

A woman with dark curly hair, wearing a white patterned jacket and a white scarf, is speaking and gesturing with her hands. She is standing in front of a wall made of orange-brown bricks. In the background, a group of people, including children, are seated and listening. One child in the foreground is wearing a blue headband with white polka dots.

THIS IS WHAT HAS HAPPENED...

HIV and AIDS, women
and vulnerability in
Zambia

THIS IS WHAT HAS HAPPENED...

HIV AND AIDS, WOMEN AND VULNERABILITY IN ZAMBIA

Compiled and edited by Valerie Duffy and Ciara Regan

Photographs by Gareth Bentley

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CONTENTS

FOREWORD: Michael J Kelly SJ	4
INTRODUCTION: Valerie Duffy and Ciara Regan	7
HIV AND AIDS: Understanding the Vulnerability of Women	10
Chiku Zulu, Juliana Maleki, Florence Hagila	12
BIOMEDICAL VULNERABILITY	18
COMMENTARY: Dr Carolyn Bolton	19
Theresa Mwansa, Mate Imenda, Kelvin Sifanu	22
ECONOMIC VULNERABILITY	28
COMMENTARY: Felly Nkweto Simmonds	29
Maureen Mwape, Oliver Liseli, Nathaniel and Beauty Mulele, Eric Mubita	34
SOCIAL AND CULTURAL VULNERABILITY	42
COMMENTARY: Professor Nkandu Luo	43
Clementine Mumba, Mercy Ilitongo, Misheck Akatumwa	46
LEGAL AND POLITICAL VULNERABILITY	52
COMMENTARY: Joyce MacMillan	53
Susan Kekelwa, Godfrey Malembeka	56
EDUCATIONAL VULNERABILITY	62
COMMENTARY: Edith N'goma	63
Patricia Pumulo	66
CIVIL SOCIETY IN ZAMBIA: A RESPONSE: Women for Change	70
THE OFFICIAL GOVERNMENT RESPONSE	72
A TRADITIONAL LEADER RESPONDS: Chieftainess Mwenda	74
IRISH AID RESPONDS: Nicola Brennan	78
KEY FINDINGS	82
STATISTICAL BACKGROUND	88
BIBLIOGRAPHY	92
ACRONYMS	94



FOREWORD

HIV and AIDS is not a democratic disease. It infects selectively. It discriminates easily. It victimizes readily. It shows this in the people it infects and the communities it affects in Zambia and several of the countries of sub-Saharan Africa. Most of all, it shows its discriminatory character in its preferential option for women and girls.

This comes out in the ways the epidemic continues to have an increasing and disproportionate impact on women and girls as compared with men and boys. Zambia is experiencing a steady increase in the number and proportion of women living with the disease. Compared with boys and men, girls and women are becoming infected with HIV at younger ages and are dying at younger ages of AIDS-related illnesses. And in every area of life, women and girls are finding themselves more extensively affected by the epidemic.

A great deal has been written about this feminisation, as it is called, of HIV and AIDS. But much that is written is

not readily available or is presented in technical and academic language that does not speak to the lived situation of the reader. The real person, infected with HIV or affected in some way by the epidemic, seems to disappear. Instead, we are left with concepts, ideas, statistics, theories and models, but we lose sight of the real human person that these are all about. As a result, we often put away the book or article, agreeing with all that it says, but not affected enough within ourselves to want to do something about changing things for the better.

“The real person, infected with HIV or affected in some way by the epidemic, seems to disappear. Instead, we are left with concepts, ideas, statistics, theories and models, but we lose sight of the real human person that these are all about.”

This book is different. It presents the picture of the AIDS epidemic's preferential option for women and girls

in terms of real people from many parts of Zambia. You will read here what the disease means to farmers, nurses, teachers, traditional leaders, fishing people, former commercial sex workers, community workers and others. You will read what infected persons are saying about themselves, how they feel, how they are coping. You will read about their joys and hopes, their grief and anguish. You will come to know their courage and resilience.

You will enter into the very private lives of many of them and when you come away you will feel yourself grateful and inspired: grateful that they have shared with you on some very intimate matters that affect them deeply; inspired by the unbroken spirit and bravery that ordinary people, above all women, can show when faced with what seem to be overwhelming odds.

But you will also feel yourself angry and sad as you read about the difficulties so many of these people, nearly all of them women, experience in keeping themselves alive: heavy transport costs in getting to clinics for their medical check-ups and renewal of antiretroviral drugs; break-downs in CD4 count machines at clinics resulting in long delays before people can begin antiretroviral therapy; stock-outs of essential drugs; long queues, even for those who are quite ill; costs and sexual risks of overnight accommodation; inability to get sufficient food of the right kind to accompany their medication; having to sell a cow or a TV to pay for necessary medicines. The problems occur for everybody, but most of all for women and for those living in rural areas.

“...so many of these difficulties are rooted in the low status of women, in the systematic and intrinsic subordination of women that originates or aggravates these problems and increases women’s vulnerability to HIV and AIDS”

Running through the text you will find another theme: the way so many of these difficulties are rooted in the low status of women, in the systematic and intrinsic subordination of women that originates or aggravates these problems and increases women’s vulnerability to HIV and AIDS.

The book identifies five levels at which women and girls become more vulnerable to HIV and AIDS and their impacts. At each of these levels, the vulnerabilities are either created or magnified by the ways society organises itself or behaves. The testimonies coming from infected and affected individuals, men as well as women, provide unassailable evidence that women and girls become more vulnerable to HIV and AIDS through sexual activities that increase the risk that HIV may enter their bloodstream, the denial of their rightful

economic independence, a wide range of social and cultural practices that express their subordinate status, legal structures, provisions and practices that favour men, and practical discrimination against them in educational and career opportunities.

Perhaps the critical point in all of this is that the majority of these vulnerabilities have been socially constructed. They owe their origin to the values, attitudes and traditions developed by communities and families and passed on to children in the almost unreflecting process of socialisation. Since they have been socially constructed, they can be socially deconstructed and replaced by values, attitudes and ways of behaving that embody equality, respect and the commitment of real power to both women and men.

Hence the challenge coming from this book is to address the norms within communities that give rise to attitudes, behaviours and practices that have the effect of subordinating women and simultaneously making them more vulnerable to HIV and its negative impacts. These norms influence behaviour, not only in the sexual sphere, but across the whole spectrum of social, cultural, legal and economic life. What is needed is to change them so that they no longer manifest themselves in behaviours that are to the advantage of men and the disadvantage of women.

Unfortunately, programmes dealing with HIV seldom set out to do this. Many programmes acknowledge that existing norms are debasing and disempowering for women and degrading and destructive for men. But thereafter the approach is not concerned with changing these norms into something that better reflects the dignity of men and women alike. Rather it is concerned with how to reduce the HIV transmission risk in behaviours that arise within the framework of existing norms (which, in practice, heighten the vulnerability of women). Given the length of time it will take to transform cultures, this is necessary. But it is not sufficient. Unless something more is done, to get down to the deep roots that legitimise the risk behaviours, these will continue indefinitely. The prevention work will be never ending, because the roots of the problem continue to flourish.

This very challenging book could have been written as a narrative commentary on what the great human rights activist Jonathan Mann said a quarter of a century ago:

“The central AIDS issue isn’t technological or biological: it’s the inferior status or role of women. When women’s human rights and dignity are not respected, society creates and favours their vulnerability to AIDS”.

Perhaps the critical point in all of this is that the majority of these vulnerabilities have been socially constructed. They owe their origin to the values, attitudes and traditions developed by communities and families and passed on to children in the almost unreflecting process of socialisation.

This book presents a shocking exposé of the way society in Zambia has done just that. It has allocated an inferior status and role to women and girls and thereby has failed to respect their human rights and dignity. And by the fact of doing so, it has created and favoured their vulnerability to HIV and AIDS.

The challenge for each one of us is: can I be satisfied that it should remain so? If not, then what am I going to do about it?

Michael J. Kelly,
Luwisha House,
Lusaka
October 26th 2010

INTRODUCTION

The vast majority of us cannot even begin to imagine what our lives would be like if what has happened in Zambia as regards HIV and AIDS happened to us. This report and its accompanying photographs try to capture something of the realities of HIV and AIDS in Zambia today.

Our title was given to us by Mutonga Muketukwa from Itufa near Senanga in Western Province, who insisted that despite all that had happened to her and despite the anger of those around her ‘... *this is what has happened, and whether you like it or not, I am living positively*’. Mutonga epitomised one of the key lessons of the research– the resolve of so many women to continue with their lives and to live positively despite the devastating impact of the virus on them and on their families. What began as a chronicle of the various vulnerabilities women in Zambia face, became the story of persistence, strength, resolve and hope. While the HIV and AIDS pandemic has stripped bare many of the weaknesses and failings of Zambian society, it has also emphasised the immense potential of Zambian women, a potential as yet unrealised.

This report explicitly focuses on the vulnerability of women in five key areas as a direct result of the beliefs, values and structures in Zambian society that discriminate against women.

In compiling ‘*This is what has happened...*’, we set out to provide a representative sample of the stories behind the statistics and to give those infected and affected the opportunity to tell their story.

