnesses in women.

List of reasons for increased female reproductive morbidity adapted from Fortney, Judith A (1995) "Reproductive Morbidity: A Conceptual Framework. Family Health International."

"HIV/AIDS Bibliography: An annotated review of research on HIV/AIDS in Zambia."
Health-L: May 22, 1997

This UNICEF/NASTLP publication contains over 200 abstracts on all aspects of HIV/AIDS in Zambia. It was published in 1996 and we have some copies left. If you did not receive a copy, or would like extra copies - please contact me, stating how many copies you need, (but we don't have that many!) at dwebb@unicef.zm or through the buffalo network. There is no charge for the documents. If you are in Lusaka, please indicate a physical address, as well as a postal address, so copies can be hand delivered. Hurry hurry while stocks last!

Douglas_Webb@unicef.zm

"AIDS and Child Health."
AFRO-NETS: May 20, 1997

"We are guilty of many errors and many faults, but our worst is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The Child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer "Tomorrow". His name is "Today"/ Her name is "Today." -- Gabriella Mistral, Nobel Prize-winning poet from Chile

AIDS is having a profound impact on children's health. By mid-1996, UNAIDS estimated that worldwide, there were: 3 million HIV infections in children - 9 million maternal orphans due to AIDS. In addition, it is likely that at least 30 million children are living with HIV-positive parents, who are at risk of being orphaned in the next few years.

What is AIDS doing to Child Health? I want to first discuss the direct impact of HIV infection on children. Secondly, I want to look at children who are not infected but affected by the indirect impact of AIDS upon them. Finally, I want to discuss implications of the AIDS epidemic on children. For the first part of my discussion, I shall use country estimates published by the US Bureau of the Census in March 1997.

DIRECT IMPACT OF HIV INFECTION ON CHILDREN -- INFANT MORTALITY RATES:

AIDS has led to increased infant mortality rates, especially in countries with severe AIDS epidemics and low non-AIDS infant and child mortality rates. Thus the greatest impact of AIDS on child health will be in countries in southern Africa which have lower non-AIDS infant mortality and severe HIV epidemics, compared to countries in eastern Africa which have less severe HIV epidemics and higher non-AIDS infant mortality rates.

Infant mortality rates have increased due to AIDS, reversing declines that have been occurring in many countries over the last few decades. In 1996, IMR without AIDS would have been 51.7 per 1000; as a result of the AIDS epidemic, IMR is estimated to be 72.8, 40% higher than expected; in Zambia it is 30% higher than expected and in Kenya and Uganda, it is nearly 20% higher. IMR is set to worsen markedly during the next decade as the epidemic spreads to affect more adults and through them more children. By the year 2010, infant mortality rates are estimated to more than double in Zimbabwe from 30 to 71 per 1000 and Botswana from 26 to 66 per 1000. In Kenya, IMR will be 70% higher while in Zambia, IMR will be 60% higher; in Malawi where infant deaths due to other causes are high, AIDS mortality will inflate IMR by 40% with similar increases in Tanzania and Uganda.

CHILD MORTALITY RATES:

Two thirds of AIDS deaths among children occur among those 1-4 years old; consequently, the AIDS epidemic impacts on child mortality rates even more than on infant mortality rates. Once again, the countries with the greatest impact of AIDS are those in southern Africa with the most severe HIV epidemics and lower non-AIDS mortality.

By 1996, CMR without AIDS was estimated in Zimbabwe to be 69.1; with AIDS, CMR was 128.3, some 85% higher than expected; in other words, 1 out of 8 children born would die before 5 years old; CMR in Botswana and Zambia was 75% higher than expected without AIDS. Kenya's CMR was 40% higher while Tanzania and Uganda's CMR was about 25% higher than expected without AIDS.

By 2010, the US Bureau of the Census estimates that about one third of adults will be infected with HIV in Zimbabwe, Zambia, Malawi and Botswana. HIV spread from mother to child in most African countries is around 30% with one half of transmission occurring post-partum due to breast-feeding. This means that some 10% of children will acquire HIV infection from their mothers. With median age of survival of children infected by their mothers of 21 months, increases of the order of 100/1000 in CMR are estimated in these four severest affected countries. In Zimbabwe, without AIDS, the CMR would be expected to have fallen to 37.8; AIDS is likely to lead to a CMR of 152.9, a fourfold increase. The increase will be more than three times higher in Botswana and double that expected in Kenya and Zambia than in the absence of AIDS. Nearly 1/4 of children in Malawi will die before their 5th birthday, with AIDS contributing nearly one half of the mortality.

In 2010 in the most severely affected countries in west Africa, Burkina Faso and Cote d'Ivoire, CMR will be nearly 70% higher. In Guyana in South America, projected CMR will nearly double, in Brazil, it will increase by one third; in Thailand, it will increase by 18%.

DETERIORATION IN CHILD HEALTH DUE TO ORPHANHOOD -- LIFE EXPECTANCY (LE):

AIDS increases IMR and CMR. But its most significant impact on demographic indicators is on life expectancy since many years of life will be lost due to the AIDS epidemic. AIDS has

already led to reductions in life expectancy. By 1996: Kenya's LE had fallen from 65 (without AIDS) to 55.6 years, to 86% of that expected without AIDS. Uganda's LE has fallen from 53.2 to 40.3 years, to 75% of that expected. Zimbabwe's LE has fallen from 64.1 to 41.9, to 65% of that expected. The greatest impact to date has been in Zambia, from 57.5 to 36.3 years, to 63% of that expected without AIDS.

By 2010, life expectancy in Zimbabwe would have reached 70 years without AIDS. As a result of AIDS, projected life expectancy in Zimbabwe will be 33.1 years, 47% of that expected. Zambia's life expectancy will fall to 30.3, and Botswana's to 33.4, both 50% of that expected. Kenya and Uganda's life expectancy will both be about two thirds of that expected while Malawi's life expectancy of 29.5 years, 52% of that expected without AIDS, will be the lowest in the world.

ORPHANHOOD:

Life expectancy for females will be even lower than these average figures, since women are HIV-infected and die at younger ages than men. Lowered life expectancy necessarily implies an increasing proportion of orphaned children. I want to present estimates of the orphan epidemic using projections from Zimbabwe which have been developed by Simon Gregson at the University of Oxford in association with Prof Roy Anderson's modelling unit. The first point to note is that the main findings of this model are in keeping with those of the US Bureau of the Census (USBC), despite considerable differences in modelling methodology.

Thus, in this model, life expectancy is estimated to be 30-35, compared to 33.1 in the USBC estimate; fewer than 20% of women can expect to live throughout their child-bearing years; only one third of girls aged 15 years will survive to their 35th birthday. And one third of children under 15 years will be orphans, having lost their mother.

In order to understand the implications of the orphan epidemic, we need to have a perspective of 20 or 30 years. The dark part of this graph represents children who are orphaned due to causes other than HIV. Before the AIDS epidemic, about 2-3% of children are orphans; there was relatively little impact of the epidemic upon maternal orphanhood until the middle years of this decade. Already it is likely there are more maternal orphans due to AIDS than due to other causes. But we are right at the beginning of the orphan epidemic. By the year 2010, the number of maternal orphans is expected to have increased tenfold due to the cumulative impact of over 30% of children under 15 years becoming motherless; although no models have yet incorporated paternal deaths, we know that a large proportion of these orphans will also be fatherless, double orphans.

IMPLICATIONS OF ORPHAN EPIDEMIC:

Orphanhood has profound implications for child survivors. Traditionally the extended family coping mechanism for orphans was their aunts and uncles. As a result of the AIDS epidemic and rapid increases in the number of orphans, the very elderly and the very young are being recruited for childcare by the extended family. Our study of 300 orphan households in Zimbabwe in 1995 found that nearly one half of the care givers of paternal or maternal orphans were grandparents. The average age of grandparent care givers was 62 years old. About 3% of households were sibling-headed; in three cases, older sisters or brothers had taken over childcare following the death of a grandparent.

In a recently completed study of 43 child-headed households, we found that in 86%, both parents had died and in 93%, the mother had died; the youngest unaccompanied household

was headed by an 11 year- old child. Older brothers as well as older sisters were involved in childcare. In many cases, relatives provided support to CHH by regular visiting and providing material assistance. We must expect considerable increases in the numbers of CHH in the future, especially in southern Africa where the epidemic has its most profound effect on life expectancy and where traditional extended family coping mechanisms are weakened.

The fact that over one third of children are being looked after by someone other than their mother has implications for child health. In child health in developing countries, we rely upon the mother as the main primary health care worker. We spend time educating mothers about good child health practices. If a child has no mother carer, the child's health is often worse. Elderly and very young care givers may not know about good nutrition. They may not know about oral rehydration in the treatment of diarrhoea. They may be unable to travel with the infant to immunisation posts. And they may be less skillful than mothers at spotting whether a young child is sick from, for example malaria, which requires travelling with the child to a clinic to receive curative treatment. Add to this the fourth wave of the HIV/AIDS epidemic, the twin epidemics of TB and poverty which follow in the wake of HIV/AIDS and orphanhood and we see the scale of the disaster being faced by future generations of children in badly affected countries.

CHALLENGES IN CHILD HEALTH:

Ensuring adequate treatment of children with HIV infection will remain a challenge to front line health workers in the next decade. But the number of cases of paediatric AIDS will not go on increasing indefinitely. Already in urban areas there are signs that we are witnessing a plateau in the number of new cases of HIV infection in children. Paediatric HIV impact in hospitals may be manageable. However better data collection on HIV impact on children is required. Recent cohort studies suggest over 80% of deaths in young adults in Rakai and Masaka are due to AIDS. No such information is available on children.

To improve child health due to HIV, a number of measures are required.

- We need to reduce the number of children developing HIV infection. The most effective method of reducing the number of children developing HIV infection is to establish programmes which reduce HIV transmission to mothers. In addition, urgent research into interventions to reduce mother-child transmission in developing countries such as vaginal disinfection, vitamin A supplementation, breast-milk substitution in the first 5 days and after 6 months and traditional alternatives to breast-feeding.
- We need to identify measures which prolong HIV-positive mother's life expectancy. Infants and young children need their mothers to ensure their health and well-being. Extending the lives of HIV-infected mothers by one or two years will help to reduce the number of orphaned children being looked after by alternative caregivers.
- We need to develop effective low cost community support programmes to orphans. We are witnessing a rapid increase in the number of orphaned children who are particularly vulnerable to HIV infection. Orphan support programmes can help to improve their situation substantially, by ensuring at-risk households are regularly visited, children's health is supervised, food supplements and income generating inputs are provided and primary school enrolment can be maintained.

G. Foster, M.D., Family AIDS Caring Trust, Mutare, Zimbabwe

"Artists Unite Against AIDS - Future Activities."
Health-L: May 14, 1997

Yesterday, 12 May 1997, the "Artists Unite Against AIDS" project, chaired by musician Brian Chengala, held a one day workshop at the Hotel Intercontinental to discuss future activities to contribute to the fight against HIV/AIDS in Zambia. There were about 50 participants: singers, musicians, drama & theatre groups, script writers, poets and others interested.

