AN ADVOCACY RESOURCE BOOK FOR HIV AND AIDS in Zambia
Across all age groups, the impact of HIV and AIDS has affected and devastated the lives of millions of Zambians. As a result both children and adults have to deal with poor health, sickness and death. Many families are overwhelmed by the social, economic and emotional costs of the epidemic.

As a nation, we can only overcome the epidemic if we all get involved. Everyone has a responsibility to join the fight against HIV and AIDS. Together, we can eliminate the transmission of the disease, provide treatment and care for the sick, and attend to the needs of the orphans and other family members affected by the loss of their loved ones. If we simply wait for others to bring solutions to our families, communities and indeed our country, the epidemic will most certainly continue to grow.

This book helps us to think about how we can tackle HIV and AIDS through advocacy. Advocacy means actions that are intended to make different institutions change or improve what they do. Institutions include formal institutions (Government, churches, newspapers) as well as non-formal institutions such as our families, communities, traditions and culture. It helps us to think about the priorities for combating HIV and AIDS in our communities, and to analyse how we can encourage the kind of actions and change that will help achieve this goal.

As one of our nation’s Traditional Leaders, I urge all Zambians to take their place in the fight against HIV and AIDS. Whether your actions are local or national, whether they focus on prevention, treatment or care for affected people; they are all necessary. For people reading this book, I hope you will find it to be a useful resource that will help you to discuss how the epidemic can be overcome, and to devise effective advocacy strategies.

HRH Chieftainess Chiya
Chiawa
August 2005
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<td>BESSIP</td>
<td>Zambia’s Basic Education Sub-Sector Investment Program</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CHAZ</td>
<td>Churches Health Association of Zambia</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DATF</td>
<td>District AIDS Task Force</td>
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<td>DDCC</td>
<td>District Development Coordinating Committee</td>
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<td>DFID</td>
<td>Department for International Development (UK government)</td>
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<td>FBO</td>
<td>Faith Based Organisation</td>
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<td>GIPA</td>
<td>Greater Involvement of People living with or affected by HIV and AIDS</td>
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<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
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<td>HBC</td>
<td>Home Based Care</td>
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<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<td>IEC</td>
<td>Information Education Communication</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>JAAIDS</td>
<td>Journalists Against AIDS in Zambia</td>
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<td>MMD</td>
<td>Movement for Multiparty Democracy</td>
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<td>MP</td>
<td>Member of Parliament</td>
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<td>NAC</td>
<td>National HIV/AIDS/STI/TB Council</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NHC</td>
<td>Neighbourhood Health Committees</td>
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<td>NZP+</td>
<td>Network of Zambian People Living with HIV/AIDS</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief (US government)</td>
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<td>PLWHA</td>
<td>People Living With or Affected by HIV and AIDS</td>
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<td>PTA</td>
<td>Parents Teachers Association</td>
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<td>SPARK</td>
<td>School, Participation, Access and Relevant Knowledge</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TALC</td>
<td>Treatment Advocacy and Literacy Campaign (Zambia)</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>THPAZ</td>
<td>Traditional Healers and Practitioners Association of Zambia</td>
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<td>TSC</td>
<td>Teaching Service Commission</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>YWCA</td>
<td>Young Women’s Christian Association</td>
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<td>ZDHS</td>
<td>Zambia Demographic &amp; Health Survey</td>
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GLOSSARY

Advocacy is targeted words and actions designed to influence the way policies are designed or implemented.

Institutions are not just formal organisations. They are systems of formal and informal rules that prescribe behaviour, constrain activity and shape expectations. Institutions include families, tribal systems and religions, as well as more conventional ‘institutions’ such as the state health service.

Mainstreaming: adapting programme work, policy and practice to take into account and reduce susceptibility of institutions and beneficiaries to HIV transmission and vulnerability to the impacts of HIV and AIDS.

Policies are more than just official statements or documents at head office, they are the impact on people of a whole series of decisions to act or not to act, intended and unintended consequences. ‘Policy is what it does, not what it says it does’.

Sexual cleansing: Sexual cleansing refers to ceremonies that take place when a married man has died, that require the widow to have sex with a nominated man, usually a relative of the deceased. The meaning is concerned with releasing the woman from her previous relationship. In some places, the ceremonies have been adapted to involve other practices that do not carry a risk of HIV infection.

NOTE ON TERMINOLOGY

The correct use of terminology and language with regards to HIV and AIDS is crucial to help fight stigma, discrimination and counter stereotypes. People who are HIV-positive or who have AIDS are often referred to by negative phrases such as ‘AIDS victim’ or ‘AIDS sufferer’. In this book we aim to use non-judgemental phrases such a ‘People living with HIV and AIDS’ (PLWHA) or HIV-positive which help counter negative stereotypes. Depending on the country, people abbreviate it to PLH, PLHA, PLWH or PLWHA.

This book uses the term HIV and AIDS, rather than HIV/AIDS as much as possible as it is important to recognise and emphasise that HIV and AIDS are two different conditions. This is particularly so when HIV is diagnosed early and positive living, treatment and care can delay or avoid the onset of AIDS for a significant time. However, names of organisations and quotes have not been changed.

This book is based on research that was carried out in the first quarter of 2005, for the National AIDS Council through a DFID funded contract with Futures Group Europe.

The research sought to establish which institutions had a significant influence on the national response to HIV and AIDS, what aspects of this impact were either positive or negative, and how the policies of influential institutions could be constructively changed to improve the national response to HIV and AIDS.

Interviews with key informants included politicians, pastors, health workers, missionaries, teachers, home based care providers and patients, journalists, community volunteers and members of various community based organisations. Focus group discussions were held in communities in two locations in Lusaka, and two rural locations. The focus group discussions interviewed old men, old women, mothers, fathers, and teenage girls and boys separately. Approximately 250 people in total participated in interviews and focus group discussions (see appendix 2).

The interviews and discussions were transcribed and analysed by the research team. The findings were used to create the situation analysis presented in this book, and as a basis for the identification of the proposed advocacy strategies.

**CREDITS**

We would like to specifically thank all 250 interviewees who gave their time and opinions to our research. Without your inputs the production of this book would not have been possible.

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1. WHAT IS THIS BOOK?

This is an advocacy resource book for individuals, community groups, People Living with HIV and AIDS (PLWHA), youth and school pupils, district level organisations, teachers associations, church groups, (local) government leaders and others concerned and wanting to make a positive contribution to the response to HIV and AIDS in Zambia.

Specifically, this book is about what influences the national response to HIV and AIDS and how we can advocate an improvement to the response. Improving the response means reducing infection, providing the best possible access to treatment, care and support, reducing stigma and discrimination that surrounds HIV and AIDS, and helping people whose lives and families are threatened by the impact of the epidemic.

Improving the national response to HIV and AIDS through advocacy is not a new idea. There have been a number of initiatives to support the development of advocacy. If you have already been involved, this book may provide an opportunity to review your advocacy objectives and strategies for achieving change. If you have not, you might consider linking up with other existing initiatives, as listed in appendix three, or starting your own advocacy efforts.

This book discusses the major institutional influences on our national response to HIV and AIDS; families, communities, culture, the education and health systems, local administration, churches, the media, and politics. It looks at what the current policies and responses are in these institutions, their strengths and weaknesses and what changes in these responses could improve the national response. The discussions are based on interviews and focus group discussions held in early 2005 with around 250 people in urban and rural areas.

We recognise that there are many views on what shapes Zambia’s national response to HIV and AIDS. The views expressed here are those of our interviewees – but this is not exhaustive and they are personal opinions, not scientific evidence. Your own views and the perspective from your community may be different. You can agree or disagree. The discussions in this book are intended to be a starting point, to help you and your friends, colleagues or group to discuss what is going on around you, and work out what you think needs to change for things to move forward.

We suggest that you go through this book section by section, using it as a basis for discussing what is happening in your household, community, district or nation. You should decide what elements of the local or national response you think are most in need of change, and how you can advocate to bring about change. When you have identified an action that you think is important, and that you think is achievable, make an action plan to carry through your ideas, and see what results you can achieve.

Don’t think that HIV and AIDS is too big, or that you are just a drop in the ocean. As Mother Theresa said, ‘the ocean is made of drops’. You can make a difference!
Zambia’s national response to the HIV and AIDS epidemic is coordinated by the National HIV/AIDS/STI/TB Council (NAC). Zambia’s HIV/AIDS/STI/TB Intervention Strategic Plan 2002-2005 provides a national framework for the response to HIV and AIDS, and is currently being reformulated to supply a framework for prevention, treatment and care priorities for 2006-2010.

Over the past two decades, Zambia has experienced a growing epidemic of HIV and AIDS. Infection rates are estimated at 15.6% for people aged 15 to 49, and 15% of children aged up to 14 have lost one or both parents. The estimated total number of Orphans and Vulnerable Children (OVC) is 1.1 million, suggesting the highest proportion of orphans in sub-Saharan Africa. The percentage of children who have lost one or both parents continues to grow.

Despite a range of interventions intended to reduce infection rates, progress in promoting consistently safe practices has been insufficient. Although levels of basic knowledge on HIV and AIDS are apparently high, many social and institutional influences dilute this knowledge, with the result that limited behaviour change takes place and new infection rates remain high.

Individual values, behaviour and choices are influenced by a range of institutions. From young children to senior politicians, the values, rules and expectations of our families, education systems, religious organisations, our government and legal system influence what we believe and how we act.

At present, many of Zambia’s institutions have policies that slow the response to HIV and AIDS. Some institutions choose to ignore the problem, whilst others have a policy of blaming the victims rather than providing help. In some cases, constructive national policies are not being implemented at community level, whilst in others promising local initiatives are not backed up by a supportive national initiative.

The NAC has recently published its Communications Strategy (2005), which presents a wide range of objectives for behaviour change and improvements in service delivery and the enabling environment. This book supports the Communication Strategy, by discussing how advocacy can support the achievement of many of its objectives.

To achieve the objectives of the Communications Strategy, influential institutions will need to adapt their current policies, creating an environment that helps people to avoid infection and provides care for people that are infected or affected. However, institutions will not change by themselves, and in many cases their policies are quite deliberate. Advocacy is needed to convince them to change.

WHAT IS POLICY?

Policy is more than just an official document or written piece of paper: it is the impact on people of a whole series of decisions to act or not to act, intended and unintended consequences. Some written policies are almost completely ignored. Some are only implemented partially. Sometimes an unofficial ‘policy’ of ignoring a situation can have a profound impact on the way people live and work.

Policy is what actually happens - not what a document says should happen. It is therefore important to look further than just at what happens at a government level (e.g. the Ministry of Education), but the need to look at what happens in reality on the ground (e.g. in the classroom).

WHO MAKES POLICIES?

The Government is perhaps the most visible policy-maker at the national level, but many other religious, inter-governmental, bilateral, non-government and civil society institutions, as well as community leaders and traditional structures have official and unofficial policies on important social, political and economic issues. For example, the policies of professional organisations such as the Medical Council of Zambia or teacher training colleges on issues including train-
ing and managing staff affect the way that services are delivered. The policies of religious institutions on whether to promote or condemn condom use have an important impact on public attitudes. Policies at all levels are directly or indirectly influenced by international policies, for example those of donors or international finance institutions such as the International Monetary Fund (IMF) or the World Bank. When deciding on an advocacy approach for policy change, it is important to understand the wider context in which policies have been developed.

WHAT IS ADVOCACY?

Advocacy is targeted words and actions designed to influence the way policies are devised or implemented. Some people think of advocacy as high-profile political lobbying by opposition parties and pressure groups. However, by far the most common, and influential forms of advocacy are lower key discussion and negotiation by colleagues, peers and between organisations that work together on similar issues. Sometimes, policies can be influenced by just holding people to account, for example by asking MPs why a problem has not been addressed, or writing letters or newspaper articles. Advocacy needs to happen throughout the policy process, from policy design down to policy implementation.

WHAT MAKES SUCCESSFUL ADVOCACY?

Lessons learned from research in Zambia and elsewhere show that advocacy is most successful:

- **When the intended audience of advocacy is successfully persuaded that the issue is important and relevant to them.**

  This means that the source of information should be trusted and the evidence used should be convincing. What makes an argument convincing depends on the individual and situation. It could be because it comes from a trusted and influential source or because targets are already aware of a problem and are keen to listen to ideas and solutions. It could be because they can see the evidence before their eyes (policymakers are also fathers, mothers, siblings etc), or it is backed up by scientific evidence.