The stories gathered here graphically illustrate a key issue in that they focus on a series of political issues that are not unique to Zambia or indeed southern Africa. They are issues of importance the world over – issues of governance, accountability, policy making and prioritisation, service infrastructure and resourcing and the broad political landscape

upon which these issues work themselves out. They also tell a story of injustice. The injustice of economic, social, cultural, educational and political sub-ordination of women and, of necessity, it is also the story of the dominance of much that a particular definition of ‘manhood’ stands for. While women continue to bear too much of the burden of HIV and AIDS, men are at the heart of the matter – the stories make this abundantly clear. What began as a research and documentation project on women in Zambia very quickly became one about universal issues and values, which ultimately impact on each and every one of us.

Valerie Duffy and Ciara Regan

PHOTOGRAPHER

GARETH BENTLEY ADDS:

It has been my privilege to contribute through my photography. Having lived in this country all my life, I need no reminder of the dreadful hardship that the HIV and AIDS epidemic inflicts on all of Zambia’s people, and most especially her women and girls. However, faced with this reality every day, it becomes all too easy to hear the statistics, see the images, be shocked of course, even angry and then get on with our lives, still significantly detached.

It is not until you set aside the time to talk, face to face, with individual people in all walks of life, that their daily struggle simply to live, finally hits home. Hearing these intensely intimate stories of hardship and grief, of hope and joy, of battles won and lost, makes it simply impossible to ignore any longer. My goal was do my utmost to capture each person truthfully, simply and without preconception, in an image that gives some insight, even if just for a moment, into the lives of each of these very different people. It is my sincere hope that I have achieved this goal.

Lusaka, World AIDS Day 2010



IF PEOPLE STOP TAKING THE DRUGS ON THE ADVICE OF OTHERS, THEY WILL BE BROUGHT BACK TO THE CLINIC IN A WHEELBARROW OR CAR WHEN THEY GET REALLY SICK, THEN THEY DIE WE ZAMBIANS SHOULD NOT STIGMATISE OURSELVES WE NEED TO CHANGE THE WAY WE ARE EDUCATING YOUNG GIRLS HIV AND AIDS IS REAL, PEOPLE SHOULD BE SERIOUS. IT IS MORE DIFFICULT FOR THE CHILDREN BECAUSE THEY DO NOT UNDERSTAND





THEY SHOULD NOT WAIT UNTIL THEY ARE SICK
HIV IS NOT A DEATH SENTENCE

PEOPLE NEED ECONOMIC EMPOWERMENT. HIV AND
AIDS CANNOT BE REDUCED BECAUSE OF POVERTY
YOU CANNOT TELL IF SOMEONE IS POSITIVE BY LOOKING
AT THEM, SO PEOPLE MUST KNOW THEIR STATUS





HIV AND AIDS:

UNDERSTANDING THE VULNERABILITY OF WOMEN

For the greater part, this stalking of women by HIV and AIDS arises from society's unjust allocation to them of an inferior status. Were it not for the unjust treatment and exploitation that women experience, the epidemic would not have its current worldwide grip. It would not have its current stranglehold on southern Africa. Fewer men would be infected. Fewer women would be infected, and because this would reduce the incidence of parent-to-child transmission, fewer children would be infected.

Michael J. Kelly SJ (2006)

It is now undeniable that HIV and AIDS is more than ever, a devastating attack on women, most notably on women in sub-Saharan Africa - the only region in the world where, according to UNAIDS, HIV rates are higher among women than men. Of the 23 million adults currently infected in sub-Saharan Africa, 57% are women with women aged between 15 and 24 years, three times more likely to become infected than men of a similar age. This increase in the number of women and girls becoming infected at ever younger ages is now referred to as the 'feminisation of HIV and AIDS'. This reality is not simply devastating for the women affected; it impacts at a variety of fundamental levels on society in general with consequences for the future development and well-being of all.

In the initial stages of the spread of HIV, men appeared to be more infected. More recently though, it is women who have become more vulnerable, especially in countries where the primary transmission is through heterosexual intercourse. The negative impact of the virus for the lives of women is more severe than for men principally due to their subordinate status in society. In many sub-Saharan African countries, socio-cultural practices and traditions sustain women's unequal status leaving them vulnerable to poverty, discrimination and violence - and ultimately to HIV infection.

THE VULNERABILITY OF WOMEN CAN BE HIGHLIGHTED AT

FIVE FUNDAMENTAL LEVELS:

BIO-MEDICAL VULNERABILITY

Women remain biologically seven times more vulnerable to the transmission of the virus during sexual intercourse than men; cultural practices reinforce this and women's role as the primary care givers also leaves them vulnerable.

ECONOMIC VULNERABILITY

The poverty experienced by women and their economic dependence on men leaves them vulnerable often with little option but to sell themselves in order to survive or to feed their children.

SOCIAL AND CULTURAL VULNERABILITY

Certain cultural practices associated with the subordination of women to men help ensure women's vulnerability to HIV and AIDS. The practice of multiple concurrent sexual partnerships is lethal in this context.

LEGAL VULNERABILITY

While women are seen to be equal in rights to men in theory, the practice often denies this with traditional law as well as constitutional law often discriminating against women and structures and institutions routinely enforce this discrimination.

EDUCATIONAL VULNERABILITY

The ongoing challenge of ensuring female access to, and completion of, education at primary and post-primary levels contributes to the subordination of women.

66

A portrait of Chiku Zulu, a woman with dark skin and hair pulled back, wearing a white nurse's cap with a blue stripe and a dark blue vest over a white collared shirt. She is smiling slightly and looking towards the left. The background is a textured, light brown wall. Large white numbers '66' are in the top right corner.

Chiku Zulu

Chikankata

**NURSE, MOTHER,
COMMUNITY SUPPORT
WORKER, VOLUNTEER**

HIV and AIDS concerns our own lives and those of our families, children and relatives. As soon as we don't take it seriously, it affects the country as a whole ”

Chiku is a nurse working with HIV programmes in Chikankata. She is fifty years old and separated from her husband. She has four children - two girls and two boys. Her eldest is twenty and works in the laboratory in the local hospital while her second born is studying to be a mechanic. Her first daughter was born in 1990 and is training to be a secretary and her last child was born in 1996 and has just started secondary school.

Most people in Chikankata are subsistence farmers. Some grow vegetables, sugar cane, maize and ground nuts. Most people sell any excess crops they have, but most of their production is used to feed their family.

Most people locally have been sensitised about HIV, but the prevalence rate remains quite high. Chiku thinks the number of infected people is decreasing because the death rate has decreased. Chiku helped to set up what is known as the Care and Prevention Team (CPT) in order to support sick people in the community. Her work is to facilitate in the training of the Team and, when visiting patients, to support the caring itself. The CPT consults with her and reports on the local situation and on who needs to be seen by a nurse. When not involved in training, the Team travels into the community to collect information and to write reports - sometimes they go to the community for up to a week at a time. The main challenges in the community are to do with food and money. People find it difficult to support their families and children.

Chiku also does Voluntary Counselling and Testing (VCT), testing for the virus and counselling those affected. She has been for VCT herself but does not want to disclose her status.

Chiku says that the main problem in terms of medication is trying to reach the people who live a long distance from services - this is when the CPT helps as they bring the drugs directly to the people. This is not ideal however, because people still need to see the doctor. Often however, it is too far for them to travel, especially if they are bed ridden. Some CPT members have bicycles, but a lot of the time, they have to walk to the communities they serve.

Chiku believes women are more vulnerable to the virus, especially as a result of traditional customs. If you are married, you have to say yes to sex, even if you know your partner has been with other women, or has other wives. Women are also the primary caregivers which also leaves them vulnerable to infection.

“When a woman gets married, her husband pays a bride price to her relatives and this then gives him the power to demand sex at any time. In my culture, sexual issues are taboo, so you cannot talk about it. If you say no to sex because you think he has been with someone else, then he will go and find someone else to satisfy him. This brings infection into the relationship. If you ask your husband to use a condom, this often results in fights and quarrels.”

In order to avoid re-infection, Chiku encourages the use of condoms within the community, even if people are positive or are on medication. The message she has for Zambian men and women is that they need to take the issue of HIV and AIDS more seriously, because if they don't, it will only give rise to additional problems and suffering.

Juliana Meleki

Livingstone

DEPUTY HEAD TEACHER,
CARE PROVIDER



Go right away to **know your status**. If you do not know your status, you are killing yourself. ARVs prolong your life. ”

Juliana is fifty four. She is living positively with four children and is Deputy Head of the Christ the King Basic School. She was promoted in 2004 to Deputy Head and is in charge of special education, teaching braille and other subjects. She personally transcribes braille for five blind children in the school because the school has no braille machine. Juliana discovered her status in 2005. Juliana was never sick, but had herpes zoster on her left side for which she was given medication in the clinic and it went away. Subsequently, her mother came to see her and told her she had lost weight and did not look well. She encouraged her to go for VCT following which Juliana was told she was HIV positive. She was obviously upset but she said God had put her in this situation, so she must accept it.

Juliana's CD4 count was too high for anti-retrovirals (ARVs), so instead she was just put on a nutrition programme. Juliana is under a lot of stress at home as she has been looking after her husband since 1998 when he became unemployed and, as a result, Juliana is the breadwinner. She had to buy the house for them. Juliana started taking ARVs in 2007 and takes one tablet per day and since starting on them, she has become physically fit and can do anything. Her sight was poor for two weeks when she began taking her ARVs, but now her sight is fine.