It was generally agreed that so far the main messages that have been conveyed by songs, drama and theatre have often been too negative, e.g. only stressing the fact that AIDS is a "killer disease", leaving little room for positive messages on prevention and support for people affected by HIV/AIDS. Artists can play a key role in "breaking the ice" and initiate discussions on sensitive issues and taboos. This does not only relate to specific AIDS related messages, but also on social problems that promote the spread of AIDS, like poverty, alcohol abuse, and the position of women in Zambian society.

The participants discussed possible new messages that would focus more on hope, and positive action. Hopefully these new ideas will soon result in songs, drama, TV programmes that aren't only entertaining, but most of all have a positive message.

"AIDS Orphans: Malawi and Zambia."

Health-L: May 8, 1997 (note: see original article below)

I agree to a great extent with what you commented on orphanages not being the solution. The fact that 99% of the AIDS orphans are taken care of by relatives is perhaps because of lack of institutional capacity (such as orphanages), but experience in richer countries has shown, as you say, that this is often not the best solution. In the end, children need to grow up in normal situations, i.e. in a family that can give them the attention and personal warmth they need.

Another example, which is similar to the one of orphans, comes from mentally disabled people. One used to think that these people needed special institutions who could best take care of their physical, mental and social needs. In many countries, this has led to 'institutionalisation' of patients, clients (or whatever word you would want to use for this), and only since a couple of years one has come to realize that the best 'institution' is the family and the community. This has led to all kinds of initiatives to enhance the incorporation of mentally disabled into society.

Here in Zambia there are - as far as my information goes - no big institutions for the mentally disabled. There is, however, a project supported by the Finnish Volunteer Service (FVS), which aims at strengthening the family's capacity to give their mentally disabled family members the best care they can afford. I could give similar examples regarding the elderly.

It all comes down to the fact that in the end the BEST (not only because there's no money for institutional support) solution for AIDS orphans, mentally disabled etc. is a family and community based one. 'Fortunately' perhaps, Zambia cannot afford these big institutions, that wouldn't be the answer. I think we have to congratulate all those Zambian (and Malawian in this case) families that are taking care of their family's (and others') orphans.

I would, however, also like to mention the fantastic work people like the Sisters of Kasisi orphanage are doing: unfortunately, sometimes orphanages provide the only 'escape' for poor

families and children who have been abandoned for all kinds of reasons. I'm sure your comments on the negative sides of orphanages don't apply to Kasisi.

Remains the fact that for the majority of Zambian families AIDS and all its consequences (taking care of orphans is just one aspect) places a very big burden on an already very limited family budget. It's not enough to conclude families have to tackle the problem themselves. The challenge is to find affordable community AND state based support to these families.

Joost Hoppenbrouwer, Associate Professional Officer, World Health Organisation Zambia National AIDS/STD/TB/Leprosy Programme (NASTLP)

"Malawi: Extended Family Overwhelmed by Orphans."

Africa Information Afrique: May 7, 1997

Widespread incidence of AIDS and official disdain for orphanages in Malawi are contributing to an escalating crisis regarding child supervision in the country. According to the National AIDS Control Program, AIDS could orphan as many as 300,000 children by the year 2000. Meanwhile, the impoverished state government refuses to augment the nation's 10 existing orphanages for fear that they stigmatize children and break up the family

Reference to the above: Zambia also has a major problem of those who have some resources having to take on more dependants. However, expanding the number or capacity of orphanages is not an answer. Firstly, there are so many children! It would be impossible to meet the need this way. Secondly, children who grow up in institutions are often unprepared for life outside the institution and have often lost contact with the relatives they do have, leaving them effectively rootless. Thirdly, experience in other parts of the world has been that institutions for the care of children attract individuals who abuse children physically, psychologically, sexually or all three. The larger the institution, the harder it is to detect these individuals. British children I have worked with have told me it is somehow worse when a stranger employed to look after them abuses them than when the abuse comes from members of their own family. I hope the Malawian government continue to view orphanages with disdain, although I hope that the children in the existing ones are being adequately cared for.

Cathy Poulter, PJP Associates LTD. Deveploment Consultants.

"How safe are condoms?"

Times of Zambia: May 6, 1997

CONTRARY to popular belief that condoms are not safe at all, they provide good but not perfect protection against sexual transmission of STDs including HIV, the virus that causes AIDS, if used correctly and consistently.

The big challenge today is how to prevent and control the spread of HIV/AIDS in a practical and tangible way. The condom offers that solution, of course bearing in mind that it is not the absolute solution to protection against HIV transmission. The condom, unfortunately, has generated much controversy about how much protection it offers. For instance, there have been unsubstantiated claims that condoms are not safe and that they tear. The result is that rather than looking at the condom as a practical way to prevent transmission of HIV, it has been seen as another Western invention which only encourages promiscuity, even though no evidence exists to prove this.

Fortunately, there is evidence from investigations in both laboratory and field situations in the US and Europe, that condoms can prevent transmission of HIV and other STDs. Laboratory studies have shown that the HIV virus cannot pass through the thin membrane of the condom (even air and water cannot pass through the condom and these molecules are even smaller than the HIV virus). Observational studies in Europe, the US, Zaire and Kenya, of people using condoms have demonstrated that condoms provide high levels of protection against STDs and the HIV virus with perfect use (i.e. consistent and correct use).

Regular users are less likely to become infected with STDs and HIV. A study from Zaire reported an annual condom-user HIV failure rate in discordant couples (one partner is HIV+, the other is not) of 3.1 in 100 (about one in every 32 couples). A follow-up of 24 uninfected sexual partners of AIDS patients for two years revealed that among 10 couples who routinely used condoms, only one partner became infected with HIV, a risk reduction for HIV of 80 per cent or better. However, in the 14 couples who did not use condoms, 12 partners became infected. It is important to note that failure rates generally speaking could be higher among users who do not use condoms consistently and correctly - key to preventing the sexual transmission of HIV.

Nevertheless, condoms appear to be gaining wider acceptance in Zambia, despite moral and religious arguments against their use. In fact evidence from Government hospitals and health centres, as well as recent media reports, all indicate a definite increase in demand for condoms.

Aside from the moral issues surrounding condom, there is the 'safety' issue. There have been claims, wrongly, that condoms are not safe because they break and that they have holes in them. One African researcher in HIV/AIDS claimed recently: "If you examine the condom under a microscope when it is stretched, you will see it has pores larger than the size of the HIV virus". However, scientific evidence has demonstrated that the HIV virus is about 30 times smaller than the head of a human sperm. It has been proved that the sperm cannot pass through a condom. Studies of people who use condoms for contraception report failure rates ranging from less than one per 100 to 16 per 100 users per year. The importance of proper condom use is evident from a recent report of Britain's Oxford Family Planning study, in which condom-user failure rates for pregnancy among married women, more experienced users were predicted to be as low as six per 1000 users per year. On the same issue of pores, one US study done by the National Institute of Health, found no pores when condoms were magnified 2, 000 times! A second study magnified the condoms 30, 000 times (a magnification at which HIV-size particles can be observed) reported that no pores were evident, even when they were stretched.

Another major concern is condom breakage. However condom breakage is not a very serious problem. Consumer surveys in the US have revealed breakage rates for good quality condoms ranging between one to five per cent. The reasons for breakage are many, including: misuse, reuse, duration and vigour of the sex act, inadequate space in condom tip, air trapped in the tip, unrolling condom before putting it on, damage caused by fingernails, poor quality condoms, and expired, exposed to sunlight, crashed .

A point to note in the studies is that most breakages occur when the condoms are being put on or taken off. Naturally, most people will say why bother with the condom. A sure way to avoid contracting STDs and HIV is to avoid sex altogether or being faithful to an uninfected partner. These two concepts need to be promoted among all age groups as primary and

totally effective preventive measures. However, it must be acknowledged that abstinence and lifelong fidelity to one uninfected partner are not the experience of many people. Sex is a very private affair and realistically speaking, it is not that easy to actually get people to change their sexual behaviour, much less to find out with 100 per cent certainly if the change has actually taken place. Consequently, measures to slow the spread of the disease must include the promotion and provision of effective protection and education.

Having said this, it is worth pointing out that certain facts about the HIV/AIDS problem in Zambia require pragmatic measures. A clear picture of the situation before us emerges when one looks at the following facts:

- There is an extremely high prevalence and incidence of sexually transmitted diseases in Zambia. (The dangers of repeated STD infections increases the risk of HIV transmission).
- STDs are the third commonest reported cause of hospital attendance in adults. (STD control is one of the most effective ways of preventing the increase of HIV infection).
- The link between poverty and HIV through lack of access to health, poor nutrition, lack of education and commercial sex is well documented. The urbanised nature of Zambia's population exacerbates this.
- A significant portion of the Zambian population are mobile. Further, trucking routes from south to Zaire, Malawi and Tanzania pass through the country; this has been acknowledged to be one of the major ways in which HIV/AIDS is transmitted.
- It is known that at least 50 per cent of Zambian girls have their sexual activity by the age of 16. The girls increase their chances of HIV infection by having sex with sugar daddies (for money, gifts) and then passing on the infection to their own age group.
- The high mobility of some professions or jobs is an issue that cannot be ignored in the transmission of HIV.

With these sobering reminders, is it not time that Zambians became more frank, courageous and realistic about condoms? The only sure way to avoid the risk of sexual exposure to HIV is to have sex in a monogamous relationship with an infected partner or to abstain. Sex with an infected partner or one of unknown HIV status is unsafe. If one engages in these highly unsafe practices, an effective way to reduce risk of exposure to HIV is to use a latex condom, consistently and correctly!

The article is a product of the public relations committee of ZAMCAM, grouping of contracting agencies and US non-governmental organisations carrying out supplementary work on behalf of the Health Ministry, in reproductive health, HIV/AIDS and child survival.

"Government Determined to Fight AIDS". by Cecilia Banda
Zambia Today, Electronic news From Zambia: April 28, 1997

GOVERNMENT has reiterated its commitment to fight the spread of the dreaded HIV/AIDS disease, Health Deputy Minister Professor Nkandu Luo said today. Professor Luo said her ministry has put in place very good policies but lack of implementation and support has hindered effective response from the public. Launching the Media Health Promotion Agency at Garden Hotel today, Professor Luo said the agency is critical to the health reforms it encompasses all health related issues that affect the community. Professor Luo said the MHPA will help the government re-define health issues by disseminating information to remote places through the different channels of communication adding that journalists should take this as a challenge to their profession.

She regretted that the HIV/AIDS disease has had an adverse impact on the Zambian society where the journalists have failed to capture the effects ever since the first AIDS case in 1986 was reported. Speaking earlier MHPA chairman, Keagan Mumba appealed for support to the agency whose establishment is still in its infancy. Meanwhile Professor Luo has been nominated matron of the agency whose membership includes journalists from both government and private media.