- **When PLWHA are involved.**

  There is now widespread agreement of the importance of the GIPA (Greater Involvement of People Living with or Affected by HIV and AIDS) principle. This means that in order to increase the effectiveness of HIV and AIDS policy and programming, PLWHA need to be included at all levels of decision making in political, legal and social spheres. This also gives a sense of urgency to the mission of HIV and AIDS advocacy, as time is a luxury that many HIV and AIDS advocates do not have. Because of this, actions and strategies do not always obey the rules of the ordered and protocol driven-world of policy makers. The inclusion of PLWHA faces many challenges, including stigma and discrimination. There is also a concern that, in some instances, the involvement of PLWHA has been merely tokenistic, as their presence has been used to justify decision making.

- **When advocacy offers solutions, rather than just problems.**

  One of the problems with HIV and AIDS is that often the challenge can just seem too big. In practice, a lot of small, practical actions by a lot of different individuals and institutions would, cumulatively, have a big effect on the impact of Zambia’s response to HIV and AIDS.

- **When social norms and attitudes are understood and taken into account.**

  Understanding the dynamics of power relations, both in terms of gender and with regards to a country’s cultural and social context is crucial. This environmental context influences the policy process and outcome. Without understanding the influence of culture on a girl’s choice whether to use a condom or not, the real issues to advocate on will not have been identified. Advocating to change the social and cultural environment can often help create attitudinal shifts that shape a more conducive policy environment. Furthermore, any efforts to create a more favourable policy environ
ment for prevention and care will be impossible without addressing stigma and discrimination.

Sexuality is one of the most difficult issues in HIV and AIDS advocacy and is highly influenced by social norms and attitudes. There is, however, no question that it lies at the very basis of the epidemic in sub-Saharan Africa, and that it is changes in sexual behaviour which are producing the declines in incidence seen so far. One key lesson learned is that, in some countries, HIV prevention messages have become too closely associated with condom promotion, which then makes many leaders reluctant to even enter the debate.

• **When goals are specific and realistic and fall within the targets’ core values, expertise and day-to-day responsibilities.**

One of the most common advocacy mistakes in Zambia and elsewhere is to advocate for unrealistic or impractical changes. When mainstreaming HIV and AIDS into the Ministry of Agriculture it is unrealistic to expect technical staff to become successful HIV and AIDS educators, for example. That is not what the institution is good at. What they could do, however, is to use their ‘comparative advantage’ and design and implement food security programmes in a way that takes into account populations that are vulnerable to HIV and AIDS, or have been made vulnerable because of it. Equally, you cannot expect religious institutions to overturn deeply held principles about issues such as contraception. You can, however, find areas of common ground on issues such as home based care (HBC).

HIV and AIDS advocates sometimes expect senior politicians to become high profile, long-term advocates about social issues that are actually very controversial. Even if they are persuaded that the issue is important, only the most confident politicians will continue if it becomes clear that doing so will alienate key constituencies. Sometimes it is better to conduct advocacy to limit the negative messages, and then try to find more positive areas of common ground, such as increasing work or education opportunities for young people.

• **When networks of interested people work together to convince policy makers and implementers to change the way they think and work.**

The most successful advocates form formal and informal partnerships to work together, combining their individual technical and political strengths. At the early stages of HIV and AIDS in Zambia for example, knowledgeable but politically uninfluential technical experts linked up with first middle level then eventually senior politicians to persuade government officials to launch a response. More recently, the potentially powerful influence of PLWHA on policy and implementation has been demonstrated by organisations such as the Network of Zambian People Living with HIV/AIDS (NZP+). Networking at a regional or international level is also encouraged, as important lesson learning and best practice can be shared.

• **When a flexible approach is taken.**

Adaptability, creativity and persistence are characteristics of successful advocacy; if one strategy does not work, then try another, until the goal is reached. Adapting strategies and redefining goals is best achieved through a process of monitoring and evaluation. Enthusiasm and momentum can be discouraged if the programme focuses only on formal goals. If new, non-agenda issues arise that opinion leaders insist on taking forward, they should be encouraged, even if it means going ‘off-track’ for a while.

**HIV AND AIDS ADVOCACY IN ZAMBIA**

There have been some notable successes in HIV and AIDS advocacy in Zambia, as well as areas where there has been less success. In the early years of the epidemic, Zambia led the way in many important areas of policy. It had one of the first national communications campaigns in the world, whilst Chikankata (a mission hospital with community outreach in the Southern Province) provided a model of home based care that was picked up by many other countries. Anti-AIDS clubs were set up in schools around the country within a couple of years of HIV and AIDS first being identified, as was a roll-out training programme for voluntary testing and counselling. All this

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4 UNAIDS/GTZ (2002).
was achieved by a relatively small group of advocates, who identified an emerging problem, brought the issue to the attention of policy makers and worked with them to develop responses.

More recently, one of the most successful advocacy interventions has been with traditional leaders, who were initially targeted by advocates and then became peer advocates in their own right. Highly influential in terms of social norms and attitudes, they have been able to cause a fundamental change in the way people think about sexual cleansing, which was once a major route of HIV transmission.

A great number of challenges still remain, however. Some high level political and traditional leaders are making harmful statements about how HIV and AIDS is punishment for wrongful behaviour, increasing the stigmatisation of people with HIV and AIDS and fostering an attitude of denial. At a district level, government officials do not always implement policies, even when they are in place.

Even though it is recognised that the GIPA principle has been a key to successful advocacy and action, achieving the greater involvement of people living with HIV and AIDS has been hampered by stigma and discrimination. Achieving the full implementation of the GIPA principle is an advocacy goal in itself. Where it happens it indicates a determination to overcome stigma and discrimination, and a commitment to embedding effective action into parts of the community that most need it. It also signals a move from a charitable response – trying to help people who are at risk or already infected or affected – to a rights-based approach, which seeks to demand and secure access to diverse rights for all.

**WHAT INFLUENCES PEOPLE’S BEHAVIOUR?**

People are influenced by a variety of institutions, according to how old they are, their sex, gender-based status, where they live, what they do for a living, what they believe, the media, and who helps them to develop and to cope in times of crisis. People also exist within multiple frameworks in life – a political leader is also a parent, a sibling, a church-goer, a member of a particular family and tribe, a neighbour and community member; a child is a boy or girl, a pupil, a peer and a grandchild. Overlooking or ‘mechanising’ our approach to who people are is likely to produce unsuccessful results.

People are usually most strongly influenced by their immediate surroundings, by what they hear from friends and peers (even to a greater extent than their family) and the social norms in their locality. These (good and bad) influences can be mitigated or confirmed by the policies of local organisations including local government and leadership.

People are influenced by their personal experience. Both positive and negative life events and things that happen in the homes, amongst their family members, friends and colleagues can provide very strong opportunities for learning and behaviour change.

Messages from outside and particularly the actions of national level institutions are inevitably interpreted in this context. Information is received and will be discarded or accepted within this framework. Preventive messages on HIV are interpreted within a social framework that is often so powerful as to outweigh warnings of risk and danger. That is why external interventions that make ill-informed assumptions about the prevailing local influences may have no impact on changing behaviour.

The following figure shows the wide range of actors and institutions influencing an individuals’ behaviour.
The research process found the following institutions in Zambia to be most influential – either positively or negatively – on how people respond to HIV and AIDS. It is important to point out that these institutions do not exist in isolation, but influence and cut across one another. The discussion on the list presented here forms the content of following sections.

- The family
- Local communities and culture
- Education system
- Health sector
- District authorities
- Churches
- The Media
- Political leadership

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*Figure 1 by Hazil Slavin and Ken Swann. Presentation on Behaviour Change (2004).*
3. THE FAMILY

SITUATION ANALYSIS

Families have a significant impact on the response to HIV and AIDS. Families influence the experiences and decisions of orphans, young people, adults vulnerable to HIV infection, and people infected and affected by HIV and AIDS. Learning about HIV and AIDS at home can help young people to access information and advice easily.

However, at present young people and their parents often say that dialogue on HIV and AIDS within the family is insufficient. Parents said they would like to talk to their children, but cannot develop the confidence or strategies to talk openly. Mothers often warn their daughters at puberty to stay away from boys, mentioning the dangers of pregnancy and disease, or other unrelated threats. These threats not only damage trust-building between girls and boys and may reduce dialogue in future relationships, but also create stigma through receipt of wrong information. Many boys report that they are told very little at home, by either their mothers or their fathers.

Young people know that their parents are often not open with them, and tell them things that are not true. As a result, they may not trust what they say, and therefore lack the guidance of an adult as they develop relationships and/or become sexually active.

Poverty was often blamed for the breakdown between parents and young people. If the parents have no money, they say that children lose respect for them and ignore their advice. Community members even suggest that some parents encourage girls to find sugar-daddies in the hope that the man will provide regular financial support in the event that the girl gets pregnant.

If children are given significant responsibility at a young age, for example, trading, child-care, cooking, farming, begging, or travelling unaccompanied without adult supervision, they are less willing to listen to their parents as teenagers. They see their parents’ advice on sex and relationships as ‘interference’.

By the age of 18, approximately one-third of children have lost one or both parents, and many depend on other relatives or guardians. If dialogue between parents and children is difficult, effective communication with grandparents, uncles and aunts and other adults is even harder. Interviewees reported that this was because the relationships are weaker; there may be resentment or anger towards the late parents; the misbehaviour of the youth may be taken as confirmation of the wickedness of the parents; and there may be a greater age gap.

The views of the family have a big impact on the care of people with AIDS. Many people interviewed

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expressed fear about contracting HIV from a patient within the home. Segregation and stigmatisation within the household is common. People are very reluctant to eat with a sick person, or to sleep in the same room. Such stigmatising practices can be stopped with practical demonstration and psychological support from a trusted care-giver. Such care-givers also report the need to spend time convincing parents and family members not to condemn the sick person, or to engage in recrimination, which is especially common when the patient is an unmarried woman.

Within families, levels of basic knowledge about HIV and AIDS are generally quite high. However, accurate information is often embedded in a jumble of other beliefs and information, some of which is very unhelpful when combating HIV and AIDS. Key priority messages tend to flow into other ideas, reducing their power and influence.

**PRIORITIES FOR ADVOCACY AND POLICY CHANGE**

There are certain ‘policies’ that are common in Zambian families that can promote an effective response to HIV and AIDS, whilst others have a significant negative effect. Positive policies include the traditional respect that young people have for their parents and elders, and the culture that requires girls in particular to be modest and to avoid relationships before marriage. Zambia also has a tradition of providing care and love to patients and to orphans.

More negative factors are the lack of dialogue, mistrust (between sexes), fear and condemnation of the sick, tendencies that are under-pinned by lack of knowledge and/or a lack of skills to put knowledge into practice. Key knowledge and skills required include HIV prevention and AIDS care, building dialogue with children and young people, parenting skills (particularly in urban settings) to provide children with appropriate supervision and care.

Lack of secure and accessible livelihood strategies is also forcing parents and young people to make choices that undermine values and reduce investment in the future. Poverty affects how families respond to HIV and AIDS, by forcing people to make damaging decisions. Children are withdrawn from school; adults and young people engage in risky income generation activities such as sex work; mothers leave children unsupervised as they try to earn an income. Such choices are not easy, fuelling recriminations and resentment that further damage the family.

Different actors can help families to build positive responses to HIV and AIDS and move away from damaging or negative responses and practices. Influential people on families include peer groups and community groups, churches, outreach workers including health and home based care workers and teachers, NGOs and others working at community level. These ‘face-to-face’ contacts are more influential than more remote sources of information, such as media or leaflets. However, since inconsistency of messages is damaging, it is also important to include these sources in advocacy activities.

Key areas for change include:

- **Implementing poverty reduction programmes**
  Persistent poverty is a serious barrier to the prevention and treatment of HIV and AIDS. Whilst people are poor they will be vulnerable to infection, and treatment and care will be hampered by economic problems. Senior Government leaders can help to rebuild families through improving the performance of poverty reduction programmes. By targeting poor and vulnerable households, young people and people engaged in risky livelihoods, senior Government leaders can help families to invest in the future, seek opportunities for sustained improvement in their livelihoods and build aspiration and confidence in their children. These programmes also have to be implemented effectively at district and community level.