Her husband did not ask her how she was or about her results when she came back from VCT. Juliana told him the next day that she was HIV positive. She told him *'that this is how we have to live in this house - we either use a condom, or abstain'*. He did not respond and refuses to use a condom insisting he is negative, but she is not sure about this. So from 2005, she has been abstaining. Her children are very supportive of her - they took it well and said *'It has come. There is nothing we can do'*.

"I remember, when I went to see the counsellor, I told him that my husband was being promiscuous, so I confronted my husband saying 'you know, what you are doing is not right. You will bring that disease into the house'. Then the woman he was with died, and I said 'I told you.'"

Juliana thinks women are more vulnerable because they follow the tradition that you cannot say no to sex with your husband. Most women are not economically empowered so they end up engaging in sex for money.

Juliana was not stigmatised when she disclosed her status. She told everyone straight away including her Head Teacher. She joined a support group and told the other teachers. People asked her, how is she so courageous, but she said, *'I have to be, there is nothing I can do with the way I am. I am a happy person'*.



Women are very affected because they do not have any power within society. Men can infect more women, because they can propose to more than one woman ”



Florence Hagila Milendi, Choma

FARMER, HEALTH CENTRE VOLUNTEER, COUNSELLOR

Florence is forty. She is married with seven children, four of whom are married, two have just finished school, and one is still in school. She herself left school in Grade 10. She also has three dependents, all of whom are orphans because their parents died from HIV related illnesses. She is a farmer growing tomatoes, maize, ground nuts and sweet potatoes. She is the local chairperson of SWAAZ in her village Mulendi, volunteers at the local health centre and visits the local community areas. She instructs people on how to use things like mosquito nets and on personal hygiene and family planning. She gets condoms from the health centre and distributes them in the communities she visits.

One of Florence's main problems with the distribution of condoms was that when she gave them to women, their husbands refused to use them because they said that sex is not good when using a condom. So Florence changed her strategy. She decided to start distributing female condoms to the women instead and instructs them to put them in

before the husbands get home, and then they will not notice it. Florence is not a shy person, so it is easy for her to talk about condoms, despite the fact that many people think it is still taboo for a woman to discuss this. She says that although some people may be HIV positive, they still have sexual feelings. She encourages them to use protection to stop further spread and re-infection. She feels that she is making progress because people are more open to talking about and using condoms. Some people still have reservations, but things are changing. She has been directly affected herself by HIV because she has lost a number of family members to the disease, and cares for a number of orphans.

Florence feels that as so many people are infected, she is not sure if it is men or women who are most affected. What is important to her is the need to use condoms and to go for VCT. Women are the most significantly affected because they care most for those who are infected, and caring for orphans usually falls on them. Because women stay at home, not many of them have access to adequate information about ARVs and so on. They see their husbands taking drugs, but they do not know what they are.

Women are also very affected because they do not have any power within society. Men can infect more women, because they can propose to more than one woman.

The reason Florence went for a test was that she was involved with DAPP and they encouraged her to go for VCT. She was very scared, but she asked her husband to go with her so they could go together and find out together. They went as a couple in 2009 and in 2010 and both tested negative.

Florence received training from the Rural Health Centre where she volunteers and where she focuses on VCT especially for couples. She remembers one couple where

the man was positive and the woman was negative, and she counselled them on how to have safe sex and look after one another. This is typical of her work.

She became involved as a result of listening to a radio programme one day where a nun spoke about HIV and Florence realised that within her community, people did not have this information. She felt compelled to do something for her community, so she went to the Rural Health Centre and became a volunteer. She also helps set up support groups to work alongside the Health Centre. That was some two years ago and there are now nine support groups within the area covered by the Mulendi Neighbourhood Health Centre.

Florence visits people who are sick and who are taking ARVs. She goes to their house and helps them with some cleaning and collecting of fire wood, depending on how well that person is. She and the other volunteers offer advice and encourage people to socialise and not lock themselves away and get depressed. Sometimes they also cook for them.

“The world is cruel sometimes and that HIV and AIDS are not curable, but that it is not the end of your life. People can still have negative children if they are positive, so long as they find out how to protect their child, and follow the instructions they are given. I feel sad and angry about people who deliberately infect others.”

Despite her religious beliefs, Florence promotes the use of condoms. If people do not use condoms they will become infected and die, then there will be no one left to go to church. They are better off going to church alive and using condoms.

BIOMEDICAL VULNERABILITY

“A disproportionate number of girls and women in southern Africa are infected with HIV, with levels of infection far exceeding that of men in the region and several orders of magnitude higher than that of women in other settings.”

Helen Rees and Matthew Chersich (2008)

Physically women are more vulnerable than men to infection during sexual intercourse. Male to female HIV transmission is seven times more likely than female to male transmission - often referred to as biological sexism. This is due to the fact that the mucous membranes on the cervix of the uterus are especially vulnerable to sexually transmitted infections including HIV. In particular, the vulnerability of teenage girls is further aggravated by how susceptible their immature cervix and genital tract is to tearing, lacerations and infection during intercourse, with this risk doubling during and just after pregnancy.

Although there has been a significant increase in the number of campaigns promoting the use of condoms in order to prevent HIV transmission, research has shown that condoms are more generally used in commercial sex than in the home. The stark reality for some women is that unless they are empowered to have some degree of control in a sexual relationship, the use of a condom during intercourse will depend on the male, thus highlighting underlying gender inequality. It is widely recognised that more needs to be done in order to empower

women to take greater control of their sexuality.

Since 2005, Anti-Retroviral Drugs (ARVs) have been supplied free from clinics and hospitals across Zambia. Despite this, not all people in need of treatment are receiving it. This is due to the fact that the ‘accessibility costs’ can be very high in terms of distance (especially for those unable to afford transport or the associated food and accommodation costs) plus the length of time people have to wait (often for days) because there is no doctor or because the machine is unavailable or broken. ARVs are not always readily available from some clinics especially those in the more rural areas. If a person is bedridden or cannot afford to pay, they regularly end up defaulting on their medication. This is detrimental to the patient’s long term treatment and well being. Although some clinics have support teams to service their clients, this is not true for the majority of clinics.

Although the biological vulnerability of women does not explain the reason why women are becoming infected at younger ages, or why some women resort to selling their bodies in order to provide for themselves or their family, it is still a significant factor in the infection rates of women.

“It thus remains that the vulnerability of women due to biomedical factors is exacerbated by a deep-rooted lack of social capital, income inequality, and social and gender justice, in themselves highly important predictors of HIV.”

Helen Rees and Matthew Chersich (2008)

COMMENTARY BY
DR. CAROLYN BOLTON

At the moment people don't think about the future, they just try to get through today

The biomedical vulnerability people talk about arises because women are the receptacles. The virus is in contact with women's mucosa for a much longer time, that's the most obvious part of it plus seminal fluid has a much higher viral load, plus micro-abrasions and STIs facilitate the entry of the virus into the body. The physical breaking down of the mucous-based barrier leads to inflammation and when there is inflammation, you have CD4 cells and where you have CD4 cells you have more receptors for HIV to bind to - so inflammation itself causes risk. If a man has a sore on his penis it is easy to see and they often get treatment, and will a lot of the time refrain from sexual activity until it is gone. For women, it is inside and you cannot see it. They may not even be listened to if they say it is sore inside, nobody will listen so the sex continues.

There are also issues with early sexual debut to do with the junctions and epithelial lining at the cervical entrance - it puts girls at a higher risk. And early sexual debut can mean more sexual partners, more high risk sex, and more exposures.

ARVs are now available at most district clinics within the provinces but the care women should be getting is both pre-ARV (those who



are enrolled into care, but are not yet on ARVs but who need regular care and counselling) and post ARVs. The goal of Anti Retroviral Therapy (ART) is to suppress the virus, so that many of the complications we see in HIV patients are minimised. The virus attacks CD4 cells and the body's immunity drops causing ongoing acute inflammatory reaction, which can lead to other problems. The objective of ART is to lower the virus, which leads to an increase in CD4 count. To achieve this, we use a combination of three drugs for the basic 'first line' therapy - D4T (Stavudine), 3CT(lamivudine) and NVP (Nevirapine). It works quite well but there can be severe toxic side effects, however, it is cheap and can be taken in one tablet twice daily.

We do have some fairly low level ART clinics so the therapy can be brought to the people, but ART is not a simple thing. We have tried to simplify it for equity reasons and for accessibility but there are limits; you need people with some medical training to hand out ARVs. Some countries are using basic lay counsellors, which is fine for giving out ARVs. But to monitor patients and to decide if 'second line intervention' is needed, you do need some medical training; we need more nurses and more nurses with specialised care experience.

In the past four to five years, we have had much better drugs and have switched to ones with fewer side effects. We switched all our patients to a new first line drug. In ideal circumstances where patients respond well, where treatment is consistent and available, the first line ARVs should be good for ten to twenty years. But that is often not how it is, for instance, we have people becoming infected with primary drug resistant strains, which means the drugs don't always work, we also have malnutrition, chronic diarrhoea infections etc. so we are now seeing the drugs being effective for maybe six or seven years. Then we have to switch to second-line drugs which, in Zambia, should give patients another five to ten years of resistance. We now also have patients on third-line treatment. Cost is an issue – third line drugs are up to ten to fifteen times more expensive than first-line. In this context there also needs to be greater patient accountability.