"Zambian Women Oppose Polygamy."
Xinhua New Agency: April 26, 1997

The Southern Province Tonga Traditional Association is calling on women to avoid married men. The chairman of the southern Zambian group, Dickson Namanza, reportedly said, "We want to promote the 'one man one women' motto in our country as we believe that this will go a long way towards helping to reduce the numbers of HIV and AIDS cases as it will encourage the development of a monogamous society." The effort has the support of both traditional leaders, as well as women's rights activists in Zambia.

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Last updated February 13, 1998

to live in a world of do's and don'ts. They cannot work, marry and have children like any other human being. He comes across a man with radical ideas and thoughts. For instance, though he does advise HIV positive persons not to have children, he went ahead and had a child with his wife a year ago. In his mind, he had made a bold statement to society. "I went ahead to have a child because I felt society was giving us a raw deal. Society has told us what to do and what not to do yet they go ahead and do the something. People are encouraged to have their blood tested yet I can bet you people who work in the testing laboratories and AIDS counselors have not been courageous to know their status."

Mr Mufuzi says society was not being fair to AIDS carriers. While he recognises his role as chairman of the network, Mr Mufuzi feels he has a calling to counsel smaller groups and those who need the attention and care of a trusted friend. "I will avail myself to people who need me. I have forged good relations with smaller groups. We have established mutual trust for each other and easily open up to each other."

What bothers him the most? Teenagers, he says, who go ahead and have sex as if nothing has happened. "By the time they realise that AIDS is a reality, they will already be infected. It will be too late when it knocks on their doors." Mr Mufuzi is also cheesed off by government's deliberate negative attitude to the whole epidemic. The top brass have turned a blind eye to the situation. They have not confronted the issues critical to finding a solution to the problem."

Mr Mufuzi said society had been fed with so many myths and misconceptions about AIDS. The media has not been spared from blame. He suggests that people must be given adequate information and let them chose their destiny. People must be empowered to make informed decisions not out of fear. For a man who tested positive to HIV in 1991, Mr Mufuzi looks healthy. Not even a fourth look at him would convince anyone he was an HIV carrier. He explains his secret.

"Being a carrier and having symptoms of AIDS are to different issues. I believe that health is a state of mind. I look forward to another day. God has a purpose for me being alive and so I live one day at a time." He is vegetarian and eats a lot of fruit. He quickly seeks medical attention when he has the slightest complaint.

"America Pledges to Help Orphans." By Dickson Kaminda The Daily Mail: April 27, 1998

Americans have pledged to come to the rescue of some Zambian children who had been left destitutes by the AIDS pandemic. United States Agency for International Development (USAID) director for population, health and nutrition Robert Clay said in Kitwe at the weekend that Americans were concerned about the children's plight in Zambia. Addressing a meeting at the civic centre on Saturday, Mr Clay said vital information was wanted in Washington D.C. so that assistance could be rendered to orphans and other vulnerable children.

Mr Clay said his government wanted to help children secure their future which appeared to be bleak in these hard economic times. He urged Zambians to mobilise local resources and continue to supplement government efforts at the community level. Mr Clay said the children would be assisted through the Project Concern International (PCI) which has already formed a committee in Kitwe. He was accompanied by PCI programme director Masauso Nzima and

some American officials who were impressed by the Zambian commitment to community development.

Meanwhile, government has promised to play an important role in rehabilitating the children who had been thrown out of school because of poverty. Community Development Minister Dawson Lupunga assured the nation when he toured Saint Martin's Orphanage, Holy Family Children's Home, Bumi Children's Home and CINDI offices in Kitwe. Mr Lupunga said government was committed to the future of children and paid tribute to NGOs which supplementing government's efforts. He warned that Zambians should brace for more street children because of the economic hardship and the AIDS pandemic.

"Chitika Urges Youths to Participate in HIV/AIDS Awareness Campaign." By Liseli Kayumba
The Post: April 23, 1998

The youths' participation in the dissemination of information on reproductive health and HIV/AIDS is very pivotal, said youth, sport and child development deputy minister Elizabeth Chitika yesterday. Chitika, speaking at the launch ceremony of the project on reproductive health and HIV/AIDS youth awareness campaign at the Commonwealth Youth Centre in Lusaka, said the subject was not new to the ministry. Chitika said she was pleased to see the involvement of the youth because participation was a key to successful implementation and appealed to non-governmental organisations, businesses and other institutions to assist in such ventures.

"HIV/AIDS is a major threat to society, especially in developing countries where there are low levels of literacy. It is not just a health issue, but affects all spheres of life," Chitika said. She urged students to channel their exuberance into the project and not to limit their activities to schools because this would exclude the youth who are not in school.

Commonwealth Youth Programme (CYP) director Professor Richard Mkandawire said the project was a collaborative initiative between the United Nations Fund for Population Activities (UNFPA), the University of Zambia and CYP. The launch was for the piloting of the first ever initiative involving university students as disseminators of reproductive health and HIV/AIDS messages.

"In the past, there has been a misconception that students are usually troublemakers, naive or partisan. This attitude needs to be changed. Instead the University should be viewed as a huge reservoir of knowledge that has been under-utilized," said Professor Mkandawire.

Over the last two weeks, 22 University of Zambia students have undergone an intensive training workshop on issues related to reproductive health. These students will then impart their knowledge in their local communities, and will also gain additional knowledge through interaction with their target audiences.

"AIDS Awareness Programme Coming."
Times of Zambia: April 21, 1998

FAZ will from June this year introduce an AIDS awareness programme through drama sketches at league matches. FAZ president Teddy Mulonga said at the opening of a one week HIV-AIDS awareness camp organised by the Zambia Family Planning Services Project (ZFPSP) in Chongwe that AIDS was a killer disease that targeted the most productive

"On two occasions, I became pregnant. But he forced me to abort the first pregnancy, claiming that he was not ready to have a child. And on the second one, he was honest by revealing that he was HIV positive and it was unnecessary to have a child. "In January this year, his sister chased me from his home as they said I was barren yet Chisala himself forced me to abort. Your worship, my life has been ruined by him and I have no doubt I have been infected with the HIV virus, " Sakala lamented.

In defence, Chisala admitted that he had different tablets in his house but said they were for his late cousin who died of TB. Chisala denied being HIV positive. "She is not straight. She stole my underwear and K90,000. I cannot reconcile with her anymore," he said.

The court reminded Chisala that his wife's main worry was her poor health and asked whether he was ready to undergo medical tests. Chisala was doubtful, "But how are the doctors know the who afflicted the other?" However, the court granted a divorce and ordered Chisala to pay his wife K1 million to be in instalments of K100,000 every month for her treatment.

"Breastfeeding and HIV/AIDS: Why Babies Born in Poor Countries are at Greater Risk of HIV."
Reproductive Health News: March 1998, vol. 2:1

Ninety percent of the four hundred thousand children in the world who became infected with HIV in 1996 inherited the virus from their mothers. Mother to child transmission of HIV may occur during pregnancy or delivery, or through breastfeeding. Not all children of HIV-positive mothers become infected with HIV, but the risk is much greater in developing countries. Zambia, in recognition of this issue, is now developing a policy about breastfeeding and HIV. There are many issues that are being considered in the development of this policy.

Researchers estimate, that if no treatment is given, the rates of HIV transmission from mother to child are between 25% and 45% in developing countries. In industrialised countries these rates are lower, from 15% to 25%. There are three main factors which explain why babies born to mothers from poor countries are at greater risk; breastfeeding, the poor nutrition of many mothers in developing countries, and the lack of access to drug treatment that can help prevent HIV transmission during pregnancy. Preventing HIV infection

Primary prevention, however, is the key. Most mothers have been infected with HIV through unprotected sexual intercourse. The importance of promoting condom use and other safe sex measures, as well as prompt and adequate treatment of STDs must not be underestimated. We must also continue with programmes to reduce women's vulnerability to being infected with HIV; programmes to improve their social and economic status. Breastfeeding and HIV: a desperate dilemma

Recent data from developing countries indicates that up to one half of mother-to-child HIV transmission is due to breastfeeding. We promote breastfeeding because it gives vital protection against deadly childhood diseases, particularly diarrhoea and acute respiratory infections (ARI), which are far more common than HIV. It is also free, whereas the cost of dried milk and even the clean water to prepare it, are often beyond the means of poor families. Providing infant formula is impossible within Zambia's health budget. Moreover, the dangers of infant formula feeding must not be underestimated. Breastfeeding experts warn

that if African mothers stopped breastfeeding, the death rate in under-fives could more than double. It has been estimated that infants who are not breastfed are 14 times more likely to die from diarrhoea, compared to babies who are breastfed exclusively. They are also three times more likely to die from ARI.

However, concern over transmission of HIV during breastfeeding presents HIV-positive mothers, and the health workers who care for them, with a desperate dilemma. Do we risk passing on the virus through breastmilk, or risk feeding babies with infant formula when mothers may have no access to clean water or may well not be able to afford it?

The Joint United Nations Programme on HIV/AIDS (UNAIDS) along UNICEF and WHO now recommend that we counsel HIV-positive mothers and make available to them as much information as possible on the relative risks of breastfeeding and infant formula feeding. We should encourage and, if possible, provide for voluntary HIV counselling and testing. Then mothers can find out if they are HIV-positive and use this information, along with information about the risks of artificial feeding, to decide for themselves whether to breastfeed or not. Voluntary testing must be offered, though, in a supportive environment. Clients should never be made to feel guilty about being HIV positive.

Lack of nutrition is also implicated in the higher rates of mother-to-child transmission of HIV in developing countries. Thousands of babies are becoming infected with HIV because their HIV-positive mothers don't have enough to eat, or are not eating the right kind of foods.

There is some evidence to suggest that women who are vitamin A deficient are more likely to have HIV-positive babies. Vitamin A is found abundantly in leafy green vegetables and liver. Trials are now underway in Malawi, South Africa, Tanzania and Zimbabwe to determine whether vitamin A tablets might reduce vertical transmission in African women. If vitamin A, or a combination of other vitamins, really can reduce the risk of transmission of HIV from mother to child, it could provide a cheap, inexpensive way for HIV-positive mothers to help protect their unborn children. Such measures will not, however, solve the larger problem of malnutrition among women. AZT: An expensive magic bullet.....

In 1994, French and American researchers found that if the drug AZT was administered to pregnant HIV-positive women and to their newborns, the rate of HIV transmission from mother to child by was reduced by 68%. While clearly an important research breakthrough, it soon became clear that this finding would create an enormous ethical dilemma. AZT is very expensive. A full course of treatment for a pregnant woman and her newborn costs about US \$1,000 (Kw 1,350,000). It must be administered over many weeks during pregnancy and delivery, as well as to the newborn child. In addition, the baby must not be breastfed.

As most women in Zambia and other developing countries breastfeed, the efficacy of the regimen is unclear. Other factors contributing to this concern are that women in developing countries often attend antenatal clinics too late in pregnancy to receive the full regimen of treatment, the lack of capacity to give drugs intravenously in many facilities, and that women cannot make frequent visits to clinics to receive treatment for themselves and their infants in the antenatal period as well as the six weeks following birth. Moreover, the AZT regimen is too expensive for Zambian women or the Zambian government.