  Government has identified four key economic sectors for poverty reduction – agriculture, tourism, industry and mining – and funding to improve these sector will potentially increase. Other focal areas may also present opportunities for employment or business, including
infrastructure development, telecommunications, social service delivery, or water and sanitation. Look at opportunities in each of these sectors in your region: have you got any potential activities in these areas? What will work? Who can you present your ideas to? How can you involve and how do these areas impact on PLWHA? Do not wait for someone to bring poverty reduction to you; insist on involving yourself from the very beginning.

Successful advocacy depends on a good analysis of how poverty can be reduced in your area. Try to be specific in your advocacy work, and show what the results can be. When you request for credit and loans for business development, give figures to show what you can do with that business, and how it will help your family, group or community. When you request for a pay increase, show what your household costs and obligations are, and how an increment will make a difference.

• Strengthening families
The strength of family relationships is critical in combating HIV and AIDS. Making sure that children are well brought up, with a clear commitment to high moral standards, hope for the future, and strong support from home, can help protect them from HIV infection.

Strong families start even before marriage. Understanding your spouse, agreeing on how your children should be brought up, and setting a good example in your own life should be the priorities of all husbands and wives. Churches and community-based organisations (including women’s groups) are developing programmes to build parenting skills and to improve dialogue and trust in families. Improved parenting skills will establish dialogue and ensure appropriate supervision of children from a young age.

If you think stronger families and improved parenting will help in combating HIV and AIDS in your community, try to identify an institutional home. Often, churches are most appropriate because people are happy to accept teaching of this nature from their church.

In some places, groups of churches work together for the implementation of social programmes. Talk to the church leaders, share your views, and see how you can move forward on this.

• Caring for orphans and vulnerable children.
Helping families to support dependent orphans will improve the care and guidance that they receive from the households where they live. Interventions by NGOs and churches, often supported by donors, have focused on income generation, school attendance and psychosocial support. Where these three activities are combined, the economic and emotional well-being and health of all members of the household improves.

There are many communities in which these activities are present – but others where there are not. If you find yourself unable to locate such a programme, why not try to get one started? You can look around for NGOs, and ask them how they are supporting communities and families caring for OVC. Or link up with your church; many of the best initiatives are run by churches who have the advantage of being truly embedded in the community.

Once you have found an initiative, try to help build the activities they engage in. If there is an income generation programme, does it target widows and families caring for OVC? Does it provide training and group activities to help ensure business success? Does the programme address all household needs, and include psychosocial support? Why not examine the programmes being undertaken, and make suggestions that will create a more prosperous outcome.
4. LOCAL COMMUNITIES AND CULTURE

SITUATION ANALYSIS

Communities and culture have a significant effect on how people respond to HIV and AIDS. Some elements of Zambian culture are deeply traditional, whilst (in urban areas in particular) others are much more modern. Whether traditional or modern, culture and community life is governed by unwritten ‘policies’ that shape many aspects of peoples lives and relationships. This section reviews some of the features of Zambian communities and culture that have the greatest impact on the response to HIV and AIDS. It starts with a brief overview of gender issues in relation to HIV and AIDS as this cuts across many of the sections of this chapter.

GENDER ISSUES AND HIV AND AIDS

Apart from women’s physically higher vulnerability to infection with HIV, cultural and traditional beliefs put women in roles and situations that expose them to increased susceptibility. In their role as mother and carers, women are often economically dependent on their partners, which can make it hard to insist on safe sex. Culturally, men make the decision on sex and women fear or experience violence if they refuse sex with their partners. Women in poverty also engage in transactional sex in exchange for goods or services. Also, poverty can lead to reduced nutrition and thus lower immune systems. All this, as well as lower access to information on HIV and AIDS, rights and reproductive health due to literacy rates, are generally seen as factors that make women more vulnerable and at risk of HIV infection than men.

Men, in turn, take pride in their masculinity, and culture fosters this behaviour. Having multiple partners is often encouraged, as it demonstrates the virile, macho stereotype. However, the decision making power with regards to health budgets, as well as with regards to sex puts men into vulnerable situations as well. It is crucial to recognise that any response to HIV and AIDS should involve both men and women together, as gender dynamics always come into play.

These general findings with regards to gender and HIV and AIDS are confirmed by various research documents relating to Zambia which show that:
- Women in Zambia are more likely to be HIV positive than men (18% versus 13%)\(^9\).
- Men are twice as likely as women to seek treatment for STDs;
- To enhance male pleasure, a number of women continue to practice dry sex, which can increase vulnerability to infection through exposing genital organs to bruising and cuts;
- Women are taught never to refuse having sex with their husbands, regardless of the number of partners he may have or his non-willingness to use condoms, even if he is suspected of having HIV or any other STD;
- Exchange of sex for money or gifts is treated as a coping strategy for dealing with poverty and not perceived as commercial sex work.

RELATIONSHIPS

Modern times have seen an increase in boyfriend/girlfriend relationships. Relationships between peers may be cited as a way of seeking a spouse, although in other cases this prospect is not very serious. Having a girlfriend or boyfriend may be a matter of social prestige amongst peers, or of ensuring sexual activity. However, the risks of boyfriend/girlfriend relationships are exacerbated by the fact that a girl’s family usually ignores any relationship with a boyfriend, and actively avoids meeting the partner until the couple wishes to marry or the girl gets pregnant. This means that parents do not advise their children, or reassure themselves that their child is developing a relationship with a suitable partner.

SEX AND PRESENTS

Many men give presents to their girlfriends as a token of love and respect. In Zambia, such presents are normal, and would wrongly be interpreted as ‘payment’ for sex. However, in some cases sex is offered in exchange for money or presents. This form of relationship is


referred to as ‘transactional sex’. Many relationships today are said to involve a degree of transactional sex, although these reports are highly subjective. Women are socially stigmatised for engaging in transactional sex, whilst men are considered natural predators, and such behaviour often thought to be regrettable, but understandable.

Relationships between older men (‘sugar daddies’) and younger women are also prevalent (in urban areas in particular). Men may believe that younger girls are less likely to be HIV+, or that they cannot be infected by a young girl. Such relationships are most likely to be transactional. Girls from poor backgrounds are particularly likely to seek such an arrangement, and some suggest that parents even encourage them to do so. However, the ‘sugar daddy’ phenomenon is heavily criticised by community members and observe that such relationships usually end badly for the girl. The ‘sugar daddies’ phenomena has contributed to the disparity in HIV prevalence rates between boys and girls aged 15-19, which is 1.9% and 6.6% respectively. For the 20-24 age group prevalence for men is 4.4% where as for women it has increased to 16.3%\footnote{ZDHS 2001-2002 (2003)}.

The word ‘prostitution’ is used broadly in Zambia. Its meanings include commercial sex workers, transactional sex/relationships, and women who go to bars, dress scantily, or behave in a manner that is not modest and retiring. In urban areas, prostitution (in its narrower form) is said to be on the increase, due to the lack of jobs and high levels of poverty. Reducing prostitution is seen to lie in developing opportunity and hope amongst young women, whilst further HIV and AIDS awareness and condoms promotion is generally seen as a waste of time, as it is believed that the women concerned already know enough but choose to ignore it.


**POVERTY AND CULTURAL BREAKDOWN**

Poverty and the lack of employment opportunities is specifically identified as a major cause of HIV and AIDS, and as a significant reason for the breakdown of social practices in many communities.

Many problems are attributed to changing standards of dress. Modern fashions including low-cut jeans and skin-tight trousers, which are contrary to traditional expectations, are perceived to deliberately invite sexual attention. Many older people say that Government should ban such clothing.

There is an overall perception that traditional culture has gone, especially in urban areas, and that what has replaced it is highly destructive. Many comments were made that suggest this ‘new culture’ is a western, foreign way of doing things, which has taken over in Zambia. It is perceived to have no bounds or limits to what is acceptable, and leaves a sense of bewilderment amongst many older people.
High levels of stigma are apparent against people affected by HIV, and by conditions closely linked to HIV. Patients, their families and orphans all experience stigmatisation at some stage. The origin of stigma towards HIV is linked to its sexual transmission, and association with immorality and promiscuity. The threat of stigma means some people resist seeking treatment, preferring to hide their condition.

In urban areas, stigma is often in the form of psychological abuse from within the community. Name-calling and judgemental accusations are common, creating feelings of shame and humiliation. In rural areas, families and neighbours are often emotionally kinder to those who are ill, but may be forced by poverty to take more brutal decisions such as withdrawing food from patients.

INITIATION

Many Zambian girls undergo an initiation ceremony when reaching puberty. These ceremonies vary from tribe to tribe. In some places the instruction is focused on social roles, whilst in others the initiation is more explicit in teaching about sex and sexual technique. Some expect the girls to go through a ‘first sex’ experience after the ceremony, and in places a cousin or other partner is nominated for this. In some areas, boys also go through initiation. Amongst some tribes, this also includes a ‘first sex’ experience.

Girls undergoing initiation are taught for some days by old women, known as alangizi. In rural areas, it is more likely that the alangizi will be a relative or local woman who sometimes carries out these duties.
In urban areas, the alangizi are women who regularly conduct these ceremonies as their job. In Lusaka, the girls and women interviewed said that prevailing practices amongst alangizi were often very explicit, rather rough, and sometimes even cruel.

There are three key concerns about the current practices of alangizi. Firstly, girls are reaching puberty at an increasingly younger age. This means that girls as young as 11 and 12 are being taught a lot about sex. It is believed that this will tempt girls into practicing what they have been taught.

Secondly, it is feared that girls will be preyed upon when they finish their initiation, especially when they have danced in public. Traditionally, this would attract marriage proposals, but men may simply talk girls into a sexual relationship, posing risks of pregnancy and HIV infection.

Thirdly, initiation ceremonies never include any mention of HIV and AIDS or other STIs, creating a deficit in many girls' major instruction in matters concerning sex.

TRADITIONAL LEADERS

The potential of traditional leaders to promote behaviour change, reduce early marriages and address stigma is very substantial, particularly in rural areas. Over the past few years, there have been a number of initiatives that have helped traditional leaders to consider how they might address HIV and AIDS, and take action to support both prevention and care. The vast majority of traditional leaders have responded positively to these initiatives.

PRIORITIES FOR ADVOCACY AND POLICY CHANGE

The changes that have already taken place in practices and attitudes towards sexual cleansing in Zambia show that it is possible to change long-held traditional attitudes and practices. Prevailing culture and traditions in different communities can vary and these can impact on HIV and AIDS. Solutions for changing traditionally harming practices and attitudes will have to be local, and supported by traditional and community leaders, local development organisations and peers. As with sexual cleansing, traditional leaders can lead the way in changing attitudes towards what is considered acceptable, responsible behaviour.

- Reducing stigma

Stigma has a profoundly negative effect on the HIV and AIDS epidemic. It stops people from tackling the disease head on, and increases the negative impact on people affected by the disease. The first step in tackling stigma is to discuss how it works in your community, and what its effects are. Raising issues of stigma contributes significantly to overcoming it. What are the most harmful manifestations? Who perpetuates stigma, and who can help to overcome it? How can you change the attitudes and practices of those people? Make sure you involve PLWHA when deciding on how to move forward.

Tackling stigma is also the responsibility of leaders – national leaders, community leaders and traditional leaders. Advocacy can stimulate action, by demanding that leaders take active steps to overcome stigma.

For people living with HIV and AIDS, stigma is a reason to remain silent. But this is not a good strategy, because it actually honours and perpetuates stigma. The best way to destroy stigma may be to ignore it! For this to work, you need to ensure that your activities involve a cross-sector of the community, including people living with HIV and AIDS.

Every individual can help to reduce stigma by standing up to name calling and abuse. Form groups of friends or community groups to complain about insults and abuse in local courts. Ensure that you have the basic
information on HIV and AIDS on hand so that misconceptions and myths can be easier dismissed. Wear a red ribbon to show your support to those affected by the epidemic, and to show you are not afraid to talk about HIV and AIDS. It will also raise questions and start dialogues.

- **Reducing the acceptance of transactional sex.**
  At present, the fact that girls are involved in transactional sex, often with much older sugar daddies, is often being tolerated or even actively condoned. The men involved in these relationships are also usually left alone. However, by speaking out against the practice, religious and community leaders could play a role in reducing the acceptance of transactional sex.

If you think that transactional sex is a problem in perpetuating HIV and AIDS in your community, discuss this with your peer group or neighbours. How is it taking place, and who is encouraging it? Are parents aware of what is going on? Who can help to reduce it? Your analysis may lead you to identify advocacy policies with the local council (with regard to implementing the regulations on bars), with churches (who may counsel affected families), with schools (who can start awareness activities with young girls), or in groups within the affected communities (marketeers groups, workplace groups).