Part of the problem is the whole 'Africa Shrug'. I was born in Africa, I am an African, but you see the shrug. Life happens, people die, people get born. It's a very accepting attitude and it has had drastic implications, particularly with HIV. Women need to be empowered and take the power and stand up, particularly with education. We cannot win with HIV unless women are empowered. It doesn't matter how many drugs we have.

Bio-vulnerability does have a role but it is not the most important thing. Ultimately, it is about women not being able to say who they have sex with and when they have sex, it's

about women not enjoying sex. On average women in Africa have sex when the men want, there is no wooing or foreplay or natural lubrication and I think that's really important, all too often it is a traumatic experience. The micro-abrasions and all the other things that come with traumatic sex make it high risk, plus the number of partners you have and the number of times and the fact that your husband isn't faithful, all of these aren't going to change unless women become empowered.

It's not all about 'poor women in Africa' – women in Africa need to stand up.

Yes they may get kicked out of their homes, but they need to fall back on some system that will allow them to be single. Because

here, you are no one until you get married. Not just here, all over Africa you are defined by your marriage. Society is not ok with single women in Zambia and I think that is the fault of both men and women. We need to be changing paradigms, if people don't see that it is ok to be a woman who is not married and without children, we actually won't be able to change any of this.

Women want to get married and women see their lives as being complete when they get married and have children. And yes it is acceptable for your husband to have multiple partners. The women reason by saying, "he will kick me out if I complain," but maybe we need a generation of women who get kicked out. We cannot win otherwise, it's not all the man's fault; women need to take responsibility for themselves. I have been working in HIV for 10 years, people are being infected every single day, babies are dying every single

day. Ten years down the line and where are we? Women are strong, women can change the world, and they need to. We need to start putting the responsibility back on the patients. It can't come from outside, it has to come from the bottom up.

In terms of what needs to be done, education must be emphasised. Women have to believe they can change the environment, they must want to change the environment and they must believe that HIV is a virus, that it can be stopped by changing current practices. Until women believe they can change, that their children can get better, it's not going to change. People need to dream of a better and realisable future. At the moment people don't think about the future, they just try to get through today.

The government needs to ensure policy is kept updated and they need to ensure the education of the girl child. We need stronger laws against violence and rape but if we wait for the government change, we will lose generations of people. We need to recognise there is only so much the government can do but I am also sure that there are some in government who believe that women should still be barefoot and pregnant in the kitchen.

There are so many things that need to change – the health and education systems, the subordinate position of women, individual attitudes and behaviours, cultural beliefs and practices, and our inaccurate statistics etc. There are ways of moving on.

I'm not a sociologist, I'm not an anthropologist, I'm a doctor and I don't know how to change these things. Its so complex because it's so taboo, sex is so taboo.

However, things are improving in that we are treating a lot of people and a lot of people who were very sick are doing well, much better. They are productive and so they are able to go to work and look after their families and children. Particularly for children HIV is a terrible illness and ARVs improve the quality of life dramatically. I have had kids

who had contratures, sores, bedridden, crying, who are now running around playing, painfree, which to me is a huge step forward. And our system is definitely improving.

Yes we have come on in leaps and bounds but we are still spreading the disease, engaging in high risk sexual practices, people not taking drugs properly.

It must be that they don't believe in the drugs or that they don't believe the future is worth living for, otherwise they wouldn't stop their drugs.

It's not all about 'poor women in Africa' – women in Africa need to stand up, yes they may get kicked out of their homes, but they need to fall back on some system that will allow them to be single.

Dr Carolyn Bolton works with CIDRZ - a not for profit organisation affiliated with the University of Alabama, which started in 2001 to assist the Ministry of Health to roll out a national PMTCT programme. In 2004 CIDRZ began to provide ART to patients in Lusaka, Southern, Western and Eastern province and has been working closely with the Ministry of Health to expand ART and PMTCT programmes.



Theresa Mwansa Lusaka

ORPHAN, EX-SEX WORKER,
MEMBER OF A SUPPORT GROUP

There is a lot of support for each other in our group ”

Theresa is thirty five years old and started working as a sex worker when she was sixteen, at that time she was in Grade 9 at Kasama Secondary School.

I started prostitution when my father died. My relatives took me in but did not care for me. They would buy books and things for their children, but never for me. So I started going out clubbing with my friends after school. We would bring clothes in our bags and change after school. Life became very difficult. I stopped going home because no one loved me there. Sometimes I would go to a friend's house, or else I would just find a man and go and sleep and have sex with them. I didn't care how old he was or whatever. I would just have sex with him.

We were three in our family. One died and my sister got married. She had a difficult marriage, so I could not go to live with her. I dropped out of school and became a sex worker full time. I would go to bars and clubs and have sex with men. I did not care if they were old, young, neighbour, whatever, 5 or 6 men in a night usually, so long as I got the money I wanted. I would raise maybe K600,000 or K700,000 and I would show off to my friends. A lot of friends joined me, because they were attracted to the money. There were 12 of us in a group working together but there are now only 2 of us left from that group of 12. 10 have died. We never cared where we went. We did not look out for each other. The only thing we did was to make sure we all had condoms.

Theresa says she used to keep female condoms. If the man refused to wear a condom, she would pretend to go to the toilet and put in a female condom.

It was uncomfortable to use them, but I put up with it, to protect myself, to save my life.

Theresa is now a member of a support group for former sex workers.

There is a lot of support for each other in our group. We care for one another because we understand. We all come from the same background, so we understand what we have all been through. I am so happy here. I have learned a lot. I can take care of myself. I have learned how to garden, to sew, tailoring and I have been for anti-drug training.

There were a lot of challenges. A lot of the men were violent. There was a group of men who would take you to the graveyard, have sex with you and beat you, then just leave you there. Some would take you, give you money, beat you, take back their money and run.

I go for VCT every three months. The first time I did the test, it came out negative, but I did not believe it so I went to another clinic. Again, I was negative but I did not believe it again because of what I had done in the past. I went again to another clinic and was tested negative.

Everyone is at risk to HIV, especially those who are married. They are more at risk than any person. As for us who are not married, who just have sex with men, it is easier for us to tell a man to use a condom. In our culture, women have to submit to their husband. They cannot ask their husband to use a condom. If you are his girlfriend, you can say more, and you can tell him no!

If I met a young girl getting into prostitution, I would try to advise her not to because of the diseases. You need to respect yourself. I used to be violent and got no respect from people. Now I have respect from my neighbours in my compound. A lot of things have changed in me. I no longer sleep with lots of men. I used to smoke dagga and drink, I no longer do this. I used to fight, I no longer fight. I never had respect. I never cared for myself. I used to wake up and just go to the pub. Now I wake up and I clean my home and care for myself.



Mate Imenda

Mulamba Compound, Senanga

SUBSISTENCE FARMER, MOTHER,
SUPPORT WORKER

...women are more vulnerable because they sometimes use sex to generate an income ”

Mate is a single, forty-two year old, small scale farmer. She lives with her uncle, her father's younger brother in Mulamba Compound. She says life is very hard for two reasons – she does not always have access to land to farm and because, since 2002, she has had a rash all over her body.

Mate was married for ten years. She has five children with two different fathers. When she moved to her husband's village Mukule, she began to develop the rash and her father-in-law told her to return to her own people, as they needed to find a new wife for his son. She was chased away from the village in 2008. She does not know if her husband was HIV positive but he insisted he would rather listen to his father than defend her. He told her to leave, but she did not have the money for transport back to Senanga.

Her father-in-law insisted that she not be given food by anyone else in the village, including her children. Mate could not farm at the time because her rash was so bad. She had to sit under a mosquito net for days because if she went out, the flies would attack her sores. She could not even hold her child. Most of the time she spent in the net, she prayed to God to die, but was worried what would happen to her children if she did.

There was one woman in the village who helped Mate and supplied her with a small amount of food. She

then asked if Mate had any relatives who could help her and Mate told her of her uncle in Senanga. The woman's son located her uncle and informed him that Mate was going to die at any time. The uncle came to collect her and took her and her children back to Senanga, even though he is very poor and has little. Mate then went to the hospital to see if she could get treatment. While she was there, she heard people talking about HIV and VCT. She was tested and learned she was positive. After being tested, Mate went to get her CD4 count, but at that time, the machine was broken and Mate had to wait four months for it to be repaired. Then her CD4 count was too high, so she was not put on ARVs. She was also found to have an STI and received treatment for it. She began to take ARVs in January 2009.

Mate did not feel too bad when she was diagnosed, because she knew people got better once they started taking ARVs. She was relieved because it gave her a solution to her problem. While she did not have many problems with the medication, the rash did not go away easily. She was given different medications and now the rash is beginning to clear. Mate has to walk for one hour to get to the clinic.