Clinical research is now underway in developing countries to develop a shorter, less expensive course of treatment for pregnant HIV-positive women in poor countries. Studies

conducted by UNAIDS in South Africa, Tanzania and Uganda aim to compare the use of a short course AZT treatment to no treatment at all, or a 'placebo' (sugar pill) to find a way to prevent mother-to-child transmission in developing countries.

Late last year, certain critics labelled these trials unethical. Citing UN guidelines drawn up after World War II that said that human research subjects should receive the best available treatment, they argued that babies born to women receiving a placebo during the trial will be infected unnecessarily. There are also concerns that once their babies are considered no longer at risk of contracting HIV, these women may then be denied access to these drugs.

UNAIDS, supported by other international researchers, recently defended the trials, arguing that African realities make the developed world regimen of AZT treatment in pregnancy unfeasible in poor countries. Placebo-controlled trials were therefore set up to evaluate whether shorter regimens that can be realistically implemented in developing countries. The alternative is no treatment at all. UNAIDS has also stressed that the HIV-positive women who are participating in these trials have signed a form testifying to their informed consent to participate, are counselled about HIV infection and prevention measures, and are fully informed about the way the trial is being conducted.

We in Zambia need to watch for the results of the AZT trials. The findings will guide our both our policy development and, for those of use working in health facilities, our advice to HIV positive mothers about breastfeeding. But first and foremost we must continue to prevent HIV infection in the first place.

The report was adapted from a paper by UNAIDS. Other references used were HIV and Breastfeeding: A Policy Statement by UNAIDS, WHO and UNICEF and The 4th Annual African Regional Meeting Statement on HIV and Breastfeeding, IBFAN.

"Zambian TB Cases Rise as HIV Prevalence Gets Higher." By Mildred Mulenga
PANA Wire Service: March 23, 1998

According to public health manager Moses Sichone, the number of tuberculosis cases in Zambia rose to almost 40,000 in 1997, up from about 8,500 cases in 1985, with TB accounting for 13 percent of primarily adult deaths in the country. Sichone cited studies that indicate that 50 percent to 70 percent of infected people are co-infected with HIV. He noted that the immunodeficiency caused by HIV allows the normally dormant mycobacterium to become active, leading to an explosion of TB cases. Whereas TB used to be found more commonly among older people, the primary infected group is now aged 15 to 45. However, Sichone also noted that HIV was not responsible for all of the changes in TB demographics and that other diseases can trigger tuberculosis as well. In an effort to combat the disease, the Zambian Ministry of Health has decided to decentralize diagnosis and treatment of TB to health centers, in addition to major hospitals, which had previously dealt with the majority of the infections.

"Training of Presenters in the AIDS Impact Model." By Robie Siamwiza
Health-L: March 18, 1998

During the week of March 9th Project Concern International in conjunction with The POLICY Project, on behalf of the Central Board of Health, trained 15 people to make formal presentations on HIV/AIDS using the AIDS Impact Model (AIM), developed by The

rate is so high. "If we do not advise each other on sexual health we are committing suicide," Mrs Kadandara said.

She further stressed that the male sexual organ was created for a good purpose, but its abuse has made it lethal. "If this was a United Nations Declaration it would have been declared world's most dangerous anatomical arm," said Mrs Kadandara who was still holding the floor. Having shown qualities of an empowered woman she went on to implore fellow women that only in unison and love can they make it, and that women are their own liberators because HIV is not abstract but real.

Inadequate supply of drugs and distribution in the region was seen to be another great source of worry. And even if drugs were enough, in Africa people in rural areas live far off from the main roads of trade making it difficult to distribute drugs to the needy on time, and tragically, many people are dying earlier before their time.

SANASO conferences are held every after two years and the hosting rotates with the member countries. Regional networking such as SANASO should be promoted as this encourages sharing of information and field experiences, also strengthening understanding for our similar cultures as the fight against HIV is not for one single person or country, but humankind as a whole.

"Orphan Numbers to Swell, Warns Minister"
Times of Zambia, December 13, 1997

The number of orphans in Zambia will leap to 600,000 by the year 2000 if the AIDS epidemic continues to ravage the population at the current rate. Copperbelt Minister Matthew Mulanda said in Chingola yesterday that there was a sharp increase in the number of children orphaned by AIDS and figures continued to rise. The number of orphans currently stood at 300,000 and the sharp increase was because of the high number of deaths caused by the deadly pandemic. Mr Mulanda who was officiating at a belated World AIDS Day commemoration also said children especially girls were vulnerable to infection because of negligence of their human rights.

"Commercial sex, exploitation and domestic abuse of children are contributing factors for HIV infection among children. "The physical and mental abuse of children increases the likelihood of their engaging in risk-taking sexual behaviour and thus increase their vulnerability to HIV," he said. He said Government was trying to control the spread of AIDS by providing information and improving the social safety net. Government was also improving the health delivery system by decentralising and making communities participate in health care. Mr Mulanda said another way of controlling the disease was by giving and strengthening income generation opportunities to people so that they did not indulge in commercial sex.

Chingola district director of health Silvia Chila challenged guardians of orphans to provide proper guidance. "We have people who adopt children at a distance. They say they would be providing money for education and food but children need more than that. They need guidance and care," Dr Chila said.

African mayors and municipal leaders have said the precarious economic conditions in cities intensify the impact of HIV and AIDS on vulnerable communities in particular women and

the youth which was jeopardising long development plans. The African mayors and municipal leaders made the observation during their 10th international conference on sexually transmitted diseases held in Abidjan on Tuesday.

"Zambia to Host Next African AIDS Conference"

PANA Wire Service, December 12, 1997

At the close of the International Conference on AIDS and Sexually Transmitted Diseases in Africa, Zambia was designated as the location for the next meeting, to be held in 1999. Meanwhile, on behalf of Ivory Coast President Henri Konan Bedie, Health Minister Guikahue noted that it is critical to bridge the gap between developed and developing nations in providing treatment to HIV/AIDS patients. Guikahue also cited French President Jacques Chirac's proposal for international and African funding for AIDS drugs as a new effort in the war against AIDS, but said that safer sexual practices are still essential.

"Squad to Undergo HIV/AIDS Test" by Goodson Machona

The Post, December 12, 1997

National soccer team coach, Burkhard Ziese, resumed training the team yesterday after a ten-day absence and immediately announced that all players will have to undergo an HIV/AIDS test next week. Ziese, who took nearly 30 minutes addressing the players before they played a practice game at the Independence Stadium, also lambasted them for what he termed "a laissez faire attitude" towards training.

"Anti-AIDS Workshop" by Sam Mujuda

The Post, December 11, 1997

I listened with sadness the other day to a television broadcast about Solwezi youths demonstrating against the use of condoms. Apparently the youths were doing it as part of their five-day anti-AIDS workshop. I felt for the lives of the youths not that demonstrating is a bad thing but because I felt some people do not really realise how serious the HIV/AIDS pandemic is. I am one of the people who strongly feel the campaign against HIV has been viscous and vigorous and why some people have decided to ignore it, is hard to understand. Apart from say that we are earthly beings.

I strongly feel the HIV/AIDS scourge is one serious battle which should not be treated with kids gloves or we will get knocked out. More NGOs have been formed with an aim of fighting HIV, but the numbers of young men and women dying from this deadly disease has not been reduced if it has not even increased. It will not be just, to say condoms will increase promiscuity among the youths. With or without condoms, those who want to indulge in sex will do it.

After listening to that broadcast, I decided to make spot interviews in which I spoke to various people whose names I have withheld. "It is unfortunate that some people still want to go round and tell youths not to use condoms. That is very bad pretense. Yes I know the best protection people can have against HIV is abstaining, but it seems they cannot," said the woman, adding, "I think it is very bad for people to advise our young people not to use condoms because we risk situation where all our young men and women will be infected by this disease." I spoke to another who said she had lost a friend and strongly believed the friend died of AIDS.

was a sharp increase of infections in the rural parts of Zambia.

He was speaking at the launching of a joint project aimed at combatting the spread of AIDS by Kara Counselling and the Rotary Club of Lusaka Central. Mr Mwansa warned that there would soon be a sharp decline in Zambia's population if people did not change their attitudes and behaviour. "Unless something is done in a hurry our future as a people is very bleak. It may not be long from now when we shall notice a sharp decline in our population growth," he said.

Deputy Minister of Education Betram Mmembe commended Kara Counselling for helping people living with the virus to be positive about their status. And Rotary Club of Lusaka Central president Hugo Mubashi said all stakeholders should take part in the fight against AIDS. He said the Rotary Club would continue supporting efforts to control the spread of the deadly disease. -Zana.

"Children Up Against AIDS." By Charles Chisala
Times of Zambia, October 5, 1998

IF you are one of those Thomases who doubt the power of children you should have been at Hope Humana in Ndola last Saturday. You surely would have swallowed your doubts. The children, through drama, made it clear that without their active involvement the fight against the HIV/AIDS pandemic would be futile. They have now taken up arms to join the war.

"We have suffered for too long from the effects of HIV/AIDS. Now is our time to fight for our rights. We will show you our power, and you will feel it!" the children declared. The message was loud and clear. In shrill, tearful voices the children vented their innocent anger and justified indignation at a society that appears to be indifferent to their plight. They sounded their war cry at the primary and basic schools drama festival on HIV/AIDS organised by Hope Humana, a project under the Development Aid from People to People (DAPP). The event drew 10 drama groups from Ndola primary and basic schools which had been short-listed from the initial 27.

The schools included Chifubu A, Masala, Dola Hill, Pamodzi, Ndola basic and Tug Argan. The most incisive message came from second prize winners Chifubu A 's two upcoming 13-year old actors Don Mwale and Evaristo Bwalya featuring as Mr Death and AIDS respectively. Clad in a black robe depicting his title and his mouth dripping with what looked like human blood, Mr Death sauntered onto the stage to announce how evil was, to thunderous applause from the audience. "I am Mr Death, I have no brother and I have no sister. I will strike anyone who plays with me. If you want to prove that I am evil ask Mr AIDS, he will tell you," Mr Death tells his hushed audience in terror inspiring tones.

Enter Mr AIDS (Evaristo Bwalya) draped in scarlet from head to toe. In equally sharp tones he affirms what his brother Mr Death has just said: "Yes I, Mr AIDS, confirm that Mr Death's declaration is true. I strike those who are careless with sex and Mr Death finishes them off." Mr AIDS further warns those who want to keep clear of him and his brother Mr Death to refrain from careless sex. Standing on the stage side by side the two made quite a fearsome pair.

In another production by the same school young Mwale (Mr Death) returns to the stage as an illiterate, old father. As he hobbles onto the stage Bwalya sends the audience into a

frenzy of laughter with his bald head and distorted features. Walking with a slight stoop in his tattered clothes you could be forgiven if you mistook him for a diminutive village old man. The boy is a born actor.