- **Increasing opportunities for women and young girls.**
  Reducing tolerance of sugar daddies will not solve the problem on its own. Many of the problems associated with communities and cultures in relation to HIV and AIDS concern the attitudes towards and opportunities for women and young girls. Improved access to education, skills training and employment opportunities could reduce girl vulnerability to HIV.

Young women have often been taught to be quiet and not to make demands and so may not be very forceful in expressing their needs or views. Advocacy may need to focus on ensuring that we work with young women, not merely on their behalf. We must allow young women to voice what strategies would be successful in creating hope and opportunity for their future.

When you look at activities that promote education, vocational training or income generation, ask yourself how they involve young women. Are the services, schools and other activities we find in these communities properly reflective of their needs? What do they have to say themselves? Are PLWHA involved? What do they feel would be helpful? Not only must opportunities be created to help prevent HIV, opportunities must also be created for PLWHA.

- **Reducing the risks of sexual initiation.**
  Some sexual initiation ceremonies are inappropriate and increasing young girls’ vulnerability to HIV infection. Evidenced-based dialogue with traditional leaders should encourage new practices that could perhaps start when children are older, or provide safer messages about sexual behaviour, reducing the emphasis on inappropriate sexual elements.

In town, where the alangizi are more independent of traditional leaders, changes will only come about through reducing demand for unsafe or inappropriate initiations ceremonies. Changing parents attitudes through community groups, civil society or religious organisations so that they no longer choose to send their daughters to rough or inappropriate alangizi should help to reduce the risks to young girls. Organisations involved in teaching parenting skills could ensure this topic is included in their discussions.
SITUATION ANALYSIS

Young people and adults commonly agree that schools provide an excellent opportunity to teach children of all ages about HIV. The taboo that forbids parents from talking to children about sex means that schools are potentially one of the best avenues for improving access to knowledge. Teachers are relatively well-qualified, trusted members of communities, and schools provide an entry point for a large proportion of children to receive reliable and accurate information.

The school curriculum has included sex education and HIV and AIDS awareness for many years, through science, social studies and other subjects. Official curricula are often backed up by the activities of Anti-AIDS clubs that exist in many schools. In community schools, the four-year SPARK\textsuperscript{11} curriculum covers issues of HIV in each year, in progressively more detail.

However, there are several constraints to the effective use of schools as a means of reducing the spread of HIV, and a number of challenges to overcome in order to fully utilise this potential.

SEX EDUCATION

The design and content of sex education and HIV and AIDS awareness material has been heavily affected by the conservative social views prevailing in the Ministry of Education and other influential organisations. These views state that schools are for children, and sex is for married people. HIV and AIDS education is therefore intended to inform children, but not to engage with them as people affected, at risk or even infected with HIV. These beliefs were demonstrated in 2000 when the announcement that condoms would be banned in schools was made in very strict and moralistic language. The school curriculum on HIV and AIDS is also rather narrow, focusing on transmission of HIV, rather than broader issues around stigma, respectful gender relationships or sexual violence.

Children need information earlier than curriculum planners estimate. Many girls become sexually active in their early teens, or even before, as illustrated by the high rates of HIV infection and pregnancy in the 15 to 24 age group. They may be sexually active for two or three years before they get even the most basic sex education at school.

ROLE OF TEACHERS

Teachers suffer from the same shyness and inability to talk to children about sex and HIV as parents. Just because they are trained to teach an academic subject does not mean they are comfortable to talk on such matters to children. Often they find it difficult to shift from their role as educator and discipline enforcer, to discussing social and sexual issues in a ‘youth-friendly’ way.

Teachers who run Anti-AIDS clubs volunteer for this duty and are often less reluctant to talk openly to children. However, the members of Anti-AIDS clubs are also self-selecting, and the clubs are not always popular with the children who are most vulnerable. At one secondary school visited, only 34 out of 765 pupils aged 12 to 19 years old were members of the club. Pupils found the club boring and felt it did not address their own needs and concerns. An Anti-AIDS club curriculum (called Happy, Healthy and Safe) has been developed and distributed country wide. However in many cases the curriculum did not make it beyond the Head Master’s office.

\textsuperscript{11}School, Participation, Access and Relevant Knowledge.
Through low pay, poor staffing, lack of equipment and excessive class sizes a lot of teachers are demotivated already. Being called on to spearhead HIV education creates additional demands. Teachers and pupils both suggested that improved performance in HIV and AIDS education in schools will require increased financial and technical resources.

Even though generally respected members of the community, teachers are not always thought to be trustworthy. Besides their sexual motives, teachers are accused of helping pupils cheat in examinations, frequent absences from classrooms, drunkenness, and demanding payments for after-hours ‘tutoring’ to actually teach the required curriculum. These issues are frequently discussed in communities and in the national press. Male teachers in particular are accused of making sexual advances to female pupils, leading to pregnancies and HIV infection.

Since teachers are in a position of power over their pupils many girls ‘agree’ to their demands and may suffer abuse over a long period. If the ‘relationship’ results in pregnancy, it is likely that the girl will be expelled from school\(^1\). If it is discovered through some other means, it is still very likely that she will be forced to leave school by the authorities or by her parents, or through her own discomfort.

Nonetheless, the abuse of pupils by teachers is illegal and – besides criminal law – punishable by dismissal and a life-time ban from teaching in the public sector. The Teaching Service Commission has not been active in this respect, and pupils and parents complain that school inspectors no longer tour schools to address such issues amongst teachers. Since they are not supervised, it is assumed that the temptations to abuse pupils or otherwise engage in unprofessional behaviour will continue. In Government schools, head teachers lack disciplinary authority over staff, and are equally resigned to the likelihood of such events.

Moves to decentralise school authorities have been taking place for over a decade, with the creation of school boards and District Education Boards. However, there is little evidence that parents and the local community as yet have much actual power to address these problems. The decentralisation process has devolved many responsibilities, but fewer rights and little authority over resources has been delegated.

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1. New policies exist that will give girls the right to return to school. However, they are being vigorously opposed by school boards, head teachers, PTAs and churches.
could be identified and helped to develop appropriate skills and strategies to be more effective, and to provide them with the time, space and materials to implement what they have learned. It may also be possible to team up with local PLWHAs, NGOs or health specialists who have better understanding and training of how to communicate effectively.

Opportunities for advocacy for improved support for teachers and schools exist at local and national level. At a local level, you could see what is happening in both GRZ and community schools. Is the head teacher supportive of the Government policy or obstructive? How are the teachers being trained on HIV and AIDS issues, and how are they working with pupils? Do they have access to educational materials and support for their work, or are they isolated? Is their Anti-AIDS club active, and are they registered and receiving support materials? What are their links with other programmes that may be promoting HIV and AIDS education, child counselling and psychosocial support? Is their District Education Officer or Head Master giving them any advice or encouragement?

At a national level, more resources and action are required to support teachers. There is a need to highlight the shortages in teacher availability, the need to integrate HIV and AIDS further and more appropriately into the curriculum, and the opportunity to offer much greater support through the community school system. Advocacy can help by showing how necessary these improvements are, and by creating demand for improved performance from both Government and NGOs. The role of the NAC in advocating for HIV and AIDS mainstreaming in line-ministries such as the Ministry of Education at a national level is vital.

• **Anti-AIDS clubs and youth groups**

Anti-AIDS clubs have begun to link up with businesses and community groups to provide incentives such as sports equipment and vocational training to attract more pupils, and are opening membership to out-of-school youth. Lessons about HIV and AIDS, relationships and sexual behaviour are still being taught, but in a more open, encouraging environment.

The Anti-AIDS movement needs to be refreshed and renewed. Meetings between local Anti-AIDS clubs could be used to generate new ideas, which can be suggested to the national secretariat. Effective advocacy should highlight new opportunities and strategies that will have clearly identified results. But remember that advocacy is not just a request for funding, and that you must highlight solutions that have their roots in local action and ownership. In fact, some solutions do not need financial resources at all. If you are active locally, and are able to convey your issues clearly, you are in a strong position to demand for complementary or supportive policy change and institutional support from national organisations.

• **Campaigning to end pupil/teacher relationships**

Relationships between adult teachers and young children are inherently unequal and exploitative, and send out a damaging message to young girls that their primary value is sexual rather than academic. At present, there is an unofficial policy of ignoring sexual relationships between pupils and teachers. If they are revealed, it is usually the young female who is punished rather than the adult teacher. The Ministry of Education, teacher unions, head teachers and Parent Teacher Associations (PTA) could do more to censor these types of exploitative relationship, making it clear that they are not acceptable and shifting blame away from young girls towards the adult teacher.

The Teaching Service Commission (TSC) has extensive authority to deal with teachers who transgress acceptable ethical standards. Community groups and PTAs could develop advocacy strategies to request the TSC to implement their mandate more vigorously.

Advocacy is needed to review the penal code, which
does not provide sanctions against people who abuse girls over the age of 14. Supported by a stronger legal code, you may advocate for the police, possibly through the Victim Support Unit, to become more involved in both the prevention and response to the abuse of pupils by teachers.

- **Campaigning for increased access to education**
  Apart from campaigning for better policies for those already within the education system, advocacy work related to increased access to education is also vital. In aiming to achieve education for all, vulnerability to HIV can be reduced. In 2001, a nationwide survey found that only two-thirds of primary-school-age children attended primary school and that less than a quarter of those aged 14-18 years attended secondary school. Twelve percent of all respondents said that a child in their own family did not attend school because a parent or guardian was suffering from AIDS or had died from AIDS. In 1999, the government launched Zambia’s Basic Education Sub-Sector Investment Program (BESSIP), which envisages education for all by 2015. Maybe you can find out what progress the Ministry of Education has made and what action you can take to encourage the decision makers to deliver their commitments.

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6. HEALTH SERVICES

SITUATION ANALYSIS

There are mixed views at community level about whether health staffs are approachable or not. The following quotes, from different communities, illustrate the different views:

Most clinics discriminate against AIDS patients. They are not given proper care, or given the chance to ask questions. They are asked to leave the consultation room quickly.
Home based care volunteer, Lusaka

At the clinic they welcome us properly..... They treat patients in a nice way......
Home based care volunteer, Lusaka

In contrast to the mixed views on the quality of health staff, people from all the research sites were unhappy with the quantity of resources available in Government clinics, citing a lack of beds, drugs, staff, equipment, food and so on. Mission facilities, however, were very much admired in rural areas\(^\text{14}\), even when patients from more remote areas face problems in reaching the hospitals.

In urban areas, many people use private clinics, usually seeing a Clinical Officer. The rationale for this is that the staff are politer, the queues shorter and there is more privacy. Since free drugs are often not available at the Government clinics, the cost of attending a private clinic may not be very much greater.

People in rural and urban areas seek traditional medicine for many complaints. Traditional medicine is locally accessible, and said to be very effective. However, no respondents said that traditional healers could cure AIDS, and indeed identified this lack of a traditional cure as the underlying problem with HIV infection.

The decades of work raising awareness of HIV and AIDS amongst traditional healers appears to have been helpful in reducing the numbers of false claims of cures. However, there are many other pseudo-scientific ‘remedies’ that offer dramatic effects and even cures, tempting people to abandon the health care system and spend significant sums in the hope that the promises are true.

Long ago, African medicine used to help for slimming or getting thin. But this disease that has come now is different. Even for those people that could be helped by traditional medicine can’t be helped. This AIDS virus doesn’t agree with any African medicine. So these n’gangas fail to help, and just advise you to take the patient to the clinic. You take that person to the clinic, and that is the end. You say bye-bye, and he has gone. That is the problem that we have – this disease doesn’t work with African medicine, not at all.
Old man, rural

From the Small Ads:
The Post, March 28th 2005
Fungal Infections: Beyond where others have failed. Get treated in 10 days
TB Treatment: In 28 days only.
Phone now.
Unique Remedy: Amazing Herbal Cocktail proven powerful and effective against HIV/AIDS and numerous illness

There is anecdotal evidence that some doctors and other health professionals do not adopt a vigorous pro-testing and pro-treatment approach when talking to their patients. This attitude can assist their patients to remain in denial, even when they request an HIV test. They report a number of reasons for avoiding this issue: a reluctance to become bound up in the psycho-social complications ensuing from a positive result; a reluctance to handle intimate issues in counselling; fear of losing the patient to another doctor; lack of familiarity with the technical advances in Anti-Retroviral Therapy (ART) made in recent years; a simple humane desire to avoid distressing the patient.