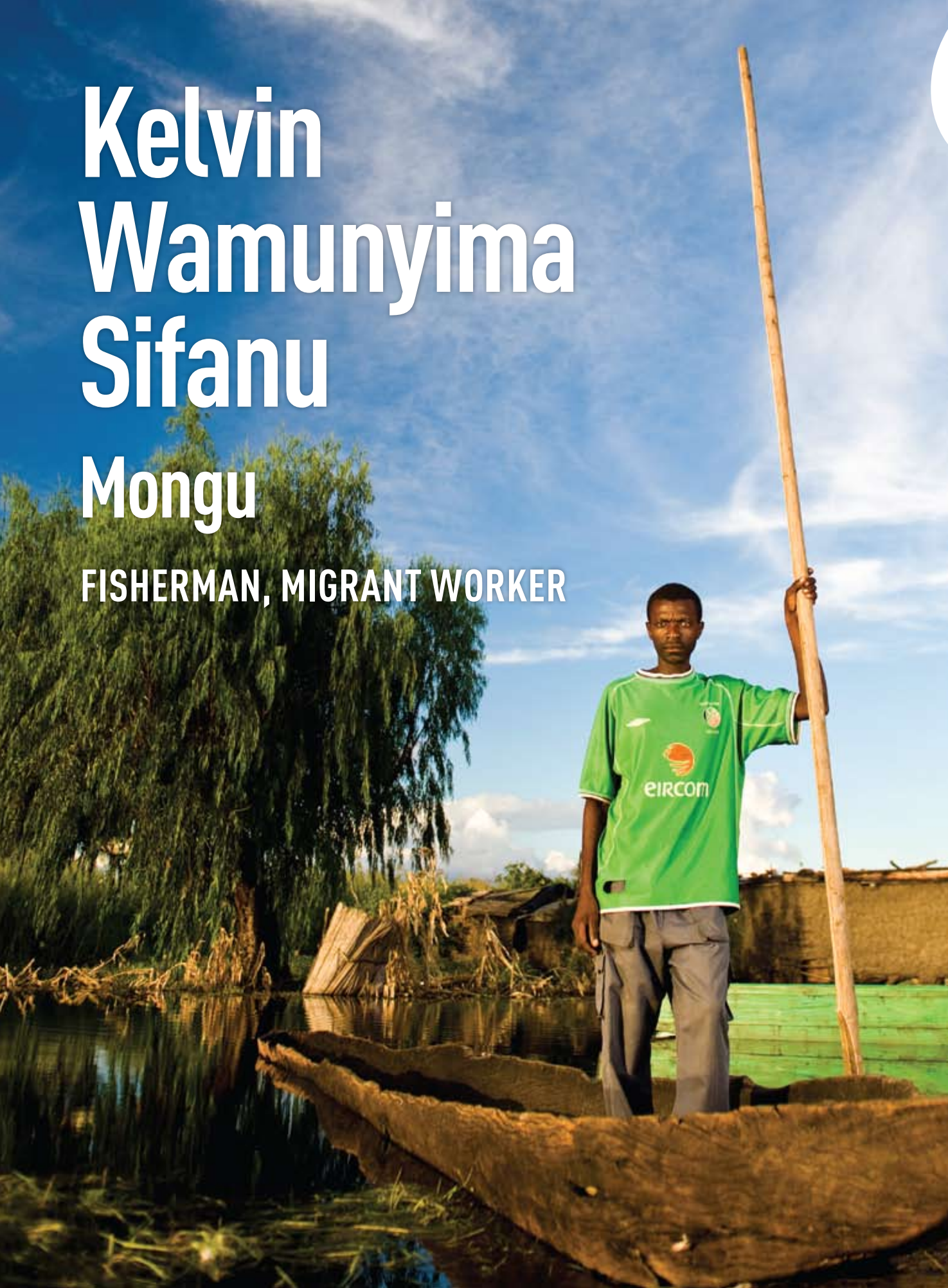
Her uncle is very supportive and does not blame her for her situation. Oliver, the NZP+ co-ordinator in Senanga encouraged her to have her children tested with the result that one of them is positive. Mate thinks it was her husband who infected her because he was having an affair with another woman whose husband was very sick. Mate's former husband and his new wife have both died.

For Mate, women are more vulnerable because they sometimes use sex to generate an income. Mate is now a member of a support group and enjoys being involved – she is learning a lot while also helping others.

Kelvin Wamunyima Sifanu

Mongu

FISHERMAN, MIGRANT WORKER





...not enough people know enough „

Kelvin is forty years old and a fisherman by trade. He is not married, but he has a three year old child. He is a migrant worker and comes to Mongu from May until December to fish as fishing is prohibited at other times in order to let the fish breed and the water is too high between March and May. The fishermen migrate between the different fishing camps on the plains. The camp Kelvin goes to is Nandombe near Mukoko. During the fishing season, they camp near the banks of the Zambezi River and Kelvin fishes in one of its tributaries. Life among the fishermen is hard as they live in temporary huts which often get washed or blown away.

Kelvin begins fishing at about 20:00 and continues through the night, returning to sell the fish in the morning at about 05:00 where the fishmongers wait. Depending on net size, there can be up to four people on each net. When they return from a night's fishing, some sleep while others often go drinking. Kelvin feels that the issue of HIV and AIDS is very significant. Fishermen do not usually bring their wives and partners with them when they go fishing and as many of the fishmongers are women, the situation can be difficult. If a woman refuses to have an affair with a fisherman, he can refuse to sell his fish to her until she does. It is common that a woman will come to buy fish and sleep with one man on one day, and then the next day with another. Some can even have three or four men in a few days. If any of these are infected, the virus can spread quickly.

Kelvin argues that because the area where they are is so rural, there are few people to teach about HIV and AIDS and that, as a result, not enough people know enough. He does not know of any organisation that teaches about HIV and AIDS in this area. While some people go to the hospital to get condoms, he believes there is little condom use in the fishing communities, despite the amount of sexual activity. Some people in the area know their status, and continue to have unprotected sex because they say they do not wish to die alone.

He has been for VCT a few times, and is negative. He tries to educate people about HIV, because he has an advantage as he lives half of the time in an urban area, and half of the time in a rural area. But some remain uninterested. Kelvin argues that every Zambian should go for VCT so that they can take care of themselves. Above all, if they are in a relationship, they should stick to one partner and be safe.

ECONOMIC VULNERABILITY

“In the fields, in the home, and in the marketplaces throughout Africa, women workers reign. Although ‘household activities’ are not calculated into the national income, we all know how invaluable their work, while sometimes invisible and nearly always undercompensated, can be.”

Linda Fuller, 2008

Even though African women produce three-quarters of the continent’s food, they are still amongst the poorest of the poor. Despite the fact that women do the majority of the informal work within the economy, they are still heavily dependent on men due to the lack of access to capital or credit or control over household resources and due also to patriarchal practices and traditions including those that relate to the economic position of women. These practices and traditions extend into the ownership of land or property. In many cases, women are restricted in owning or inheriting land or wealth. Lacking power or control over household or communal resources makes women subservient to men and relatively powerless in negotiating, including in the realm of sexual relations, thus increasing their vulnerability to infection.

Only 10% of economically active women earn wages in the formal economy and are likely to earn the least amount in the informal sector. Due to the informal nature of the majority of their work, women’s vulnerability is heightened by the fact that if they or a family member becomes ill, they do not get paid for days missed while caring for themselves or a family member.

It is for reasons such as these that many women are often forced into prostitution or ‘transactional sex’ (or risky sexual relationships with, for example, older men or ‘sugar daddies’) as an economic necessity in order to provide for their families, despite knowing that this may lead to the transmission of HIV. It is a survival strategy for many as they are sometimes left with few other options.

Many girls are taken out of school early in order to help at home or to provide care for sick family members and are subsequently deprived of education, thus reinforcing their subordination, vulnerability and disempowerment.

“Global evidence suggests that the relationship between poverty and HIV risk is complex, and that poverty on its own cannot be viewed simplistically as a driver of the HIV epidemic. Rather, its’ role appears to be multi-dimensional, and to interact with a range of other factors – such as mobility, social and economic inequalities, and social capital – which converge in a particularly potent way for young women living in southern Africa.”

Julia Kim, Paul Pronyk, Tony Barnett and Charlotte Watts 2008

COMMENTARY BY FELLY NKWETO SIMMONDS

Some of the worst cases of violence against women in Zambia have been with professional women who begin to challenge the economic power of men, in particular their power in decision making – the power to say how many children they have or the power to say when or whether they leave the house. Economic empowerment comes with its own problems and that’s where we need to start. For me what makes young women vulnerable is the basic issue of power dynamics where both gender and economics work at the same time.

Traditionally, the power of decision making lies with the men whether as fathers, heads of household, husbands etc. From the moment a female baby is born, they are disempowered; decisions are made whether they can go to school, whether they can go out and play instead of doing chores etc. So even before we consider economic vulnerability, females are already less empowered in the way they are brought up as girls.

As a result of how they are socialised and reared, women often do not believe they



deserve economic empowerment. What we need to appreciate is that girls and women become adults already disempowered at a very fundamental level, where you think of yourself as being less because you don’t have the same privileges, the same education and even if you do you are encouraged to think of it ‘as less’. You go to college the choice of courses for men and women are already different. This is not only in Zambia, it is everywhere, but here it is exaggerated.

So women go and do those courses but they still want to get married and the degree they do enables them to get married - that is what it is there for. And of course their parents are quite happy to get a big dowry for them because they have that education, which is really why they made you stay at the University of Zambia (UNZA). So although they get that extra education, it is not necessarily for them, it is for the benefit of those around them. If they have a degree from UNZA they are a commodity.