In the play the father (Mwale) conspires with his wife's relatives to force his teenaged son (Isle Phiri) to succeed his late uncle who died of HIV/AIDS barely a few days ago. By the time he died the man had been reduced to a skinned skeleton with literally no flesh left on his bones. But with no-one to support him and after threats of death from his own father the boy reluctantly marries his uncle's widow who also soon becomes bed-ridden, melting away from a mysterious illness. As it becomes clear that she will die the same way as husband alarm grips the boy, his parents and the rest of the village. A witchfinder is quickly brought in to find out what this new killer, which is threatening the whole village is. The diviner, in usual fashion, blames witchcraft and offers to heal her. He leaves the family with an array of herbal concoctions for the woman's medication. But her condition does not improve and death lingers over her bed.

The distressed village realises through a roving medical team that what has struck their community is HIV/AIDS which no witchfinder can ever stop. But it is already too late. The woman dies while the boy, now a widower, is diagnosed with the deadly infection. "All we can offer you is education to ensure that this killer does not finish you all," consoles a young doctor. He warns the villagers that if they did not refrain from casual sex the disease would wipe them out.

What was amazing was the professionalism with which the children presented the play. They could easily have outshined some of the mediocre performances we watch on television by some local senior theatre groups. The mourning for the dead aunt, which climaxed the play, seemed so real that a few people in the audience unconsciously dropped a couple of tears of grief. Best actor Evaristo Bwalya (Mr AIDS) shed real tears and repeatedly blew his nose on stage while the others were keening so tearfully for the departed HIV/AIDS victim that you would think the funeral was real. It was a heart-rending scene. Chifubu A primary school drama group director Mwaka Mulwanda, a teacher and herself an actress, must have done a tremendous amount of hardwork to drill the young ones. They observed internationally accepted standard stage etiquette to the letter, which drew nods of envy from some theatre pundits who had come to observe the event.

It was an event worth attending. As representative of the British Council, one of the sponsors of the event, Irene Chella said it was a cause worth spending money on. "HIV/AIDS is not a problem for some sections of society only. It affects everyone and the British Council is ready to help to hold events like this one," Ms Chella said. Organiser Thomas Kabwe Chaongopa said the festival would be an annual event and Hope Humana planned to increase the number of participating teams to include secondary schools. He said Hope Humana had decided to involve children, especially those aged between 13 and 15 because they were the window of society who suffered the worst effects of the HIV/AIDS pandemic. Pamodzi primary school scooped the first prize while third went to Ndola Middle Basic school. Bwalya (Mr AIDS) from Chifubu A was voted best actor and Mika Matanda (Ndeke) best actress.

"AIDS Scourge Has Advantages." By Mike Moono
Times of Zambia, October 1, 1998

When I was first asked the question I thought it was ridiculous, outrageous even. How could there be advantages . . . about AIDS/HIV! But after giving the question a second thought I decided there was merit in it. Information available appears to emphasise so far only the devastating aspects of the scourge. But you have to think hard to see through the maze.

For instance, society's attitude to death caused by HIV/AIDS has changed whereby there is a positive finality about it. In the past, wills were taboo because it was believed death was something that was not discussed. Now a will is the easiest of all because of the time it takes before death occurs. The victim is able to think and reflect on it over a long period. There is plenty of time to write the will.

Those afflicted by HIV/AIDS often find solace in God and religion. Before that many had little time for it. The moral attitude of people has changed. Whereas in the past you never gave a thought what you ate or who you went to bed with there is now self-restraint, thanks to the various education campaigners. Food plays a big role in whether the virus is reactive now or later. Sex has taken the biggest chunk of the blame. Yet is inevitable part of the human society's reproductive process and relaxation.

The HIV/AIDS scourge has boosted the sympathetic and natural rubber industry through the manufacture of condoms and related products. New protective apparatus and gadgets have come on the market adding to the expansion of research information. In Zambia a condom sales company short over its target of K26m sales in 1997. Resources have been mobilised globally to try and find a cure. For Africa the development has helped to narrow the gap between the traditional healer—till now despised—and the Western trained expert.

They may not use the same methods of tackling HIV/AIDS but they are tackling and sharing experiences. The patients too are having a choice without feeling guilty about it. The rich who have fallen victim are releasing money to researchers who, as is often the case, may discover another virus to combat the HIV and ensure better methods of maintaining and prolonging life. Nations are for once cooperating instead of talking war and trade barriers. In the SADC region soon member countries are to sign an HIV/AIDS code aimed compelling industry and other employment agencies to take measures aimed at alleviating suffering among victims.

At a family level drinking habits have changed from heavy to mild. Individuals fear the temptation that goes with much alcohol intake. This has led to people to be more rational in making decisions than before. The cost of the medical care when taken ill entails that those who are in employment have it at the back of their mind to save for the time when the virus strikes.

The pandemic has offered employment opportunities to both skilled and non-skilled labour in various countries. There has been movement of expertise from development to developing countries engaged in one form of activity or another. Those are involved mainly in advisory services, counselling and information. Locals have been engaged to translate the aim of donor countries and financing bodies like the World Bank into reality on the prevention of HIV/AIDS. Seminars and conferences on HIV/AIDS have provided the hotel industry with business. New teaching and information dissemination methods have been the production of the community video telling the story of victims. Literacy campaigners have improved communities; understanding and galvanised action against a common cause.

In Zambia a project is underway to investment in medicines that would be affordable to the majority of the people suffering from HIV/AIDS. A formula dubbed the K-Punch has been developed by researchers and is now open for investors to try out, says one of the researchers Dr Francis Khama. Our overriding objective is to try as much as possible to have cheap and affordable medicines for our people. This new drug, the K-Punch could be manufactured on the same basis as fansida, which is a combination of two separate old drugs, Sulfadoxine and Sulfadoxine and Pyrimethamine discovered long time ago." So like cash earnings from war and pain of childbirth the HIV/AIDS pademinc has had advantages.

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Guide to Medical Resources WWW site: <http://www.medguide.org.zm/>

Last updated November 25, 1998

The Situation of Orphans in Zambia

from "Orphan Programming in Zambia: Developing a Strategy for Very Young Children." By Susan Hunter and Deugene Fall, Draft- July 19, 1998

Orphan Estimates in Zambia, Year 2000 Children Under 15 Orphaned

	"Children on the Brink" Estimates (All Causes)	Official Estimates Zambia NACP (AIDS Only)
Mother or Both Parents Dead	745,492	500,000+
Father Dead	911,157	Not Available
Total Orphans	1,656,649	Not Available

1. Current and Future Estimates of Orphans in Zambia

Zambia has had an active National AIDS, STI, TB and Leprosy Control Programme (NASTLP) since 1986, following diagnosis of the first case of AIDS. It has produced an impressive body of documentation on epidemic growth and impact in its first decade of operation. Despite heroic efforts to stop the epidemic in Zambia, it has deepened inexorably in the country, and its effects on families and children, coupled with economic problems, has been devastating.

The Table above juxtaposes the estimate of children orphaned by AIDS provided by the National AIDS Control Program in the Plan (right hand column) and the number of orphans estimated for Zambia in "Children on the Brink" (left hand column). As can be seen from the table, US Census Bureau estimates and official government estimates for maternal and double orphans are different. This is primarily because the official estimates include only orphans of AIDS, while the Children on the Brink estimates include orphans of all causes of deaths. For 2010, the number of maternal and double orphans is estimated by official sources to be 1,013,000, close to the estimate contained in Children on the Brink.

The National AIDS/STD/ TB and Leprosy Control Programme has not developed estimates for children who are paternal orphans, children who have lost their father to AIDS or other causes. As a consequence, there are no comparable official estimates of paternal orphans to those contained in Children on the Brink. This is an important

estimate because such children may be de facto double orphans (missing father and mother both) due to a variety of cultural reasons. However, the ratio of orphans by type (maternal/ double/ paternal) reported by recent situation analyses in the country support the estimates for paternal orphans made in “Children on the Brink.”

2. Beyond 2010...

Zambian health authorities assume that HIV seroprevalence peaked in Zambia in 1997 because of significant behaviour change reported in adult surveys. They also project that the number of infected adults will remain relatively constant through 2010, which means that orphan populations will not peak until 2020. As a consequence, Zambia will have a high orphan population, as a proportion of children under 15, through at least 2030.

The chart above shows the proportion of children under 15 who will be missing one or both parents for five year intervals through 2030. The estimates for 1990, 1995, 2000, 2005 and 2010 come from Children on the Brink, and show breakdowns of orphans by type and total. The estimates for 2015 to 2030 are derived from projections of numbers of infected persons made by the Ministry of Health in their 1997 analysis of serodata, HIV/AIDS in Zambia. The Ministry anticipates that numbers of infected adults remains fairly constant through 2010, on the assumption that prevalence rates peaked at 19.9% of adults in 1997. If they start to drop after 2010, then the proportion of children under 15 orphaned will begin to diminish after AIDS mortality peaks (2020), and fewer new orphans are born. The mushrooming of the orphan population which will occur in the next 20 years is due to the typical result of the exponential growth of AIDS infections and death in Zambia and its neighbours in East and Southern Africa.

In understanding the orphan data, it is important to separate the estimates of children who are in single parent households from those who are orphaned, whose parents are dead. “Children on the Brink” and other orphan estimates do not include parents who are not dead although they may not reside in or provide support to the households. The estimates of orphans in Zambia contained in “Children on the Brink” also do not include any children born HIV positive. This group is subtracted because, without treatment, these children are likely to die before their second year of life.

Deaths of HIV positive infants and children will substantially curb overall growth of the under 15 population in Zambia. As a result, by 2010, the under 15 population of Zambia is anticipated by U.S. Census Bureau estimates to be only 5,402,402, 26% more children than Zambia had in 1990. In addition, these infant and child deaths will increase infant and child mortality and lower official estimates of life expectancy in Zambia by more than 20 years. This does not mean, of course, that HIV negative adults will live shorter lives, but on the average, when additional child deaths are included, life expectancy is reduced.

While they are not included in the model, HIV positive children will number in the hundreds of thousands and present a substantial burden of care for families, communities, health facilities and health and social workers. Between 2000 and 2010, there are

expected to be 1.1 million infected persons in the population, roughly 84% of whom will be adults 15 and above, if estimated on the basis of current AIDS case data. As a rough estimate, 176,000 children will be infected.

Zambia's sentinel surveillance system began in the early 1990's, and 1994 was the first and only year for which data was available from all sites. Data collection did not occur in 1996 although it was scheduled. However, Zambia is unusual in having had population based serosurveys in 1995 and 1996. In September, 1997, data from these surveys was used by an Expert Group Meeting convened by the Central Board of Health to correct the biases in the surveillance system data, drawn from antenatal clinics only.

The epidemic in Zambia is among the most severe in the world. HIV infection is currently estimated at 19.9% in persons above age 15, where it is assumed to have peaked because the rising number of deaths has begun to balance the number of new infections. Adult seroprevalence varies somewhat among provinces, with the concentration of infections in the urban areas of the Copper Belt, Central Province and Lusaka. According to the 1997 Ministry of Health analysis, "Prevalence rates appear to be modestly lower in Northern, Eastern, Southern and Western Provinces and lower still in North-Western. The differences are not the important story, however. Much more important is the fact that reported rates are extremely high everywhere in the country. The HIV/AIDS epidemic has left no corner of Zambia untouched."