If a sick person goes to the clinic, the doctors just say ‘this disease you are suffering is that disease your friends are suffering from’. They won’t discuss this with you, and it makes you become depressed.
Home based care volunteer, rural

\(^{14}\) Rural missions often attract patients from town. They can be charged additional fees, but the quality of service makes the payment very much worthwhile.
PRIORITIES FOR ADVOCACY AND POLICY CHANGE

• Improving training and support to health workers

The contrasting views about whether or not health workers are approachable suggest that greater consistency is required, which would be supported through improved initial training, in-service training and regular supervision.

The possible medical responses to HIV and AIDS have changed dramatically over the past few years, and will continue to change. Doctors, nurses and health care workers need continued in-service training to update their knowledge, as well as building their capacity to deal with some of the social and psychological barriers mentioned above. New areas of expertise are constantly being generated – a recent need being that of increasing capacity to deal with children on ART. A previous programme that required attendance at in-service training sessions to fulfil annual registration requirements has ceased operating.

Advocacy demanding improved initial and in-service training may be usefully generated by medical staff themselves, supported by groups involved in health care. At a local level, Neighbourhood Health Committees (NHC) and other committees engaged with issues concerning HIV and AIDS may be able to advocate for training for themselves as well as their local health staff.

• Integration of private sector providers

Private sector providers play an important role in the provision of curative sexual health services. However, they are usually excluded from health service planning, health education, preventive services, school health and outreach programmes. Encouraging better linkages between private and public health workers would help to improve choice and access to the full range of basic health services.

Private sector doctors working on HIV and AIDS have an association in Lusaka. This group is working with the Ministry of Health to overcome some of these issues. However, their work could be strengthened by support from health user groups who could reinforce the views of patients who attend these clinics. Targets of advocacy can include District Health Boards, District AIDS Task Forces (DATF) and the Ministry of Health itself. NGO service providers should also be encouraged to engage with the private sector, to strengthen linkages and improve the quality and accessibility of services.

• Neighbourhood Health Committees & quality of health staff

NHCs can become more active in ensuring a decent and non-discriminatory service is offered to all patients. By increasing awareness of minimum standards and ethical practice, NHC members can work with health centre staff and patients to ensure consistent delivery.

By generating a local agreement on service delivery, the NHC and health centre will be able to monitor performance and set targets for future improvements. The NHC will also be able to provide assurances on standards of care and treatment to the general public, and thereby enhance confidence in accessing services.

• Continuing work with alternative medical practitioners

In line with previous work with traditional healers, continued efforts are needed to ensure that people offering herbal and other alternative cures to HIV and AIDS operate within ethical guidelines. Additional activities will help educate the public, particularly those who may consider taking such remedies, to be able to make informed judgements about the treatments they choose to accept.

The Traditional Healers and Practitioners Association of Zambia (THPAZ) advocates for good practice amongst traditional healers, and for appropriate recognition, support and training from Government and other service providers. Local groups could give their views and experiences to the THPAZ, advocating for activities and changes that would strengthen the role of traditional healers in the response to HIV
and AIDS. Encouraging local traditional healers to work with the THPAZ is another way to help develop best practice throughout all communities.

- **Rights to sexual and reproductive health services**
  
  At present, access to sexual and reproductive health services and education for young people is often dependent on the views of local service providers. If service providers have strong views on premarital sex, for example, they may deny services to young women, or refuse to distribute condoms to unmarried people. The expectation of problems or criticism may deter young women from seeking services even when they might in fact be available.

  On a national level, clearly expressed guidelines are needed to define the rights of young people to sexual and reproductive health services. These guidelines should specify ethical medical standards for service provision for young people, and define the age and status at which young people can access sex education, family planning and other services. NGOs, civil society organisations and your local groups should advocate for Government to develop, disseminate and implement these guidelines.
**SITUATION ANALYSIS**

Zambia is divided into seventy-two districts. The district is the basic unit of decentralisation, and plays a significant role in the quality of Government service delivery, and the coordination of NGOs, churches and CBOs.

District administration comprises an elected Council and Council Administration, together with the district offices of many of the national line ministries. Line ministry officers report up through their provincial officer, but are also obliged to coordinate on a local level. The head of each district administration is the District Commissioner, who is appointed by the President and mandated to oversee all district activities.

Each district has a District Development Coordinating Committee (DDCC), which is responsible for coordinating all development activities. All line ministries are members of the DDCC, together with any NGOs and churches that are deemed to be active in development in the district. The DDCC has a number of subcommittees, although some of these may vary from district to district.

The District AIDS Task Force (DATF) exists in all districts. This committee brings together all stakeholders concerned with HIV and AIDS to plan and coordinate district activities. Related but separate are other relevant committees, including the District Welfare Assistance Committee (in all districts) and the District Orphans and Vulnerable Children Committee (in around 20 districts).

If these committees work well, the quality of service delivery is expected to rise. Although it is unlikely that effective committees will access more resources, they will make better and more efficient use of the funding available in the district. Successful committees are reported to share experiences of good practice (and mistakes), and to negotiate sharing arrangements (e.g. on transport) that save time and money. Coordination and joint planning is believed to create better coverage, consistency and higher standards. Of course, where services are threatened by wholly inadequate access to resources, better coordination will not provide a full-scale solution, but can at least ensure that available resources are used to the best possible effect.

Effective committees also monitor new actors in the district. Although most new arrivals will be welcomed, there is occasional need for vigilance against the possibility of ill-motivated people. This can guard against institutions that promote misleading messages on HIV and AIDS, or exploit or abuse the interests of orphans and vulnerable children.

Committees offer an important opportunity for civil servants and NGO staff to work closely together. In too many cases, NGO staff will dismiss GRZ officials or services as useless, and even treat them with disrespect, whilst civil servants may be resentful of the well-equipped and resourced NGO staff. Tackling this problem requires close cooperation, which can have valuable results. Closer cooperation at district level should be prioritised by all institutions that work at this level.

Local government regulations provide control of many aspects of community life, which if implemented could create a less high-risk environment for HIV transmission. An example is the failure to implement regulations on bar licensing, opening hours and underage drinking. These are rarely enforced, thus leaving space for illegal bars to exist, and all bars to open and close at will. Many people, particularly in urban compounds, complain about the noise and poor behaviour that this permits.

District authorities sometimes ring-fence HIV and AIDS as a specific health problem. By not seeing the broader causes and solutions to many aspects of HIV and AIDS, the actions that are taken are unnecessarily limited. Issues such as domestic violence and child abuse could be largely dealt with inside existing legal provision if district authorities were to identify them as a priority and take concerted action.
The Decentralisation Policy (2004) presents plans for significant de-concentration of the planning and implementation authority. Once implemented, the human and financial resources that are currently lacking should become available at district level, enabling local authorities to have greater determination over development activities. However, it is likely that the planned decentralisation will take time to implement, as the cost of relocating and training staff is as yet not budgeted.

PRIORITIES FOR ADVOCACY AND POLICY CHANGE

The performance of district authorities has an impact on the national response to HIV and AIDS. Service delivery improves with increased coordination, resulting in greater knowledge about HIV prevention, better treatment and improved access to quality education.

• Increasing Government, NGO and donor commitment to coordination

Promoting better coordination depends on the policies of all institutions that need to engage in coordination. If the jobs of district based officers do not specify and prioritise their participation in district coordination, there is a risk that other activities will take precedence. This is often the case amongst international NGOs and similar projects, where officers are judged solely on their implementation of programme activities, not on their wider impact in the district. District leadership, donor agencies, and central Government are all in a good position to advocate for strengthening this policy in all NGOs and project-type organisations.

Coordination can start at district and community level, even if it is not mandated from the top. A variety of committees and initiatives exist in each and every area. Why not try to find out what each one in your area does, and see if there is benefit in greater coordination? If it is a good idea, you could use advocacy to make the advantages of your suggestions known.

• Community support for better coordination

Better coordination at district level can be supported by evidence and information from community groups and local councillors, who can provide reports of conflicting or overlapping programming, or (conversely) of the grassroots benefits of improved coordination.

Improved coordination at community level will provide information on how better service provision can be supported by districts and other service providers. Experiences at local level can inform advocacy arguments, by providing practical examples and solutions for policy change. Make sure that PLWHA are involved when discussing your plans for action.

• Implementation of local authority regulations

Local authority regulations should be implemented consistently and transparently. These include regulations governing bar opening, as well as social policy including domestic violence and child abuse. Resident Development Committees can talk to their Councillors to learn more about what local authorities regulate, and about how they can be encouraged to improve performance in this respect.

• Decentralisation

The implementation of the Decentralisation Policy depends on the commitment and resources of central Government, and of the international community. Central Government has demonstrated commitment by adopting the policy, but the harder decisions – that will involve cuts and relocation for people currently at the centre – are notoriously difficult. The international community has so far not embraced decentralisation as a priority for Zambia; although without their funding progress will be substantially delayed. Central and local Government should advocate for more support for decentralisation from the international community, by moving forward on some of the next steps required to implement the decentralisation agenda.
SITUATION ANALYSIS

Churches in Zambia have played a significant and complex role in forming the national response to HIV and AIDS. Some church policies have been very helpful, and others have not. Some results have been deliberate, and others inadvertent. A large number of people attend church regularly, and the church has an important effect on how they deal with matters concerning HIV and AIDS, sex, morality and marriage.

Churches in Zambia can be divided into two categories: the large and well-resourced ‘mainstream’ churches, and the smaller, often one-off, independent churches. The former have access to diverse sources of funding, skills, support and advice, and have established network organisations including the Churches Health Association of Zambia (CHAZ), the Expanded Church Response to HIV and AIDS, and the Zambia Interfaith Network. The latter, in contrast, may be one-man institutions, with few members, no buildings, communications, or contact with network organisations.

The response to HIV and AIDS in Zambia is also considerably impacted by Faith Based Organisations (FBOs), particularly international and local NGOs. The activities of international FBOs have expanded significantly since the inception of the PEPFAR programme, with funding expanding to tens of millions of dollars per year. Local FBOs are amongst the longest standing and best established, including the YWCA, Catholic Women’s League and Anglican Street Kids initiative.

PREVENTION

Most churches clearly emphasise that the main cause of HIV is immorality, and that by avoiding sex outside marriage, they can avoid HIV. The vast majority do not discuss any other means of reducing risk, such as condoms, as this is seen as condoning immorality. It appears highly unlikely that this position will change.

In rural areas, churches are able to work together to promote a consistent message of high moral values accompanied by factual knowledge, home based care and training for family dialogue skills. This has contributed to prevention and helped reduce stigma. However, in urban areas, where churches contradict each other and the community is heterogeneous, the positive impact of the churches on prevention is harder to identify.

Churches may inadvertently promote the spread of HIV. All-night choirs, funeral attendances and prayer vigils are cited as common opportunities for illicit sex. Churches may give out messages that are misleading, such as the many that claim that condoms cannot prevent the transmission of HIV, or that using a condom is acceptable if you make a hole in it.

Some churches have identified the need to improve parenting skills, which they believe will help in the prevention of HIV. The Seventh Day Adventists and the Salvation Army have both developed programmes to help their members to examine the changing demands for good parenting, and to identify ways to update their parenting skills.

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There is increasing concern that churches are creating fears of Satanism, which has had a negative impact on the response to HIV and AIDS. TB testing, the Blood

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15 President’s Emergency Plan for AIDS Relief – United States Government funding
Transfusion Service and VCT services have all been linked to Satanism. This belief is reinforced by the observation of the involvement of foreigners in these activities - also indicative of Satanism.

FBOs tend to focus preventive messages on abstinence and be-faithful-in-marriage messages. Combining abstinence messages with other life-skills and/or income, employment or business-oriented programmes, has increased the ambition and aspiration of participating youth, and reportedly helped to strengthen resolve to abstain. However, the refusal of many FBOs to engage with condom promotion has produced some criticism, particularly when their influence and access to resources is so significant.

**DIAGNOSIS**

When a member of church gets sick they stop being friendly and stop going to see that church member. That is the discrimination from the church members.