People actually believe that there is no point applying for a job if it is in the paper because they think *'if I am not beautiful, I won't get the job'*. Women need to value themselves; to value yourself is really difficult unless someone values you. And sometimes people value you for reasons that are not about you – *'I value my daughter because she will bring me a nice dowry, she can maintain me'* and all of this. So by the time a woman gets a job and a salary, is she going to get to keep it? The tension starts there. The women will have to ask for the money because the man thinks *'I am the one with the money, I should have the money'*. There is an 'asking' relationship going on. When we talk about girls and empowerment, we need to empower them in terms of a better education, and better money but the empowerment also needs to be internal. Women need to be given self confidence, they need to be people and have the right to make decisions and have the right to marry someone who is not going to belittle what they have done.

Economic empowerment has to go in tandem with other types of empowerment. If we do other income generating activities, they cause problems because they just throw money at people. For example, if a woman gets a loan in her women's group and she goes home with the money, most of the time the money will be taken by the husband. When we do economic empowerment activities, we have to be very careful what it is that we do, so that we don't disempower women even more. This is what has happened - I have seen it.

So although you get that extra education, it is not necessarily for you, it is for the benefit of those around you. If you have a degree from UNZA you are a commodity.

Economic empowerment for individual girls is first of all internal. Get the girl to think about themselves, to value themselves - that is internal self confidence, self esteem and then the money can work because you are your own self. You can make your own decisions about your life, your children's lives, where they go to school etc. What makes women feel less empowered, even if they have money in their hand, is that they have no control, no power. All of these things undercut women. All women need to be empowered, but there is more work to be done to get there. I know women who are economically empowered, but it is at a cost – most of them are not married and, for example, when a woman dies, where do you think her property goes? To the husband! So once people are empowered, they need to know how to keep what they have.

I want girls to go to school, to be taught how to be people, to think that they are worthy; they are real whole people with integrity, so that if they do economic empowerment, they have that as a baseline for themselves so they will have the power to negotiate. The more economically empowered you are, your house will fill up with orphans. Women always have to care for their parents, their siblings, their siblings' children. I don't think there is a woman I know who works who doesn't have orphans and other children in the house. They put their siblings through school and care for them.

Rural women are better off in some ways because they don't depend so much on money. For rural women, it is land that is important. If women can have access to and legally own land which they can farm, they can grow. If you can grow maize to eat and sell the surplus you can buy the other things you need. People are better off, not in terms of cars and things like this, but in the way they live. I am not saying they are not poor in the rural areas, they are poor. They are poor and getting poorer. But when people get sick and die in towns, where do they send the orphans - back to the village!. So the woman who has a small piece of land and grows some vegetables now has a burden of children. So those children then have to go to school, as well as her own children if she has them. HIV and AIDS is making rural people poorer because the burden is getting bigger. When women have access to land, they are so resourceful, they grow things! Even in the towns, the most resourceful people are women. They grow vegetables, they keep chickens - they have several jobs at the same time. They are looking after lots of people. So the more money women have, the more responsibilities they are expected to shoulder, especially in the time of HIV and AIDS.

There are lots of women who have power out there who are being mentors to the younger women, so it is not all bleak. But Zambia is still not ready for these women.

If women don't have economic power, they are totally at risk of HIV and AIDS infection. To survive, women will put themselves at even

more risk, so a married woman who knows her husband has two girlfriends is never going to say 'you are not coming back into this bed'.

What makes women vulnerable to HIV? It is utterly the lives that women live, the lives girls are born into, the lives they are forced to live in, the only lives they can live.

The cultural expectations are that he is a man; he can do whatever he likes. Most HIV infections are in stable relationships, in marriage. Women will look for money - if they have children to feed, they will sell their bodies, even for a drink, they will sell their bodies. Women are more at risk the less money they

have and the less control they have over their lives. And of course there is the whole thing about older men and younger women - so girls expect to have an older boyfriend to supply things e.g. finance, transport, communications etc.; a young guy is the one they go partying with.

What makes women vulnerable to HIV? It is utterly the lives that women live, the lives girls are born into, the lives they are forced to live in, the only lives they can live.

It sounds very bleak for those women and it is bleak for them, but we should be giving them education, giving them skills - risk assessment skills - know when you are at risk. Women walk blindly into things not realising they are in a terrible place. They think 'you don't want us to have fun'. Have fun, but just have fun safely, otherwise you will never get old! You need to have control. A woman's life is a risky life in Zambia. It is not that women are always victims but sometimes women think they are in control and act on it, assuming they are actually in control.

Men are more at risk because they are the ones with more control and in theory, they can control the risk factors, but they choose not to, whereas it is the opposite for women.

To choose to not be at risk is to stand up to a lot of things. It's not as simple as saying *'I'm going to protect myself'*. This is why you can have as many abstinence programmes as you want – people don't abstain. In the moment, girls think they choose to have sex, but all sorts of other things are happening actually. They don't have much choice. The abstinence messages need to be targeted at older men - men need to abstain from having sex with children, men need to abstain from having sex with every woman that they see.

A lot of people don't realise what marriage is. It is like a big game but you only have a marriage certificate when you get married, not a marriage. Marriage in Zambia is very different. Traditional teachings tell women that when you are married you need to please your husband this way, if he travels, don't worry, he will come back to you. In the day of HIV and AIDS, they are saying it is ok for your husband to go and get HIV over there etc. until you are completely infected – that is marriage, and that is acceptable because you are a wife. If he does anything to you, keep

it in the house! If he slaps you, beats you, bashes your head against the wall, keep it in the house!

In the day of HIV and AIDS, they are saying it is ok for your husband to go and get HIV over there etc. until you are completely infected – that is marriage, and that is acceptable because you are a wife. If he does anything to you, keep it in the house! If he slaps you, beats you, bashes your head against the wall, keep it in the house!

People who have power don't exercise it directly; they get you to do it yourself. They teach you how to oppress yourself. A man doesn't have to come to the kitchen parties and bridal showers to tell the woman how to behave, her mother will do it. Because if her husband sends her back to the family, people will point to the mother and say, what kind of mother are you? Did you not teach your daughter? Men go drinking under a tree, and women are killing each other over here. Oppressed people are very good at oppressing other people.

Women in positions of leadership are also on the side of the oppressor because they are powerful people. They play the same game. There is no women's movement in Zambia; there was a fledgling movement in the 80's. Zambian women were sent to international conferences to speak about Zambia and then come home and do nothing. So that was seen as one way to gain power – to become a spokesperson. For me it is the same as people who say they are activists, but don't do anything. Unless you actually do something, it is just noise.

The main thing is how do we bring up the next generation of women in Zambia? We have to start at an individual level in terms of behavioural change, so we have to start at an individual level of beliefs and values, and this is a problem. You can't just say change your behaviour by using a condom - that is nonsense. You have to start with what is sex to people, how do they use it, for each other, against each other? You need to challenge belief systems but also enable young people to see that there are different things that will, and can, happen. And they can happen. If things are going to change for young people, then adults need to change. It should be up to adults to say - "*we will not marry our daughters off until they are 18.*" A girl cannot say this. If parents say our daughter is not going to get married until she finishes school, can you imagine the difference that would make in the way that we value our girls, in the way they value themselves? We can all do something, no matter where you are.

Oppressed people are afraid of freedom because if you are free you have to make decisions and take responsibility. Victimhood is sometimes a very comfortable position.

Oppressed people are afraid of freedom because if you are free you have to make decisions and take responsibility. Victim-hood is sometimes a very comfortable position. People need to stop thinking like - "*look at your daughter, she is 27, she has a degree, she has a job, no one will marry her*" - that is totally the wrong way around. They should be falling over themselves for her. But people are afraid of freedom. Girls need to know they have a choice.

Felly Nkweto Simmonds is a sociologist and has worked with the Corridors of Hope HIV and AIDS Prevention Project, and is currently an advisor with the Population Council in Zambia.

Maureen Mwape

from a rural area, visiting Lusaka

GRANDMOTHER, CAREGIVER,
SUBSISTENCE FARMER





Women are moved by the situation, so they care for people ”

Maureen is sixty. She had three children but they have all died. She now cares for her grandchildren. *'Community life can be very hard because there are so many orphans, no parents and, at times, there is no food. Sometimes the children have to work for people in order to get fed'*. Sometimes Maureen cooks a lot of food and invites the children from the area to come and eat.

She decided to go for VCT because of her husband's lifestyle. He was always moving around, meeting different people and finally he left Maureen to live with another woman in Ndola. When she learned she was positive, she prayed. She goes for CD4 count every three months and is not yet on medication because her CD4 count is still quite high. She is not in touch with her former husband anymore so she does not know his status.

Maureen does small scale farming in her village and sometimes she does some piece work. She lives with her three grandchildren, all of whom attend school, since it is free although she has to provide their books and bags, etc.

Maureen has not experienced stigma in her family or community. People have approached her for advice and she tells them about personal hygiene and eating correctly. She says that within her family and community, they sit together and talk about the issues, and teach each other how to stay healthy. She has educated her grandchildren on how to do the farming so that they can provide for themselves in case she becomes ill.

Maureen insists that programmes that are meant for those with HIV do not reach village level. They get to organisations or clinics but there is insufficient sharing with the communities. Women are the most vulnerable as they are the ones who always care. Men would rather just leave. Women are moved by the situation, so they care for people.