Zambia successfully controlled tuberculosis until the late 1980s, when the interaction of tuberculosis and HIV infections contributed to an almost five-fold increase in the TB rate. According to the NASTLP, two-thirds of TB patients may be HIV positive, and TB cases will increase rapidly, reaching at least 50,000 per year 2005, and possibly more because of emergent drug-resistant strains. TB in HIV positive people can be transmitted through casual contact, threatening even further growth. Lastly, TB treatment is expensive and fills hospital beds, according to the Ministry of Health. As a result, deaths in adults may be even higher than that projected for AIDS alone, with obvious implications for orphan rates in Zambia.

3. Estimates of Other Vulnerable Children in Zambia AIDS, Families, and Economics in Zambia

In Zambia, estimates of the numbers of street children have swelled from 35,000 in 1991 to over 75,000 in 1996, numbers of children in primary schools declined, chronic child malnutrition (stunting) increased from 40% in 1992 to 53% in 1995 and known cases of child abuse (sexual and physical) are now beginning to be discussed in public. The breakdown of families as a result of AIDS – NASTLP estimates 500 new infections per day in Zambia – and the disintegration of economic and social coping mechanisms is placing increasing stress on 'traditional' extended family coping strategies.

"Continued austerity measures, implemented by the government in line with obligations under economic and structural adjustment programmes, have hampered government efforts to provide adequate and timely social welfare assistance to families and children

in need. Communities have been taking proactive measures to respond to the problem, through NGOs and community-based organizations, but their resources and reach are limited by the sheer volume of children and families affected by HIV/AIDS and chronic poverty. Research conducted in 1996 estimated that 72% of households in Zambia are home to at least one orphaned child and that 54% of all children in Zambia have lost one or both parents.

4. Zambia Will Rank First Among Sub-Saharan African Countries with Large Orphan Populations by 2010

In Order of Magnitude by Percent of Children Under 15

Zambia	Rwanda
Botswana	Uganda
Zimbabwe	Burkina Faso
Malawi	CAR

Source: Children on the Brink

5. Variation in Orphan Needs

The needs of orphans are the needs of households in poverty (food, shelter, bedding, clothing), the needs of children generally under age 15 (health, schooling), and the needs of children for access to work (age 15 and above). A consistent picture emerges from Zambian data, which is corroborated by data from many similar surveys in other Sub-Saharan African countries. Major material needs include food, health services, education, and protection. School aged orphans have higher rates of non-enrolment compared to non-orphans. In urban areas, 32% of orphans are not enrolled compared to 25% of non-orphans, while in rural areas, 68% of orphans are not enrolled, compared to 48% of non-orphans (Rossi and Reijer, 1995; Webb, 1996). Other types of discrimination in treatment between orphans and non-orphans are not detected in Zambian surveys (Poulter, 1996; McKerrow, 1996).

Studies in other countries have demonstrated that maternal (mother dead) and double orphans (both parents dead) under 5 are at higher risk for sickness and will be less likely to get immunizations, while paternal orphans (father dead) of school age would be more at risk for lack of education. Double orphans are potentially the most vulnerable, but maternal orphans left with little or no resources following the death of their father, will also face serious disadvantages.

HIV/AIDS cases under reported in Zambia

January 11, 1999

By Reuben Phiri

Lusaka - There has been underreporting of the statistics of the HIV/AIDS pandemic for various reasons like researchers not reaching certain areas, programmes officer at Family Health Trust Prisca Chintomfwa disclosed.

Chintomfwa, speaking at a stakeholders meeting at Pamodzi Hotel last Friday, also disclosed that Zambia had joined a multinational campaign to promote responsible sexual behaviour and self-empowerment among African youths.

The initiative dubbed Africa Alive according to the organisers of the meeting was meant to sensitise the youths on the HIV/AIDS pandemic.

The campaign will culminate into a 12hour concert which will take place about the same time of the International AIDS conference in Durban, South Africa in the year 2000.

During an overview presentation, Chintomfwa further disclosed that there was an estimated number of more than one million Zambians infected with HIV/AIDS.

"The figure could be more but there has been under reporting for various reasons," she said.

"Poverty and relatively low health status and certain traditional practices like dry sex are also some of the causes of the spread of AIDS," she said.

Is K-Punch a cure for AIDS?

January 7, 1999

By Mike Moono

Lusaka - Towards the end of the fifteenth century, a pandemic of venereal syphilis swept through Europe with a high death rate. Since syphilis, unlike plague, was sexually transmitted there was panic and chaos during the syphilis pandemic. There was a claim that syphilis was brought back from the Americas, by Columbus and his sailors.

Others claimed it was a curse from God or the work of witchcraft or probably created by doctors. A more plausible claim was that, syphilis may have occurred as result of change in host-bacteria a relation of an already existing syphilis bacteria. Of course, nobody could pinpoint exactly where syphilis had come from. But syphilis has a family, the treponema, i.e. turning thread. Many bacteria belonging to this family look alike and they existed before syphilis. There was indeed panic.

Politicians and the ordinary people declared mankind will be wiped out and that nobody will be left on earth. Syphilis broke social barriers. All types of people were infected, including kings and queens, emperors and empresses, princes and princesses, master and the servant, clergy and the laity, husband and wife.

It did not spare the, manager and the secretary, villagers and the town people, the married and the single, doctors nurses and the patient, the rich and the poor, the adulterer and the adulteress too were not left out, the good and the bad, the beautiful and the ugly. Many people were infected except the very old who were not sexually active. Many children were left as orphans, and many citizens died. The rich died leaving their riches.

The poor died in dire poverty. Others died lonely and miserably.

The living feared the dead lest they contracted the disease. Wives deserted husbands or vice versa, brother deserted brother or sister.

Relatives were deserting one another. Others tried to run to other parts of the world of the time but they had already contracted the disease and in the process spread it. Since syphilis was and is sexually transmitted nobody wanted to admit that they had the disease. Families broke up.

Divorce rates shot up. There were accusation and counter-accusation between wife and husband, among families, boyfriend and girlfriend, adulterer and adulteress and fornicators.

Suffering from syphilis was a terrible stigma. People were frightened to reveal the illness lest they became outcast. But no one could tell who had the disease except the patient himself. The press of the time put the last nail into the coffin.

"There is no-cure for syphilis and mankind will be wiped out," ran the headlines. It was a miserable time for the patients. Some committed suicide.

Some crazy people used syphilis as a weapon of revenge. They deliberately infected others. Even though there was no cure for syphilis, there were various means of treatment.

Claims and counter-claims were made on the cure the disease. Patients were bled white in order to remove the germ from the body. For the same reason, they were purged to the bone.

Others were given medicine to sweat or salivate the germ out. Various concoctions were used but to no avail. Heat treatment was used in order to kill the germ in the body. Of course there were tattoos too and men of God who promised miraculous cure.

However, even those who claimed to have the cure died of the same disease! Rich people were discouraged from seeking treatment and cheated by relatives or friends in the hope that they would inherit the wealth. But even the very same relatives eventually died of syphilis. Nobody was willing to pay for the treatment of the others. Preventive measures were put in place.

Crude condoms were used by those who could afford them. People were advised to avoid sex or stick to one partner. But could they stick to one partner when they were sexually active? The pandemic continued to spread. It was claiming the cream of the society who could not be replaced. New drugs were introduced for treatment. Mercury, Bismuth, Iodide, Arsphenamine and eventually Penicillin.

At first few people could afford the treatment as the medicines were very expensive.

Even then, where new drugs of hope were introduced people were sceptical. After all syphilis was a curse from God and there was no cure. The new drugs would only suppress the symptoms but not cure the disease. If they recovered as a result of the treatment, they claimed they had not been suffering from the disease, after all, there was no cure for syphilis. What happened to this pandemic? Syphilis, a tourist who had come to visit Europe but decided to stay, is no longer a killer disease. But it is still with us! Now even the untreated syphilis has a low death rate, an example of the way in which 'new' infections gradually lose their severity over time as the body adapts and builds up

resistance. People had gone back to their normal social life and it was no longer a cause of panic and mankind had not been wiped out. Syphilis is caused by a spiral bacteria, Treponema Pallidum, which looks like other members of this group, the treponema, such as treponema pertunue, treponema pallidum. Monkeys and rabbits can be infected with treponema pallidum. Does the story on syphilis remind you of something? History has a knack of repeating itself and we don't seem to learn from history. History has repeated itself in HIV/AIDS infection. Don't despair, HIV infection can be cured. A formula developed by Ndola doctor Francis Khama, exists and is available for sale to a buyer.

The medicine, dubbed the K-punch, cures HIV/AIDS by repressing the HIV genes so that they don't replicate. With repressed HIV genes no new viruses are formed. The human Immune deficiency virus in the blood is destroyed by the body's defence systems which the K-Punch restores. Because of repression of HIV genes and destruction of the HIV by the body defence systems transmission of the HIV to partners or the baby in pregnant women is minimised. Why do we say the K-Punch is a cure for HIV/AIDS? Some 70-80% of adults have herpes simplex virus or TB bacteria in the body.

But these microbes are made dormant by the body defence system and don't cause any illness in the people carrying them. The people carrying these dormant microbes are healthy and are cured of these diseases. Furthermore, six to 70% of adults carry the parasite that causes malaria without any ill effect.

A blood slide for malaria parasite will be positive in these people. These people have been cured of malaria after taking drugs. The K-Punch cures HIV/AIDS by repressing the HIV, making it dormant and you lead a normal healthy life with HIV in your body. Just like herpes simplex, TB or malaria.

For details on K-Punch contact Mike Moono Golden Media Agency P O Box 240548 Telefax 612476 NDOLA

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Health reforms undermined

January 12, 1999

By Goodson Machona

Lusaka - Political interference coupled with poor funding is seriously undermining the implementation of Zambia's health reform programme, said Medical Association of Zambia (MAZ) acting president Dr. Charles Ngoma yesterday.

Dr. Ngoma, commenting on the performance of the programme over the last 12 months, said the scarcity of funds had resulted in the scaling down of the drugs, medical and surgical supplies list in most hospitals.

"The other problem hampering the programme was staffing," Dr. Ngoma said.

"A recruiting exercise for consultants and specialists for all district hospitals failed to take off in May last year due to lack of funds."

He said presently the ratio of doctors to population was estimated at one doctor for every 100, 000 Zambians. And the University Teaching Hospital (UTH) which requires 396 doctors only has 231.

He explained that the programme, instituted on March 2, 1996 when the Medical Services Act of 1985 was revised and replaced by the National Services Act, was intended to improve the delivery of health care and improve operational efficiency.

"But it is bereft of direction because of political interference," he said, citing the dissolution of some district health boards by health minister Professor Nkandu Luo.