Rural home based care volunteer

Churches that maintain a highly moralistic position on HIV prevention may also seek to provide a generous and forgiving position on infection, helping patients to accept their condition with faith and hope. The responses of churches and members can have a significant impact on the future prospects for people who discover that they are HIV+. Through increased knowledge and consistent responses, churches can build their role as providers of care and support, and provide spiritual guidance for their members.

God is punishing them for disobedience.... because the diseases are not traditional in nature and those affected are examples of what God can do to those who disobey His commandments....

Bond et al 2003 op cit

However, some churches (particularly those that are more harsh in their beliefs) may not be very tolerant. Church members say that some churches discriminate against PLWHA, with segregation and even exclusion from church, and a lack of confidentiality from pastors. Members are therefore often reluctant to identify themselves as patients, or seek help when they are sick.

**TREATMENT, CARE AND SUPPORT**

Churches are probably the most significant source of care to patients and their families, and are of much higher and more consistent quality than GRZ services. Some, notably the Catholics but also others, are widely known for their care and kindness to the sick. They have pioneered home based care, visit the sick, help orphans and vulnerable children to access food and education, provide hospices, help with funerals, and look after widows. Whilst some churches have substantial resources to devote to these activities, others with less money still provide substantial support.

It's the Roman Catholics churches that help a lot. They go in hospitals and homes, even going to see people from other churches. They give them food and medicines. Even if you still go to your own church, they don't stop coming to see you.

Orphan girl, teenager, Lusaka

Churches offering treatment are represented through the long-established Churches Health Association of Zambia (CHAZ, formerly CMAZ)). CHAZ represents the interests of church-based service providers, and builds standards and capacity amongst its member organisations. CHAZ is a channel for Global Fund resources, and has an influential voice nationally and internationally.

Home based care (HBC) services vary from large, well-established and resourced programmes to less formal attempts to organise regular visits to patients, offering kindness and moral support. Where they exist, there is clear consensus that HBC has helped clients both physically and emotionally. They have helped families to come to terms with the difficulties of nursing a patient in the last stages of AIDS, and they have helped both patients and carers to deal with stigma both inside the household and from the community at large. HBC has promoted counselling skills in the commu-
nity, and through the experiences of their volunteers also started to develop tools for psychosocial support and child counselling. Through careful teaching, demonstration and regular monitoring, HBC workers can help relatives to care for a patient properly and safely.

A number of churches, however, are positively dangerous to people who are sick with AIDS-related illnesses. Pastors assure their members that AIDS can be cured through prayer, and that they should not take any drugs. The patient may be given water as a symbol of the medicine that may work if God wills it. Where a husband and wife have separated, they will be advised to resume their marriage, perhaps threatening a non-infected partner with HIV. The prevalence of such behaviour is hard to estimate, although many people in different parts of Zambia report similar stories.

**IMPACT MITIGATION**

Churches and FBOs have played a very significant role in responding to the wider social and economic impact of HIV and AIDS. In particular, they have had a significant influence on dealing with the growing number of orphans and vulnerable children, supporting community and family care-givers, providing direct assistance especially with food and educational needs, and providing spiritual support to both adults and children.

**PRIORITIES FOR ADVOCACY AND POLICY CHANGE**

It is important that churches are encouraged to emphasise what they are good at, and desist in areas where they are unhelpful.

- **Reducing harmful and misleading practices**

The most dangerous church policies are those that promote false information, misleading patients, people who may be at risk of contracting HIV, and frightening people who fear exposure to Satanism. The most effective way of reducing such activities is through peer support and pressure from other churches. Cooperation between churches, reaching out to the smallest churches with information and training, may help to raise awareness of the need to eliminate false information. Mainstream churches and church network organisations have a duty to participate, and to increase the capacity of small churches to intervene responsibly.

Religious groups with false and misleading information are sometimes invited to talk at schools. PTAs should encourage head teachers to vet guests carefully, and schools and other public buildings should not be made available to groups that mislead or condemn. Involving PLWHA in the vetting and in conducting these talks must be seen as good practice.

There are several ways that advocacy can help. We can advocate for churches to work together, to convince churches to desist from judgemental condemnation and spreading false information, and to request them to develop good practice in prevention, treatment and care. Advocating to churches can be done at local level, or through the network organisations that represent them. Using the various church network organisations can be a useful strategy, as churches may be more likely to be convinced by their fellow churches.

Churches have sometimes created successful results by working together on their social outreach programmes. This has the advantage of sharing capacity and promoting best practice, whilst not discriminating or grouping people by denomination. It provides a useful opportunity for churches to consider their standpoints together, and for those that are more tolerant to help others to take a less judgemental approach.

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_In some churches, if a person happens to be HIV positive, they tell that person not to drink the medicine. They tell them they must just pray. They say that the medicine does not work, because its only God can cure them. But we have seen the problem because then the HIV turns into AIDS, and the person dies._

Home based care volunteer, Lusaka
Churches

• **Incorporating factual information**
  Churches should educate members about HIV and AIDS. Besides discussing moral values, churches should promote good, factual knowledge about the virus. This practice is strong in some churches, which must help others to develop similar strategies.

Advocating for churches to provide sound knowledge on HIV and AIDS would be effectively carried out by helping the network organisations to develop policies of best practice. Network organisations have substantial credibility with their member churches, and can express arguments in favour of action effectively. Network organisations should be convinced to develop practical examples of best practice and education materials, helping to guide churches by providing accessible guidelines and direct training on how to implement the programme. Visible support to the GIPA principle will also support the reduction of stigma and discrimination.

• **Good practice in home based care**
  Home based care teams can make a significant difference to the standard of care and elimination of stigma within the home. Some churches have already adjusted policies on implementing home based care, aimed at reducing the extent to which accessing services attracts stigma. In contrast to driving nurses and nuns around communities, the new strategy uses low-key, ‘bare-foot’ community care cadres, which allows patients to access support from within the community. This approach emphasises traditional African values, and encourages communities to re-discover the value of community based care and support. Churches that have pioneered these positive developments in home based care need to document and disseminate their experiences and advocate for others to adopt similar strategies.

Churches with a good record in home based care are in a strong position to advocate for other churches to undertake similar activities. They can direct a variety of recommendations, dependent on the capacity and financial resources available to others, to ensure that interventions help families and communities to offer the best possible care to patients in their midst. If you are thinking of starting a home based care programme, or encouraging others to do so, contacting organisations with an existing good record may be a very good place to start.

• **Encouraging Voluntary Counselling and Testing (VCT)**
  Further policy changes in church policies will be needed as the ART programme is rolled out nationally. In the past, palliative care was provided to the terminally ill, and families often only sought home based care support late in the course of illness, well after the point at which AIDS could be denied. New policies are needed to persuade people to seek VCT and treatment at an earlier stage, when treatment with ARTs might be possible. HBC teams are starting to help patients on ARTs to take their drugs properly, and also to tackle problems of developing livelihoods for patients who now have much better prospects for being able to work. Appropriate policy changes should be identified by churches and health service providers, and disseminated to others seeking to establish home based care.

Advocacy for these policy changes can be led by organisations that are already offering services to people infected with HIV, including children. They are increasingly aware of the need for early testing, and frustrated by the number of patients they only see when it is already very late. However, policy change is dependent on the continued development of methods to persuade people to seek VCT, and advocacy is most effective in conjunction with the dissemination of realistic methodologies for improved practice.

• **Expanding advocacy on multisectoral HIV and AIDS issues**
  Whilst churches have played a substantial role at community level, their participation at national level in speaking about the national response to HIV and AIDS has been rather limited – a limit that is largely self-imposed. Besides debate on condoms and immorality, the churches are often quiet on other issues re-

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16 VCT serves a crucial dual role: It is an entry point to the continuum of care and is a crucial component in preventing HIV transmission.
lated to HIV and AIDS. Nonetheless, churches have a potentially significant advocacy role on responses to HIV and AIDS, which would add quality to GRZ and donor policies and practice. However, there is a tendency to avoid engaging in such activity, and therefore to isolate decision makers from the rich insights and forceful viewpoints they could otherwise express.

National stakeholders, with NAC in a key role, need to encourage the church to speak out as part of the national debate. They should advocate for the churches to become advocates! By inviting them to participate on all relevant occasions, and by seeking and incorporating their views on the response to HIV and AIDS, churches will see the value in participating in advocacy issues.
SITUATION ANALYSIS

Many of peoples’ perceptions and opinions are acquired from immediate family and peers. However, newspapers, magazines and radio programmes also have an impact – an impact that is growing as Zambian audiences gain increased access to the media.

Zambia has rich and diverse forms of media. The urban areas in particular are exposed to a range of local newspapers, FM radio stations, foreign radio and television broadcasts. Rural areas have historically been somewhat deprived, seeing only occasional newspapers and magazines outside of the district and provincial capitals. Although the Zambia National Broadcasting Corporation tries to cover the entire country, many areas have difficulty picking up its medium and short wave broadcasts. National television is relayed to most district headquarters but is not received in many villages – and anyway owning and operating a TV in the absence of mains power is expensive by rural Zambian standards. More recently rural community FM radio stations have been springing up, providing a cheap source of musical entertainment, news and discussion. However, area coverage is still very incomplete.

It is rare for media institutions – newspapers, magazines or radio stations – to have a clearly thought-out policy on HIV and AIDS. Journalists and editorial staff say they are aware of the magnitude of HIV and AIDS, and of their responsibilities in disseminating public health messages. However, they are generally unclear as to how to achieve impact. The publicly owned media – essentially the three State radios and one television service, plus two daily national newspapers – are dominated by reports on Government statements, including those on HIV and AIDS policy. This obligation certainly results in almost daily references to HIV and AIDS from ministers and other senior officials. However, stories that quote long parts of speeches are often boring, and usually ignored by readers and listeners. In fact, there is concern that anti-AIDS publicity has been overdone; that people have become habituated to it and are, if anything inclined to react by disbelieving what they hear.

With the private profit-making media the main objective is to sell news and increase circulation. Where HIV and AIDS is news, it is vigorously reported and headlined. But this may in some cases increase stigma or spread false information. For example, there have been many newspaper stories concerning the HIV status of prominent politicians, demanding they ‘admit’ their status. This tends to stigmatise HIV, by suggesting that it should force a resignation from active politics.

Some positive moves have been made to make HIV and AIDS messages both newsworthy and socially relevant. The Post runs a weekly column by a prominent anti-HIV campaigner, as well as weekly medical and social ‘agony’ columns. It has obliged its entire staff to be tested and it has frequently given space to stories concerning HIV and AIDS. Whether all this has a positive impact from a public health perspective is open to dispute, but there is no question that the Post is attempting to publish stories about HIV and AIDS that interest readers and have a positive effective on behaviour change.

Coverage of HIV and AIDS in Zambia by foreign media is relevant to knowledge and attitudes within the country. Many people watch BBC, CNN, Sky News and SABC on satellite TV. The BBC World Service is broadcast on FM in Lusaka and on the Copperbelt. The international media has made HIV and AIDS one of the biggest topics to be broadcast on Zambia, but there are concerns about accuracy. International stories about Zambia are often sensationalised and shocking, but are difficult to correct. A good example of this is the long-standing dispute over life expectancy said to be the lowest in the world. A mix-up by a correspondent in 2003 confused adult survival (further years of expected life of a 15 year old) with full life expectancy. Repeated official attempts to correct this mistake have been largely unsuccessful, and the lower figure is often reported.

The UN system makes much use of the media to promote their key advocacy messages. Tours by celebrity ‘goodwill ambassadors’ accompanied by journalists
The media

are made to draw attention to pressing social issues. However, there has been a tendency to sensationalise and exaggerate, which has resulted in horrific but false reports about the social, health and economic circumstances in Zambian communities. It is important that the international media maintain the highest professional standards in reporting bad news from Africa.

PRIORITIES FOR ADVOCACY AND POLICY CHANGE

There are several priorities for change in the media. These could be brought about by various advocacy activities. Ultimately, the media must respond to the views of its customers. As readers and listeners to privately owned media, the general public can exert a significant influence on what is reported. For state-owned media, the public can make demands through Government, as well as directly to the service provider. Organisations and groups working in HIV and AIDS can also influence the content of the media, often by helping to provide positive solutions to existing problems in content. Training, awareness raising, and challenging the media to support key campaigns are all likely to yield positive results.