For Maureen, village voices need to be heard. In terms of access to necessities, they get paid or work for food or soap. Access to these things is not easy for her and work is hard. People come from town and need someone to weed their garden, so she weeds and then buys shoes or clothes for her grandchildren.

She grows cassava, maize and sweet potatoes, groundnuts and beans for the family. They keep the seeds so they can grow them the following year. During the rainy season they would go into the field at 06:00 until 10:00 – that is the busiest season.



Oliver Liseli Senanga

FATHER, SUPPORT WORKER,
CARE PROVIDER

All my
children are
HIV positive”

Oliver is forty four, married to his third wife and has six children. He divorced his first wife. He ran away from his second wife because he initially thought he was being bewitched but eventually discovered it was actually HIV. He moved to Livingstone and stayed there for three years but when he returned home, he still had the same health problems - a rash all over his body and constant coughing. He was tested for TB, but it proved to be negative. HIV tests were not done at this time.

Oliver spent considerable amounts of money visiting witch doctors in search of a cure. He was a business man and eventually realised the problem was being bewitched. He was treated by a traditional healer for his rash, but almost died. Eventually he recovered and married his third wife, with whom he has been since. His second wife met someone else, but after a few years, she died.

Oliver obtained some information about HIV, and felt he might have the virus but was told that if he

tested positive, he might die of depression, so he avoided being tested. He then began to realise that his ill health was out of control, so he eventually went for VCT in 2004 and tested positive. He had to travel to Mongu to get the drugs because at that time there were no drugs in Senanga where he lived. The drugs cost him K40,000 as they were not free at that stage. For Oliver, finding out he was HIV positive was a solution. He was relieved as he looked forward to being well again.

When he married his third wife, Oliver did not yet know his status. Four months after his marriage, he began getting sick again and was brought to hospital in Senanga for a month. He stayed with his wife until 2004 when he was tested. At that time his wife was pregnant, but when she gave birth, they lost the baby. When he was found to be positive, Oliver was too weak to get to Mongu to buy drugs and could not afford to get there either. His father had to sell a cow in order to pay for the medication. So in September 2004 he started ARVs, but was bedridden and almost died. However, eventually he responded well to the treatment.

Oliver decided to come into the open about his status so he could help his friends and family because he could see people around him who were very sick and wanted to help them and provide information. This is why he started a support group.

When he found out his status, his wife went for testing and tested positive. She started taking drugs, but did not respond well to the treatment. She is now on the second line of treatment but is still not responding. She is on tuberculosis (TB) drugs, and she also has a pelvic infection also.

Oliver says he became infected from being 'too playful' – from multiple partners.

ARVs are not a cure, he says, but can sustain health in your body. *'You can remain healthy if you are taking them correctly, if you respond well'*. As soon as he began taking ARVs, he began to feel better. Oliver thinks women are more vulnerable to HIV, due to poverty. Some women have no source of income, so have to engage in sexual activity. Women are also more vulnerable because they cannot negotiate condom use. According to Oliver, women need to be empowered socially and economically.

All of Oliver's children are HIV positive and he argues that people are dying due to lack of proper information on HIV and AIDS, and it is difficult for people to access treatment in the district. There is only one CD4 count machine in Senanga and Sesheke District. It breaks down a lot, and some people have to wait months for tests. More ART is also needed and while ARVs are free, for some people they are not because they have to travel, pay for food and accommodation, etc. There are over five hundred people in Senanga district who have defaulted on their medication because of the distance they have to travel. Although we are addressing HIV, in another way we are promoting it, because people stop the treatment and engage in further sexual activity.

Nathaniel and Beauty Mulele

Lubosi, Mongu

DISCORDANT COUPLE, PARENTS,
SMALL SCALE TRADERS, STUDENT



There is a time for everything ”

Married for four years, Nathaniel (twenty seven) and Beauty (twenty) have one child, Nathaniel (after his father). They live in Lubosi where life is difficult with most people unemployed surviving through small scale business activities or cleaning or working as guards. Nathaniel and Beauty sell maize which they buy from farmers in Kaoma. They buy 50kg for K50,000, then divide it into small buckets which they sell for K10,000 in the market in Mongu.

In 2005, Nathaniel went for VCT in the clinic in Mongu. He tested positive. He was pessimistic at first but with counselling, he began to feel significant more positive but it took him two months to learn to cope with the situation. He is not on ARVs, but was given Septrine, a medication for infected men. Nathaniel and Beauty were not married when he went for testing but he did not tell her of the result until she found the papers he was given at the hospital. Beauty confronted him and while he expected her to be angry, instead she comforted him. Beauty stays with him because of the love she has for Nathaniel.

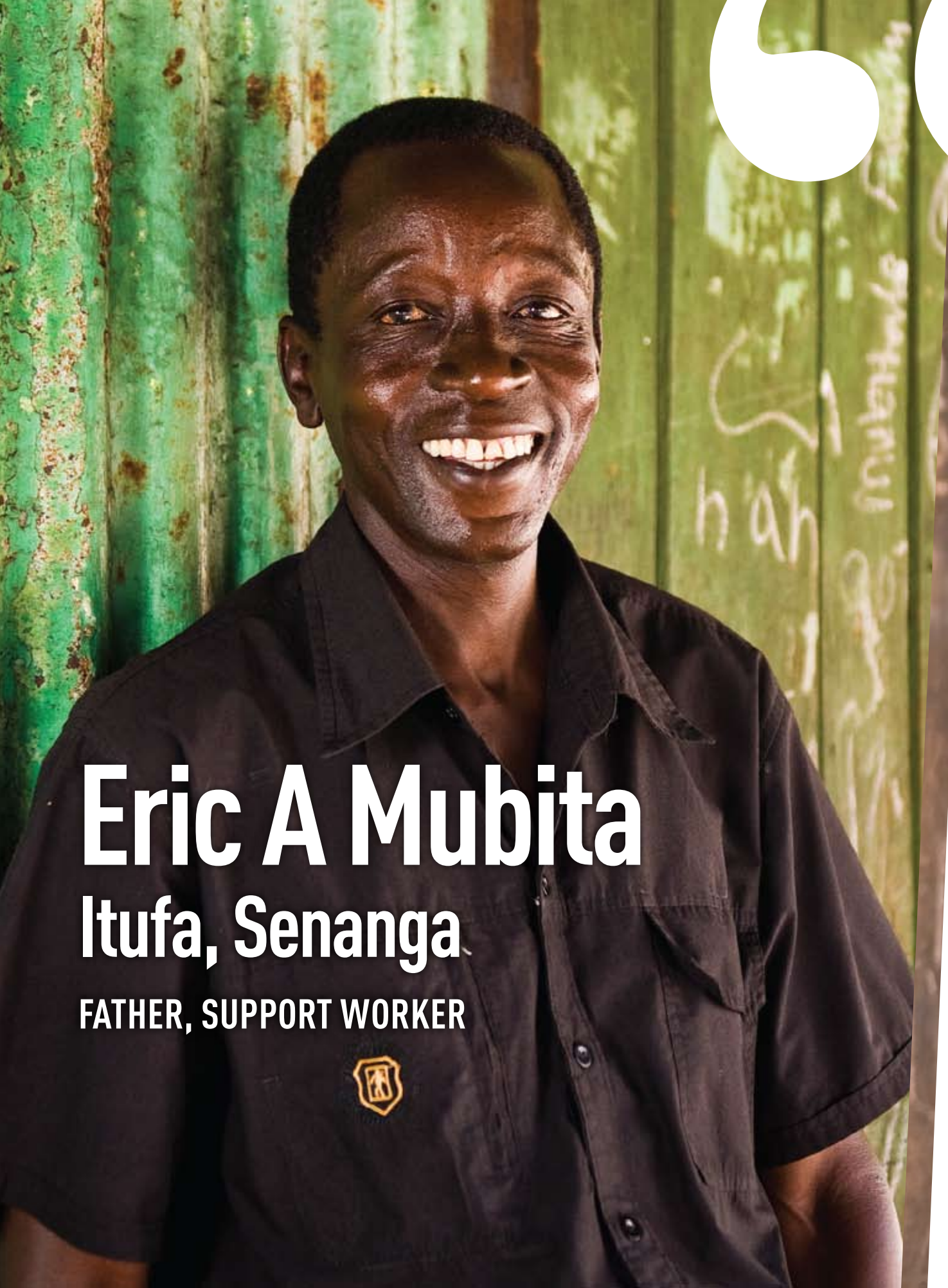
Beauty says she was very disappointed that he did not tell her about his status, but supported him anyway. She was pregnant when she found the papers so she went for VCT and was found to be negative. She went again after she gave birth and was still negative as is their baby. Beauty told her parents who were very supportive as they are also a discordant couple meaning that her father is positive and her mother is negative.

People in the community do not know of Nathaniel's status, because he does not talk about it with them. He feels maybe now is the time for them to find out, saying that there is a time for everything. Nathaniel and Beauty feel that as human beings, they are entitled to a sex life and they use condoms routinely.

They argue that HIV and AIDS affects all of us in some way. If you are in a discordant relationship, this should not separate you. Couples should continue being together, because the love they have for each other will support them. Nathaniel believes women are more affected by the virus, because they are sexually vulnerable, especially due to the myth that sex with a young girl can cure AIDS. Also, too many women do not get to choose if they use a condom or not.