He said under the programme, district health boards are supposed to be autonomous but "the boards are appointed by the minister and naturally they have to dance to the tune of the appointing authority".

Most medical practitioners expressed misgivings at the programme with some saying they did not even know what it was all about.

"I just read about it in the newspaper," said one senior doctor at the University Teaching Hospital (UTH). "As far as I am concerned, I have not seen any changes ever since the reforms were implemented."

But government is pressing ahead with the 'reforms' and according to the latest edition of the Health Reform News, "there is a new and exciting emphasis on moving health towards achieving measurable health impact".

UTH public relations manager, Don Mwape, said there had been "some positive results" ever since the programme was started.

He cited, as an example, the referral system where UTH was only required to see patients referred from clinics and health centres as having helped decongest the hospital.

But a survey conducted by a research student from the Institute of Child Health of the University of London recently, showed that out of 51 per cent of parents who felt that the quality of health care at UTH was poor, 26 per cent of these attributed the poor quality of care to congestion. Long waiting time accounted for 8 per cent, bad staff attitude was attributed to 6 per cent of respondents while uncleanness 5 per cent and lack of drugs 4 per cent.

Poor Nutrition Stunts Zambian Children

January 7, 1999

By Mumba Mupesolo

Lusaka, Zambia (PANA) - His eyes sunken in their sockets, his bare and emaciated torso protruding, four-year-old Crispin Mwale of Lusaka's Chawama shanty compound is a typical example of a stunted child.

He is among the estimated 40 percent of stunted Zambian children as a result of chronic under-nutrition over an extended period, according to nutrition and medical experts.

According to a recent study incorporated in a report on "prospects for sustainable human development in Zambia," the rates of under-nutrition and stunting among the country's under-fives were nearly twice the levels in neighbouring states of Botswana, Lesotho and Zimbabwe.

It says the most extreme levels of malnutrition were found in the more remote Northern and Luapula regions, where more than half of under-fives are said to be stunted.

"On average 46 percent of rural children below five years are stunted as compared with 33 percent in urban areas," the report notes.

Northern and Luapula regions account for between 50 percent and 60 percent incidences of stunting overall in both urban and rural areas followed by the eastern region with 48 percent. The central region has 46 percent and northwestern region 40 percent.

The report adds that the industrialised northern copperbelt region, Lusaka, southern and western regions account for 38 percent.

A nutritionist, Maggie Muwowo, says the high incidence of stunted growth among children in Zambia was closely related with widespread early cessation of exclusive breast feeding which contributed to poor child health and slow growth.

She says there is a strong correlation between the incidence of childhood infections and poor growth during the first five years of life and especially during the first two years when the child's health is most vulnerable.

"It appears that infection may have a strong role in reducing growth since very high incidences of infections precede the high rates of under-nutrition and stunting," Muwowo adds.

Malnutrition has also been attributed to the rising levels of poverty in the country.

According to Bishop Lester Gobah, overseer of the Apostolic Faith Church in Zambia, undergrowth among children is also due to inadequate care of children by parents.

"Problems of inadequate child care are closely related to the conditions of poverty that most Zambians are experiencing, especially women," Gobah says.

Some sociologists say that poverty reduces the time and resources mothers devote to caring, including providing a nutritionally adequate diet for their children.

This is said to be more so among illiterate women whose knowledge of healthy practices of child care is limited.

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Very soon education will be a preserve for the rich (Editorial)

January 11, 1999

Lusaka - As schools open today, parents are expected to pay one levy or another. The worst hit are those with children either going into grade one, grade eight or grade 10.

Higher learning institutions have not been spared, colleges and the two universities have their own fees. Yesterday University of Zambia (Unza) Government sponsored students discovered that contrary to an earlier impression they will also pay the 200 percent increase in tuition fees.

That means they will be required to pay between K250,000 and K300,000 per each academic year compared to K100,000 before. The Unza administration has no option but to effect the fees. The two universities like other educational institutions in the country are among the organisations that are under-funded.

This is the more reason why places at Unza have been liberalised. But the fear among Zambians is that as the economy gets more depressed not many families will afford the fees, thus education will only be for the well to do. The danger with this is that the people with brains will not have access to education but those with the financial muscle.

As a result illiteracy will rise. That is not good for any nation at all. The situation is already bad. Zambia has enough uneducated people. With the new fees the situation will worsen.

It is with this in mind that Government should begin working out measures to ensure that as many people as possible get university education. One of them is to create some kind of revolving fund where bursaries can be sourced. Zambia should take a leaf from other countries where governments provide bursaries but at the end of training recipients are tracked down and money is recovered from them.

A system is worked with employers to deduct and remit to government. A similar arrangement can be devised here where all beneficiaries are traced, what is owed recovered and re-routed to a bursaries revolving fund, that way there will be funds for education and for sometime tuition fees will stabilise. The current arrangement where students get bursaries and there is no system of paying back is rather outdated and should be reviewed.

Certainly our economy cannot allow any more squeeze on parents' incomes. With the new fees many parents will fail to send children to universities, colleges or even nurses training institutions. It should be acknowledged that Zambia's long association with socialism has even worsened the situation.

Parents cannot cope and are finding difficulties to adjust to the changing times. However, any measure taken to ease the load on them would be welcome.

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Women's lobby group spent K150m on polls

January 11, 1999
by Times Reporter

Lusaka - The National Women's Lobby Group (NWLG) has spent K150m in supporting women candidates in the last local government elections as the organisation bemoaned the low women voter turn out.

NWLG chairperson Theresa Kambobe said at a press briefing in Lusaka yesterday the lobby group assisted some of the 257 women candidates in Lusaka, Central and Copperbelt provinces out of whom 67 sailed through.

The 67 represented a 300 per cent increase from the 26 women councillors elected in 1992 out of 1,275 candidates. During that period only 88 women contested the elections.

Of the councillors, 57 belonged to MMD, five UNIP, four independents and one United Party for National development (UPND). She said the lobby group helped the candidates through training, campaign and publicity.

The organisation also distributed bicycles and mealie meal to candidates. Mrs Kambobe who criticised the poor adoption system of political parties noted that out of 574 women trained by NWLG only 220 were adopted by their parties.

The problem was compounded by the fact that women themselves still believed that they could not perform as decision makers. "Although we are happy with the 67 women who have so far been elected, we are disappointed that most councils will continue to be exclusively run by men and without women's participation.

"We are also happy that women actively participated in the facilitation of the elections as presiding officers, polling officers and monitors, but we are disappointed that the turn out of women voters was very low," Mrs Kambobe said. Mrs Kambobe said the lobby group was still compiling figures to determine the exact numbers of women who voted.

She said the test case in the three provinces showed that money was a vital instrument in elections adding that as a new strategy for 2001, NWLG would have to mobilise more resources to help women candidates on a larger scale. The NWLG raised disquiet about the registration, timing of elections and the unfair use of Government resources saying that this denied candidates especially women a conducive atmosphere.

Mrs Kambobe called for intensive civic and voter education by political parties and stressed the need for parties to recognise the skills of women. She urged the Electoral Commission to engender the electoral process by tabulating the statistics, drawing comparison between sexes and age.

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Calls for Gender Sensitive Constitution in Zambia

January 18, 1999

Lusaka (AANA) - Human rights activists in Zambia are calling for a review of their Constitution and the removal of any phrases that stigmatise women.

Leading the campaign is lawyer Daisy Nkhata Ng'ambi, who caused an uproar recently when she told a human rights meeting that the terms "prostitutes" and "prostitution" should be replaced by "commercial sex workers" and "commercial sex work." Despite the fire this caused among some male delegates, the meeting resolved that the government should remove the term "prostitutes" from the Constitution and agreed that the Constitution should be gender neutral. Articles 34 and 97 were singled out for their gender insensitivity and discriminatory references, such as the use of the masculine pronoun "he".

Another bone of contention among gender activists is the Marriage Act, which has been severely criticised for lacking sensitivity and providing no room for equality.

"While Article 23(4) of the Constitution protects women against all forms of discrimination, it has also been criticised for containing derogatory remarks and references.

This means that women may be discriminated against in matters relating to marriage, divorce, devolution of property on death of a spouse or parents, custody of children, adoption, maintenance and other personal laws," says Lawyer Lillian Mushota. She adds that emphasis should shift to gender-related crime, rape and violence in the home.

Another factor cited as contributing to women's insecurity are early marriages; girls as young as seven are sometimes pledged as wives. The only condition is that the men must pay a dowry.

Women also have fewer economic opportunities, despite the fact that they provide about 80 percent of the nation's food production. There is a higher dropout rate for school girls, a high incidence of teenage pregnancies and preference for boys to girls - even when the latter are more intelligent in selection for school.

The Catholic Church has added its voice by demanding that this year's national budget be gender sensitive.

Rev. Joseph Kamakoma, Executive Secretary of the Catholic Commission for Justice and Peace (CCJP), has already made recommendations on how the budget can benefit women.

In light of all this, lawyers are demanding that the government should introduce affirmative action in the economy and include human rights issues in school lessons.

The government is also being prodded to implement conventions relating to women and children and creating a climate of equality and human rights through legal reform and training. Support for women who are in exceptionally difficult circumstances, such as widows and orphans, is also being sought.

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'Political Parties Are Not Ready For Gender Balance'

January 18, 1999

By Reuben Phiri

Lusaka - Political parties in the country are not ready for gender balancing, Non-Governmental Organisation Coordinating Committee (NGOCC) chairperson Inonge Wina has observed. Wina said NGOCC would like to express disappointment with the support given to women candidates by the various political parties in last December's local government elections.

"We are dismayed with the fact that in comparison to their male counterparts, women candidates were pushed to the women's movement for support," Wina said.

"This could be seen by non appearance of some MPs and district officials to drum up support for them."

She noted that out of 1,257 positions of councillors in the local government elections, only 220 women were adopted by political parties out of 574 who had shown interest to stand.

NGOCC has also expressed outrage at the MMD's condemnation of elections monitoring groups which observed that the elections were not free and fair due to extensive use of government resources by the ruling party.

Wina said the monitoring groups raised these issues even during the 1996 elections which have not been addressed and attributed apathy to the same problems.

She called on all women to unite and take up the challenge and control of their own agenda.

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Women gang up to fight bias

January 12, 1999
by Times Reporter

Lusaka - The Zambia Union of Financial Institutions and Allied Workers (ZUFIAW) has formed women's committees to fight against discrimination of women at work places. Zufiaw national women's chairperson Florence Daka said yesterday women were tired of being sidelined and discriminated against at work places in terms of promotion, training and even dress codes.

"While there may be no discriminatory clauses in the conditions of service, in practice, these discriminatory tendencies are rife. The reason is simple.

Most policy makers and implementers are men," Ms Daka said. She said in the financial sector, for instance, most women were not appointed to higher positions because they were too honest and normally resisted shady deals.

She also said women managers were usually removed on flimsy grounds if they were in strategic places while men would gang up to force women bosses to resign in frustration. "It is time women united in work places and supported each other even as they rise," she said.