- **Improve quality of media messages**
  HIV and AIDS coverage must be compelling and accurate as news or human-interest stories, and the tendency for HIV and AIDS messages to violate the principles of good advertising or good journalism avoided. Boring reports that simply copy speeches or consultancy reports or are compiled at a workshop should also be reduced. Promoting higher professional standards of journalism and encouraging greater depth in reporting would have a positive influence on their impact. Training for journalists on HIV and AIDS must therefore be adequate in terms of both factual information, as well as professional skills. Advocacy attempts can focus on ensuring media institutions develop comprehensive HIV and AIDS training policies, which include in-service training involving PLWHA or on advocating for the Media Studies curriculum to include HIV and AIDS training on language and facts. Easy access to the latest developments on HIV and AIDS treatment and care will help to improve the quality of media messages. In 2004, five media organisations teamed up to form Journalists Against AIDS in Zambia (JAAIDS) in an effort to improve HIV and AIDS media coverage. Even though it currently does not appear to be very active, JAAIDS might be a starting point for developing a more pro-active involvement from journalists in Zambia.

- **Limiting false information and stigmatising language**
  Exaggerated, sensationalised or false information and the use of prejudiced language is not conducive to reducing the spread of HIV as it demeans people and promotes stigma. However likely a story is to attract readers and listeners, if it is inaccurate or misleading it will ultimately have a negative effect. Media organisations should be helped to scrutinise all stories relating to HIV and AIDS more carefully, to ensure that each contributes to a positive outcome. This is as important for the international media as for the local media. If you find false information being reported, why not write to the editor of the media institution responsible? Or offer to organise a training session for their staff, focussing on the language and facts of HIV and AIDS?

- **Promote good practice in community radio**
  Community radio stations have the potential to be very influential on people’s knowledge of HIV and AIDS. Helping station managers and reporters to be more sensitive to good practice with respect to HIV and AIDS and to report positive human interest stories in their own communities would assist in reaching people who depend upon media in the local language.

- **Backing campaigns for policy changes**
  Newspapers could play a useful role in backing advocacy campaigns for policy changes that would have a positive effect for people vulnerable to or affected by HIV and AIDS, for example campaigning against inappropriate sexual relationships between teachers and children.
The media

- **Campaigning for increased support to independent FM stations**
  A free and vibrant media is important in any democracy, and this requires a similar regulatory framework. Even though Zambia is quite fortunate in that respect, smaller and independent FM stations often lack sufficient resources. Why not document the good practice independent stations bring to the field of HIV and AIDS in an effort to increase support?
Since the beginning of the HIV and AIDS epidemic, there has never been a time when the response has been led by a consistent high-level engagement from political leadership. Both politicians in power as well as opposition parties, at all levels, have failed to engage with HIV and AIDS effectively, and in doing so have allowed the epidemic to become entrenched throughout Zambia.

Former President Kaunda recognised HIV and AIDS early in the epidemic and confirmed that one of his sons had died as a result of AIDS. A leading campaigner now, however, at the time he was generally silent on the issue. Former President Chiluba (1991-2001) led the country through a critical period in terms of responding to HIV and AIDS, but was reluctant to engage with the issue at all. Most of his remarks concerned his strong moral position as a born-again Christian. More recently, however, President Mwanawasa and his wife Maureen Mwanawasa have both been more vocal, possibly encouraged by the advent of affordable ARTs, his closer relations with the donor community, and the increasing amounts of aid available for work addressing HIV and AIDS.

Zambian political leadership is strongly centralised, and even since the return to a democratic multiparty system, the views and priorities of the President tend to prevail. The President has a free choice of whom to appoint to Cabinet and other senior positions. The President is therefore unlikely to choose people who fundamentally disagree with him on key issues. In the event that the President is not prepared to take strong leadership with respect to HIV and AIDS, or has a distinct set of views, there will be limits to the extent to which other senior leaders can act differently. These constraints were notable in the Chiluba period, when Information Education & Communication (IEC) and other activities that discussed premarital sex or condom use were often subject to bans and criticism. Even the few senior leaders who privately supported these campaigns admit that they were nonetheless active in hampering them.

There are some notable exceptions to this; however, as Members of Parliament (MP) from both the Movement for Multi-party Democracy (MMD) and opposition parties have addressed HIV and AIDS. Hon Regina Musokatwane, a MP and a widow, led her community in obtaining VCT and talked about regularly monitoring her status. Hon Alice Simango, the recently appointed Deputy Minister for the Southern Province, gave a personal testimony at the Candlelight Memorial Service in Livingstone on the eve of World AIDS day in 2003 on her experience of losing a daughter to AIDS. Other political leaders at district level have also been active in promoting awareness and improving local responses.

A key question, therefore, is why senior national political leaders take the stances that they do?

The first influence inclines politicians to do nothing. To be elected, politicians must strive to be seen as ‘one of us’ - people with whom the electorate can identify. Leaders embody or represent the hopes and fears, and the perceptions and prejudices of the electorate. Warning people who are in denial about HIV and AIDS, even in a very logical manner, comes close to preaching at them and to alarming them. Talking about HIV and AIDS may be viewed by outsiders as a simple public health intervention, but to those addressed it tends to come across as moralising. This is especially so when methods of prevention are under discussion and even the churches hotly enter the debate. HIV and AIDS constantly threatens to alienate leadership from the populace. Only the most authoritarian leaders, with nothing to fear from this alienation, or the more inexperienced politicians, embark upon anti-AIDS campaigning.

Worldwide, politicians like to talk about problems when they can also offer solutions. Even with the advent of ARTs, the extent to which the leadership can offer solutions to HIV and AIDS is limited. In the context of poverty, people will remain at risk of infection, and their livelihoods will be sufficiently fragile to jeopardise reliable access to treatment, and therefore
Political leadership

referring to HIV and AIDS is highly likely to be a difficult subject for an elected or prospective leader.

In need of a solution to the problem of HIV and AIDS, alternative ‘fringe’ theories and cures can be irresistible to political leaders. There is at present increasing political pressure for a large number of traditional medicines to be tested for their efficacy against HIV and AIDS, and the NAC Communications Strategy (2005) states that the number of local remedies being assessed will increase from 75 to 4000 per year. This demonstrates an underlying contradiction between politicians and medical professionals: the political agenda hopes to find a ‘quick fix’ cure for HIV and AIDS, whilst the technical concern seeks to quash the claims of quack doctors.

The reluctance of political leadership to engage with HIV and AIDS means that NGOs, donor organisations and projects are unusually active in developing the plans and laying down the principles that guide the national response to HIV and AIDS. The approaches and activities of these stakeholders are not harmonised or coordinated by a clear Government policy, particularly when funding is sourced from outside. This can give the appearance that Government is sometimes a passenger in the response to HIV and AIDS.

Aware of their backseat, politicians make sporadic attempts to take the lead. However, these attempts may be piecemeal or badly thought out, and may not have the effect intended. A good example is the public HIV testing undergone in the recent past by a series of high profile political leaders. The series of tests – all negative – ultimately served to entrench stigma, as it was assumed that no one would ever admit to being HIV+. In the absence of engaged leadership of the overall response to HIV and AIDS, piecemeal actions are unlikely to be neither useful nor sufficient.

Politicians themselves are at risk of HIV, and may personally be in state of denial or fear. In a highly stigmatised environment, where no public figure has ever admitted being HIV+, MPs often seek to avoid the issue of HIV. Until recently, when treatment has become cheaper and locally available, access to ART in South Africa was the only option for senior MPs. For those who could not afford it, this might be funded through the Government discretionary budget. However, this opportunity would become a threat, as continued access to treatment and confidentiality depended on the loyalty of the individual receiving treatment.

If politicians in power have difficulty in striking a positive attitude and getting things done in the area of HIV and AIDS, the situation for opposition politicians is even more negative. One opposition political party has an HIV and AIDS education programme for its officials, and even though this is currently more like a company workplace education programme than a national intervention, it could be used as a starting point for further development into a party platform.

PRIORITIES FOR ADVOCACY AND POLICY CHANGE

It is a mistake to assume that the reason that politicians are not engaged with HIV and AIDS is that they are not aware of the extent of the problem. Thus, in looking for solutions and advocacy options, we need to identify practical strategies that will help to overcome the real reasons why their leadership and participation is inadequate.

• Build Zambian ownership

For a better national response to HIV and AIDS, it is crucial for political leaders and for the President in particular, to have a clear, credible and authoritative view on fighting the HIV and AIDS epidemic. The current situation, with its many voices, features too many contradictions for ordinary people to have any confidence in any of the messages and services on offer. The ethical tug-of-war on condoms/no-condoms is only one of the conundrums that drive politicians away from even thinking about HIV and AIDS. There needs to be a voice speaking to Zambians of the Zambian understanding, the Zambian situation, and the Zambian policy on HIV and AIDS. At present this is lacking, and so long as it continues to be lacking there are very great limits to the credibility that ordinary people will assign to HIV and AIDS education in any
other shape or form. The NAC plays a crucial process on establishing this Zambian platform, but all Zambian stakeholders have their role to play.

Zambians are more likely to be able to influence politicians than any outsiders. Outsiders are often seen to be moralising, or to be lecturing Zambians about poverty and HIV and AIDS that they themselves do not share. Truly Zambian civil society is more vocal on issues of debt and poverty, but could very usefully engage with Government to promote a better response to HIV and AIDS.

• **Promote a broader analysis of HIV and AIDS**
The political response to HIV and AIDS has often focused very narrowly on the issues of condoms and morality, which has been so controversial that they shy away from any further thoughts about HIV and AIDS. The NAC can play an important advocacy role in expanding this debate. Politicians should be encouraged to look more broadly at the issues of HIV and AIDS. Politicians must be helped to realise that improving the quality and accessibility of schools and training, giving young people access to jobs and business opportunities, and improving opportunities for women and girls will all have a profound effect on reducing the spread of HIV. For families who are affected by HIV and AIDS, considerable improvements in health care delivery, housing and environmental health, services for orphans and vulnerable children, and livelihood support for grandparents raising children and households with marginal access to labour will all have significant short and long term benefits. From this perspective, the condom debate may remain controversial, but it ceases to be the paramount or sole issue in the response to HIV and AIDS.

• **Churches can influence political leadership**
Churches can help political leaders to engage more closely with HIV and AIDS. If, as is recommended above, churches were to become more active in HIV and AIDS advocacy and policy development on a national level, their influence would help create greater ownership and engagement with HIV and AIDS.
The building blocks of advocacy are the formation of networks, the identification of political opportunities, and the organisation of campaigns. When getting involved in HIV and AIDS advocacy it is vital to ensure participation of PLWHA as well as other key stakeholders who would be impacted by proposed policy changes.

Anyone can advocate for changes in policies that will help to combat HIV and AIDS in Zambia. Even at local level, it is possible to make real changes to the environment in which young people are growing up. The following are just some examples of advocacy.

- Correcting misinformed statements from friends, colleagues or opinion-formers about what is spreading HIV and AIDS.
- Exploring with CSOs and NGOs if they can expand and adapt programmes in your area.
- Complaining to local or district authorities if you hear of adults engaged in illegal or inappropriate behaviour with young people.
- Suggesting ways of improving services from district government officials, for example by:
  - Writing letters to newspapers.
  - Organising your community group to meet the District Commissioner to present your comments and ideas.
  - Encourage community groups to arrange regular meetings with Local Councillors.

Professionals, officials and members of formal organisations have added opportunities for advocating for changes, either in their own organisation, or through influencing other organisations.

- Inviting PLWHA to raise awareness and decrease stigma within the workplace and to get involved in policy making.
- Establishing formal and informal networks with like-minded advocates to lobby for particular policy changes.
- Proactively reaching out to colleagues from your own organisation and partner organisations to identify areas for better collaboration and coordination.
- Setting out and maintaining clear guidelines for expected standards of professional behaviour and diligence.
- Reporting inappropriate or stigmatising behaviour by colleagues.
- Drawing attention to areas where organisation performance could be improved.

For further support on HIV and AIDS advocacy in Zambia, see appendix 1 and 3.