She said it was disappointing that even female ministers such as Finance Minister Edith Nawakwi were keen to appoint male directors in their ministries disregarding women. Ms Daka said that Ms Nawakwi had appointed five managing directors in her ministry but all of them were male.

She charged that Ms Nawakwi was a let down describing her behaviour as a clear confirmation of lack of support for fellow women. "We note with disappointment that although there are a lot of qualified women in the financial sector, there is no woman managing director," she said .

Ms Daka said the women's committees to be formed by ZUFIAW in provinces and districts were aimed at eliminating all forms of discrimination, formulating policies on women and to coordinate with local and foreign women's organisations.

Zambia Views Zimbabwean Film On AIDS-Orphaned Children

February 10, 1999

LUSAKA, Zambia (PANA) - Zambia is using a Zimbabwean made film on AIDS to raise public awareness about the plight of orphans whose parents die of the incurable disease.

The film, entitled "Everyone's Child", was developed by the Zimbabwean Media for Development Trust with a view to help develop sustainable community based care of AIDS orphans in particular and HIV/AIDS victims generally. It tells the story of two children who are obliged to assume responsibilities of adulthood after the death of both their parents from AIDS.

Peter Sinyangwe of the Family Health Trust Zambian anti-aids NGO, which is coordinating distribution of the film in Zambia, told PANA Wednesday that its screening would be helpful as AIDS-orphaned children faced similar situations in Zambia and other African countries, which needed immediate redress.

"We intend that this film be seen by as many Zambians as possible to help change public attitudes towards AIDS orphans," said Sinyangwe.

The film portrays various aspects, including property grabbing and negligency of the orphans by the immediate members of the family and neighbours once their parents die of AIDS. It also depicts the desperation of the two older children of the four orphans left behind by parents who succumbed to AIDS.

One of the characters is forced to be a street kid in Harare while the girl is forced to indulge in prostitution at the risk of contracting HIV, which causes AIDS.

The climax of the story occurs when one of the younger children is burnt to death in the house after mishandling fire. This awakens the community to take note and start to care for the remaining orphans.

The Family Health Trust, which acquired the film from Zimbabwe, has described the work as a story of "love and triumph of the human spirit in the face of tragedy."

The Trust said the film has the potential of changing attitudes for the better among the African public in the wake of the increasing numbers of aids orphans in the region.

Zambian anti-AIDS activists, including the ministry of health, estimate that the country could have as many as 600,000 AIDS orphans by the year 2000.

Sinyangwe said Wednesday that the message contained in "Everyone's Child" is also intended to make the public more aware of their responsibility to meet the various needs of the AIDS orphaned population now and in the future. These include shelter, food, clothing, education, clean water, affection and love.

Zambian sociologists have of late reported of a dramatic increase in child-headed households, particularly in the urban areas where the traditional bonds of the "extended family" seem to be fast loosening.

Under traditional Zambian and African society, orphaned children become automatic responsibility of the surviving relatives of both parents or are expected to be adopted by non relatives where no immediate blood relations exist.

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Fountain Of Hope For Zambia's Street Kids

March 4, 1999

Henry Chilufya,, PANA Correspondent

LUSAKA, Zambia (PANA) - Zambia's drug-addicted street kids in Lusaka have formed "clan groups" of up to 40 members based mainly on the speciality of illicit drugs they peddle and consume.

Security officials and social workers in the city have reported that the so-called clans have caused so much animosity among the street kids that one street kid from one clan group who strays into another would be battered by the rival group for being "a foreigner."

"The kids consider it a violation of their group's 'territorial integrity' if a member of another other group trespasses. Instant justice is given in the form of physical beating there and then," a social worker, who preferred anonymity, told PANA.

According to the authorities, the greed for drugs and its control have been cited as the immediate root cause for the hostilities and rivalry between the "clans" who operate along the two-km Cairo Road, Lusaka's main thoroughfare.

John Kalumba, one of the street kids and an addict himself, recently fell victim to the instant justice syndrome for straying into 'foreign' land of other groups.

Kalumba had strayed from his own clan under the influence of glue-type drug, known as bostic, a fermentation comprising human waste called jenkin, and petrol.

He said he and his friends had turned to drug-taking as a way of escaping from "their reality."

The situation has become so frightening that the Zambian government is faced with the challenge of coming to grips with the scourge of drug abuse among the majority of the street kids, according to the Red Cross Society in Lusaka.

Edith Ngoma, a programme officer at the society working with the children at a drop-in-centre in a garden compound in Lusaka, said there are at least eight types of drugs being abused by the youngsters.

Speaking at a forum on the 50th anniversary commemoration of the Universal Declaration of Human Rights recently, she warned that unless government stepped in immediately, the battle against drug abuse among the street kids would be lost.

She cited alcohol, cigarettes, nail polish and nail polish remover, methylated spirit and marijuana as among the most popular substances consumed by the kids.

"Marijuana is the cheapest form of these drugs because it can be bought in small rolled packets for as little as 20 cents and is readily available. As for glue, it is stuffed in bottles and sniffed and is mostly bought from cobblers who are found almost everywhere in compounds and market places," Ngoma said.

Jenkin, the latest fad on the market, is said to be human waste collected from sewerage dumps. It is to be wrapped in plastics and left to ferment for seven days before sniffing it.

"The kids say they have a network of suppliers of petrol which they pour in empty soft-drink bottles or on pieces of cloth for sniffing," Ngoma said.

Drug consumption has been said to be a major form of "coping-up strategy" for the kids to survive in their harsh socio-economic environment.

"Most of the street kids also use drugs as a way to suppress hunger. Some of those we have interviewed say that they take drugs because it helps them forget about their hunger when they have no money to buy food, which is most often," Ngoma said.

According to Kalumba, drugs served as an escape route which enabled him reach a "better" world where suffering disappeared momentarily.

"The trouble starts when you begin the route back to normalcy. The nostalgia of that world settles in and compels you to sniff once more in order to return to that dream world," he said.

The children said they financed the drugs by doing odd jobs, including guarding parked cars and sometimes cleaning the vehicles along Lusaka's streets for a fee.

A prominent psychiatrist, who preferred anonymity because he dealt often with street kids, said boys who took drugs at an early age risked damaging their brain faculties beyond redemption.

"A lot of these young men end up at the Chainama Psychiatric Hospital - the largest in the country - with various mental illnesses," he added.

The Fountain of Hope, an organisation that looks after street kids in Lusaka, has begun an aggressive programme to rehabilitate the kids.

Street kid counsellor Sydney Mwape said that over 50 street kids have been taken back to their homes after being counselled by the organisation.

"The street kids who have agreed to go back home have also realised the dangers of being on the streets," Mwape told PANA.

For John Kalumba and his fellow 'clansmen', this realisation may have come at the most opportune time, indeed, with a fountain of hope for a better future.

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War, AIDS Cited As Major Drawback To Development In SADC

February 13, 1999

Mildred MUIlenga, PANA Correspondent

LUSAKA, Zambia (PANA) - The civil wars ranging in Angola and the Democratic Republic of Congo that have drawn in several other Southern African Development Community (SADC) member states have been singled as main threats to human development in the region.

A 1998 Sadc Regional Human Development Report launched in Lusaka Friday night also mentioned the high prevalence of HIV/AIDS and the economic problems as the other impediments to human development.

The report titled "Human Development and Governance in a Region in Transition" said that the post-election conflict in Lesotho and the ensuing wars in Angola and the DRC clearly showed that war constitutes a major drawback to human development and good governance in Sadc.

In Lesotho, the document said, the recent conflict erased that country's record of achievement in human development and good governance. It estimated that it would take Lesotho at least ten years to get back to where it was in human development and governance.

Military expenditure diverted a lot of resources from human development in 1998 in the Sadc region, where at least 50 percent of the member states were directly involved in war or conflict situations.

Four Sadc countries, Angola, Namibia, Zimbabwe and the DRC itself were involved in the internal war in DRC. Botswana, South Africa and Lesotho were involved in the post-election conflict in Lesotho.

Their scarce resources were diverted from education, health and other social development programmes to military hardware. The report charged that during the war situation, democratic principles are trampled upon by both the army and the government on the pretext of national security.

"Sadc should therefore re-double its effort to restore peace in the region and develop a culture of conflict resolution through peaceful means," the report said.

Besides conflict, the report also mentioned HIV/AIDS as a leading killer disease in the SADC, with Zimbabwe, Botswana and Namibia having the highest adult HIV/AIDS prevalence rates in the sub-region.

It said the impact of HIV/AIDS had began to be felt through the decline in the life expectancy by as much as ten years in some countries.

Zambia for instance, is shown to have experienced a drop in life expectancy from 54 years in 1990 to 43 years in 1995. "This has had a negative impact on that country's Human Development Index."

It said much more effort was required to confront and reverse the prevalence of HIV/AIDS bilaterally and collectively.

On the economic front, the report noted that in spite of the positive investment and continued efforts by governments to improve their human development performance, in 1995 only 64 percent of Sadc countries had Human Development Index (HDI) above 0.5.

These were Seychelles, Mauritius, South Africa, Swaziland, Namibia, Zimbabwe, Botswana, Lesotho and Angola. The rest, among which are some of the poorest countries in the world had some of the lowest HDIs globally.

The report noted that on average, some 30 percent of the Sadc population live in abject poverty with 30-40 percent of the labour force either completely unemployed or struggling within the drought-prone subsistence agriculture.

Mauritius, Botswana, Seychelles and Namibia have been cited as Sadc countries far ahead in their human development and democratic development record. Others such as Angola, DRC, Mozambique, Malawi and Zambia lagged far behind in human development and good governance performance.

The report was launched Friday by South African Foreign Affairs minister Alfred Nzo who is also Chairman of the Sadc Council of ministers at the end of the 1999 Sadc Consultative conference in Lusaka.

The 14 Sadc member states are: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

Luo's Decision To Stop Feeding Patients Appalls

February 26, 1999

By Reuben Phiri

Lusaka - The InterAfrica Network for Human Rights and Development (AFRONET) is appalled by health minister Nkandu Luo's remarks that the government is not obliged to feed patients in hospitals.

AFRONET executive director Ngande Mwanajiti yesterday said the remarks were "not only unfortunate and hypocritical, but also totally incompatible with democratic norms which the MMD had been preaching but have failed to practice".

"We find it inconceivable in the face of the white elephant Presidential Housing Initiative set up with questionable motives, that government leaders can relegate the issue of the right to life to the lower echelons," Mwanajiti said.

"We would like to remind Professor Luo that her government and ministry in particular has failed to address health problems of the country. Instead of hiding behind inadequate policies, she should be looking for solutions."

Luo told Parliament on Wednesday that the government was not obliged to give food to patients and had suspended lunch at Chikankata hospital as a measure to reduce costs.

But Mwanajiti said solutions were not out of reach if only the government could realign its resources towards more useful ventures than buying latest motor vehicles on the market for ministers. "The right to life is fundamental and it is not a gift to be handed out by government officials.

Zambians should not allow this sort of attitude to continue," said Mwanajiti.