**APPENDIX I: REFERENCES AND OTHER USEFUL RESOURCES**

**REFERENCES:**

http://www.avert.org/aids-zambia.htm

BRIDGE Report no. 47, Briefing prepared for SIDA, International Development Institute, Brighton November 1998. www.ids.ac.uk/bridge


Ministry of School of Hygiene and Tropical Medicine


*Note: New plan is in preparation*


References and other useful resources


OTHER USEFUL RESOURCES:


# APPENDIX 2: FOCUS GROUP DISCUSSANTS AND INTERVIEWEES

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>GROUP</th>
<th>PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lusaka – Bauleni compound</td>
<td>Men’s group – fathers</td>
<td>FGD 8 men</td>
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<td></td>
<td></td>
<td>FGD 10 men</td>
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<tr>
<td></td>
<td>Women’s group - mothers</td>
<td>FGD 9 women</td>
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<td></td>
<td></td>
<td>FGD 8 women</td>
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<tr>
<td></td>
<td>Young men age 15 to 20</td>
<td>FGD 9 young men</td>
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<tr>
<td></td>
<td></td>
<td>FGD 10 young men</td>
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<tr>
<td></td>
<td>Young women age 15 to 20</td>
<td>FGD 9 young women</td>
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<td></td>
<td></td>
<td>FGD 8 young women</td>
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<tr>
<td></td>
<td>Home based care volunteers</td>
<td>Discussion with 3 volunteers</td>
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<tr>
<td></td>
<td>Home based care patients and families</td>
<td>Visited 2 households</td>
</tr>
<tr>
<td></td>
<td>Pastors</td>
<td>Interviews with 3 pastors</td>
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<tr>
<td></td>
<td>Teachers</td>
<td>Interview and school visit with 3 teachers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(community school)</td>
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<tr>
<td></td>
<td>Neighbourhood health committee members</td>
<td>Interview with NHC member</td>
</tr>
<tr>
<td>Lusaka – Chazanga compound</td>
<td>Men’s group – fathers</td>
<td>FGD 8 men</td>
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<tr>
<td></td>
<td>Women’s group - mothers</td>
<td>FGD 7 women</td>
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<td></td>
<td>Young men age 15 to 20</td>
<td>FGD 9 young women</td>
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<td></td>
<td>Young women age 15 to 20</td>
<td>FGD 12 young women</td>
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<td></td>
<td>Home based care volunteers</td>
<td>Discussion with 2 volunteers</td>
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<tr>
<td></td>
<td>Home based care patients and families</td>
<td>Visited 2 households</td>
</tr>
<tr>
<td></td>
<td>Pastors</td>
<td>FGD with pastors from small churches</td>
</tr>
<tr>
<td></td>
<td>Teachers</td>
<td>FGD with 6 teachers (community school)</td>
</tr>
<tr>
<td></td>
<td>Neighbourhood health committee members</td>
<td>Interview with NHC member</td>
</tr>
<tr>
<td>Mazabuka – Chikankata area</td>
<td>Men’s group - very old men</td>
<td>FGD 7 men</td>
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<tr>
<td></td>
<td>Women’s group - mothers</td>
<td>FGD 7 women</td>
</tr>
<tr>
<td></td>
<td>Young men age 15</td>
<td>Interviews with 2 young men</td>
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<tr>
<td></td>
<td>Young women age 15 to 20</td>
<td>Interviews with 3 young women</td>
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<tr>
<td></td>
<td>Home based care volunteers</td>
<td>Discussion with a community based HBC (4 people)</td>
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<tr>
<td></td>
<td>Home based care patients and families</td>
<td>Visits to 2 households</td>
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<td></td>
<td>Home based care outreach workers</td>
<td>Interview with 1 HBC coordinator</td>
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## Focus Group discussants and interviewees

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>GROUP</th>
<th>PARTICIPANTS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pastors</td>
<td>Interview with leaders of 3 churches</td>
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<tr>
<td></td>
<td>Teachers</td>
<td>Interview with 4 secondary school teachers</td>
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<td></td>
<td>Neighbourhood health committee members</td>
<td>Interview with community team leaders</td>
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<tr>
<td></td>
<td>Mission outreach workers</td>
<td>Interview with 2 community team leaders</td>
</tr>
<tr>
<td>Chongwe - Kasenga area</td>
<td>Men's group - fathers</td>
<td>FGD 5 men</td>
</tr>
<tr>
<td></td>
<td>Women's group - mothers</td>
<td>FGD 7 women</td>
</tr>
<tr>
<td></td>
<td>Young men age 15 to 20</td>
<td>FGD 9 young men</td>
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<td></td>
<td>Young women age 15 to 20</td>
<td>FGD 12 young women</td>
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<tr>
<td></td>
<td>Home based care volunteers</td>
<td>Discussion with 2 volunteers</td>
</tr>
<tr>
<td>Media</td>
<td>Journalists</td>
<td>FGD with journalists from radio and print media</td>
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<tr>
<td>National leadership</td>
<td>Politicians</td>
<td>Interviews with 3 former health ministers, and 4 other senior political leaders</td>
</tr>
<tr>
<td>National AIDS Council</td>
<td>Officials</td>
<td>Interviews with technical staff and 1 Council member</td>
</tr>
<tr>
<td>Representatives of PLWHA</td>
<td>NZP+ members</td>
<td>Participation of NZP+ in research team and reporting</td>
</tr>
<tr>
<td>District structures</td>
<td>Civic and NGO leaders</td>
<td>Discussion with 5 members of 1 District OVC stakeholders</td>
</tr>
<tr>
<td>Consideration of gender issues</td>
<td>Representative from YWCA</td>
<td>Participation of YWCA in research team and reporting</td>
</tr>
</tbody>
</table>
APPENDIX 3: WHERE TO GO FOR MORE INFORMATION

CONTACTS:

The following list shows organisations that are willing to provide information or ideas that might help you to develop your activities:

Afya Mzuri
Specialises in issues relating to HIV and AIDS in the workplace, including training, prevention, treatment and wellness programmes. Technical support to community programmes, and provision of information through resource centres. Open in Lusaka, Kitwe and Choma, and expanding further in 2005/06.
33 Joseph Mwila Road, Northmead, Lusaka
PO Box 51232, Longacres
Phone 01-232942 / 232943
Fax 01-232944
enquiries@afyamzuri.org.zm

Comprehensive HIV/AIDS Management Programme (CHAMP)
CHAMP aims to develop an enabling environment in the workplace and outreach community that addresses the needs of people affected or infected by HIV and AIDS. It supports organisations in the development and implementation of workplace policies and programmes that focus on these needs using best practice in HIV care, support and treatment literacy programmes.
CHAMP is opening offices shortly in Eastern, Central (MKushi), Copperbelt (Kitwe) and Southern
Plot 5997 Great East Road, Northmead, Lusaka
Post Net 178, Private Bag E835, Lusaka
Phone 01 295029/295041
Fax: 01 293443
champ@champ.org.zm

Copperbelt Health Education Project
Collaborates with all sectors of the community to develop knowledge, values and life skills that enable creativity, responsibility and healthy lifestyles through technical support to community based organisations and companies.
8 Diamond Drive, Martindale, Kitwe

DAPP – Hope Humana
Implementing HIV and AIDS programmes in schools, workplaces and communities in Ndola.
10 Luneta Road, Northrise, Ndola
PO Box 70505
Phone 02-640265
Fax 02-640265
hopendl@zamtel.zm

International HIV/AIDS Alliance
Providing technical and financial support to NGOs and CBOs involved in HIV and AIDS.
Plot 3020 Mosi-Oa-Tunya Road, Woodlands, Lusaka
PO Box 33796 Lusaka
Phone 01-260818 / 263088
info@alliancezambia.org.zm

Kara Counselling and Training Trust
Promoting integrated human development by providing HIV and AIDS counselling and training, caring and other related services reflecting psychosocial needs in Zambia.
Hope House, 174 Luanshya Road, Villa Elizabeth, Lusaka
2982/2 Bukavu Road, Thornpark, Lusaka
Phone 01-227085/6 / 227919
Fax 01-227087 / 227920
hopekara@zamnet.zm

National HIV/AIDS/STI/TB Council (NAC)
Statutory body established by Act of Parliament 2002, to provide leadership for a coordinated fight against HIV and AIDS and associated opportunistic infections for the benefit of society.
PO Box 36718, Lusaka
Phone 01-255044 / 255092 / 294005
Fax 01-253881
aidsec@zamnet.zm
Network of Zambian People Living with HIV/AIDS (NZP+)
Membership organisation promoting support to people living with HIV and AIDS, representing their interests and facilitating the flow of information through training, capacity building, psychosocial support, IEC and advocacy
At time of printing, NZP+ was moving offices: new contact details not known
napnzp@zamnet.zm

PANOS Global AIDS Programme
The PANOS Global AIDS Programme is a network of PANOS offices in Africa, Asia, the Caribbean and Europe, working on participation, ownership and accountability in the fight against HIV and AIDS. PANOS works with the media and other information actors to enable developing countries to shape and communicate their own development agendas through informed public debate.
PANOS Southern Africa
PO Box 39163
Plot 32A Leopards Hill Road, Lusaka
Phone 01 263258
Fax 01 261039
www.panosaids.org

SEPO Centre Community Integrated HIV/AIDS Project
Coordinating VCT, community mobilisation and home based care. Implementing peer education, VCT and workplace education programmes. Assisting support groups for people living with HIV and AIDS.
79 John Hunt Rd, Livingstone
PO Box 60545, Livingstone
Phone 03-321836
Fax 03-321836
Hope1994@zamnet.zm

The Treatment Advocacy and Literacy Campaign (TALC)
TALC is a campaigning and advocacy group lobbying for equitable and sustainable access to affordable HIV treatment in Zambia. TALC brings together a wide range of organisations including NGOs, community groups, line ministries and the UN
Contact via:
Scott Robertson – CARE International Zambia
Phone 01 221701/221710
robertson@carezam.org
or
Paul Sichalwe – ZARAN
Phone 01-229648
zaran@zamtel.zm

Youth Media
Youth Media specialises in information, education and communication for young people. The purpose is two-fold: to give young people the information they need in order to make decisions about their sexuality and to protect themselves from HIV/AIDS, unwanted pregnancies and sexually transmitted infections, and to train young Zambians aged 15-25 with media skills to enable them to actively contribute.
Plot 2398, Longolongo Road, Lusaka
P.O. Box 35767, Lusaka
Phone 01 220493 / 01 220494
Fax 01 220493
trends@zamnet.zm - www.youthmedia.org.zm

Young Women’s Christian Association (YWCA)
Promoting women’s rights, economic empowerment, appropriate technology and adolescent sexual and reproductive health.
YWCA National Council, Nationalist Road, Across from UTH Mortuary, Lusaka
P.O. Box 50115, Lusaka
Phone 01 251754
Fax 01 251754
ywca@zamnet.zm

YWCA Western Region
NAPSA Building, 5th Floor, Mongu
PO Box 910245 Mongu
Phone 07-221573
Fax 07-221573
ywcawr@zamtel.zm
Zambia AIDS Law Research and Advocacy Network
Championing the rights of people living with HIV and AIDS through research, advocacy, education, law and policy development.
5th Floor, CUSA House, Western Wing, Room 592, Cairo Road, Lusaka
PO Box 39088 Lusaka
Phone 01-229648
Fax 01-229648
zaran@zamtel.zm

Zambia Business Coalition of HIV/AIDS (ZBCA)
Facilitating the implementation of workplace programmes for the private sector, to create workplace communities that are responsive and responsible in mitigating and addressing the impact of HIV and AIDS.
4th Floor, Zambian National Commercial Bank Head Office, Cairo Road South End, Lusaka
PO Box 31026 Lusaka
Phone 01-220801
Fax 01-220802
zbc@zamnet.zm

Zambia Health Education and Communications Trust (ZHECT)
ZHECT aims to reduce the impact of HIV/AIDS in the workplace by building capacity and consensus with management and employees through providing factual information on HIV/AIDS and policy formulation.
Plot 1786, Lubambe Road, Northmead, Lusaka
Post Net 221 PB E835, Lusaka
Phone 01 223267 / 232838 / 223270
Fax 01 224038
zhect@zhect.org.zm

Zambia Interfaith Networking Group on HIV/AIDS (ZINGO)
Coordinating the faith-based response to HIV and AIDS and through a holistic and compassionate approach contribute to quality of life and reduction of new infections in the community.
Plot 5505, Msanzara Road, off Libala Road, Kalundu, Lusaka
PO Box 30360 Lusaka
Phone 01 294616
Fax 01- 294615
zingo@zamtel.zm – www.zingo.co.zm

Zambia National AIDS Network
Promoting improved coordination amongst HIV and AIDS service organisations, and providing assistance in building capacity. Coordinating civil society finding from the Global Fund.
Plot 7450 Katopola Road, Rhodes Park, Lusaka
PO Box 32401 Lusaka
Phone 01-256791/2
Fax 01-256790
znan@zamnet.zm