They feel that everyone has rights and that these rights should be upheld by the government and that all financial support given to tackle AIDS must reach those who need it most. Also, they feel strongly that there should be no discrimination in employment.

At present, Nathaniel is studying to become a mechanic at Mongu Trades School.



Eric A Mubita

Itufa, Senanga

FATHER, SUPPORT WORKER



...behavioural change is the only thing which can make this country a better country 》》

He is forty eight, is married and has three children, two boys and one girl. He lives by cultivating the land, growing maize and rice. For the past two years he has worked with TALC doing outreach and advocacy work and he has been involved with the AIDS Alliance. Before accurate information was provided, people believed that HIV and AIDS just involved someone who was having sex with a woman during her period – Malili. But this has all changed now.

While Eric was married, he travelled up and down the country for his father collecting orders for his shop. This is when he contracted the virus. He used to travel to Livingstone and the Copperbelt where they were ordering clothes and groceries. On these trips, he would meet lots of different sexual partners but in 2007 he began to feel sick. His dad encouraged him to go for medication and accept his status. Eric felt very ashamed when he found out he was HIV positive, but his wife agreed not to leave him. Initially his wife thought it would be better not to take the drugs and to die, but she slowly changed her mind. They went together when he went for VCT, she did not blame him.

His first son is positive, but his other children are negative. The people in the community knew Eric was positive because he was sick. Eric's family would be considered high class in the community. People did not believe that he was positive because he was so fit, due to the drugs. They would ask Eric to assist their relatives who were sick, and give them

counselling so they could get better. His father, who is ninety one years old, did not react. His children were worried, but he educated them that would be ok, and now they support him. His youngest tells him when to take his medication, his wife is also on ARVs. They began ARVs straight after VCT. Eric got pneumonia and his wife got a rash, but they overcame these problems.

Their main challenges for them are that clinics and hospitals can run out of medication sometimes with such a large area to deal with. The CD4 count machine is a significant challenge as it frequently breaks down. More sensitisation is needed if the prevalence rate is to decrease. There is a need for a lot more sensitisation work in the area.

Cultural practices contribute greatly according to Eric. There is a practice where if someone is suspected of being poisoned by witchcraft, they cut the person with a razor blade and syphon out the blood with a horn (mulumeho), to get rid of the poison. Circumcision is also an issue. One knife is used for fifteen to twenty children, so the virus can be transmitted this way also.

Eric argues 'it is better for us to fight this pandemic, especially with initiation ceremonies – behavioural change is the only thing which can make this country a better country. Information dissemination is key. There is too much sexual activity'.

SOCIAL AND CULTURAL VULNERABILITY

“Growing aspirations in societies where the gap between rich and poor is widening and women perceive few options for obtaining financial independence, coupled with cultural allowances for age-disparate relationships and exchange expectations in sex, make young women of southern Africa exceptionally vulnerable to HIV infection.”

Suzanne Leclerc-Madlala, 2008

A critical factor aggravating the problem that AIDS poses for African women is the definition of the place of women in very many African societies. Of particular significance in terms of why sub-Saharan Africa has been hardest hit by HIV and AIDS is the subordinate social status of women and the many negative cultural practices and traditions that sustain that subordination. The majority of the vulnerabilities women face are not only maintained but are reinforced by cultural practices such as those at initiation (where women often are required to publicly display subordination), those relating to women's health (traditional 'infertility treatments'), those during sexual intercourse (e.g. 'dry sex' which increases women's vulnerability to infection during such sex) and the generally accepted practice of men having multiple concurrent sexual partners. Currently the social group with the highest risk of HIV infection are married women where infection routinely occurs through external affairs by husbands and partners. Women do not have sufficient power to negotiate condom use within a relationship. Furthermore, women have insufficient power outside of a relationship to leave it if they are at risk of infection.

Other cultural practices and traditions contribute such as polygamy, levirate (marriage by a man's brother to his widow) or sororate (concurrent marriage with a wife's sister) and sexual cleansing. The gender role prescribed for women and 'femininity', demands a submissive role, passivity in sexual relations, while the role prescribed for men requires them to be more dominating, knowledgeable and experienced about sex. This also puts many young men at risk as such perceptions prevent them from seeking information and also promotes promiscuity.

Poor educational attainment generally entrenches gender inequalities leaving many women uneducated or ill-informed as regards issues such as the transmission of HIV and protection. Violence towards women compounds the link between gender inequalities and vulnerabilities where some women are continually subjected to abuse and rape. This is particularly of concern in countries with high prevalence rates (such as Zambia) as there is a high possibility of HIV transmission if a woman is raped.

“Many cultures and religions give more freedom to men than to women. For example, in many cultures it is considered normal -- and sometimes encouraged -- for young men to experiment sexually before marriage. Also, in many cultures, it is considered acceptable for men -- even married men -- to have sex with sex workers. These cultural attitudes towards sex are leading to HIV infections in both men and women -- often the men's wives.”

UNAIDS, 2001

COMMENTARY BY PROF. NKANDU LUO

What is particularly sad about the impact of HIV and AIDS on women in Zambia is that when you stratify by age, it is younger women that are more infected. In fact if you look at the statistics for women, they are 1.4 more times more likely to be infected than men, and young women could be as much as four times more likely to be infected than men. A UNICEF study found that, up to the age of 15, you see an equal infection rate for young women but somewhere between 15 and 19 something happens in the lives of these young women and the infection rates sky-rocket, especially around 17, 18 and 19. The infection rates again are quite high for married couples and it is true to argue that to be married is to be at risk.

I think a lot of us have been trying to understand why this is the case. Now we know that one of the main reasons for high infection rates among women is the whole gender inequality issue. We need to unpack what gender inequality means, and that's where the issue of the socio-cultural aspects come in with, for example, the whole issue of gender based violence. We have evidence on the way women are socialised (as against men), women are socialised to be subordinate. They are socialised to be tools, not human beings. They are socialised not to enjoy their rights. Therefore as a woman grows, their primary goal is to be married. If you look at the opportunities available – if you go into a home with few resources, the choice of who attends school is very obvious; the boy will attend school and the girl will get married. You will find situations where older and



younger women stay in abusive marriages, simply because that is what they are expected to do by society; do what you are told, do not question your husband even if he has multiple concurrent partners. But what about the rights of the woman, what about the rights of children in the home?

Traditional practices happen in urban areas as well as rural areas although because it is not so pronounced people don't discuss it. Sexual cleansing, for example, happens in both urban and rural settings. What is interesting is that sexual cleansing traditionally is not just about sex; some people jump over a goat, wear some white beads or have mealie meal thrown over them to say *'you are cleansed, you have moved from that husband, you are free to remarry.'* That is its primary meaning but now the sexual cleansing has become predominant. While it is decreasing in prevalence, it is still an issue upon which we must continue to campaign.

Another practice involves the use of herbs to dry the women's vagina as it is believed that

men enjoy sex more if the woman's vagina is dry, so women put herbs in their porridge, in tea or even insert it into their vagina. However, as a result of awareness campaigns and increased knowledge, the practice is also decreasing.

The other practice that is hidden and that people don't talk about a lot is the situation where a man fails to make a woman pregnant – the 'blame' is passed to her. Often, the family gets together and talks about it quietly and arranges to find a brother or a cousin to father the child, there is a secret arrangement where the 'arranged' man makes the woman pregnant and the husband knows that this is not the child. That's why, in our tradition it is never a child from the male side who becomes chief; it is always from the female side. This is because the woman then knows for sure that this is her child.

In a lot of African countries there is very poor access to health services and people have to walk up to 50kms to get to a rural health centre and even further for access to a hospital.

What is even worse is that having walked that far to a centre, there may be nothing, not even drugs. You might find unqualified people delivering health services and so, for many years, traditional healers have filled the gap in health services since they are the closest health providers at household level. Because people do eventually get well, so they

...for many years, traditional healers have filled the gap in health services, they are the closest health providers at household level. Because people do get well so they believe in traditional medicine because there is no other alternative.

People in the rural areas have not been adequately reached in terms of information messages, awareness etc., especially as regards how they translate that knowledge to risk reduction.

believe in traditional medicine because there is no other alternative. Personally, I think we have not used traditional healers adequately in the fight against HIV. On a daily basis in a village, the homes of healers are full of people

seeking help and this is a good opportunity to increase awareness and knowledge. For example, campaigns on the use of condoms and so on could have worked through these traditional healers.

A witch doctor is very different from a traditional healer. A witch doctor is someone who is believed to have

magic, and can do things through magic whereas a traditional healer is someone who delivers traditional medicines to the people and this usually comes from the roots of trees, barks of trees and leaves - it is organic.

If you look at how some medicines are made, they are made with the same ingredients; it is just that a traditional healer does not have a defined dosage, so they may 'overdose' the person or they may not know fully what medication for what disease.

People in the rural areas have not been adequately reached in terms of information messages, awareness etc., especially as regards how they translate that knowledge to risk reduction. They have to risk. They have often not had adequate access even to condoms (or to non-defective condoms). So we need to do a lot more. The whole crisis of orphan children has shown how the whole extended family

system has broken down; given the poverty of rural areas it is increasingly difficult for people to look after these children.

We need to rethink our strategy for HIV. Despite the fact that we have known for a long time that women are more infected than men, we still undertake 'general' interventions; it is now time for interventions that target women directly. And not women generally, but women at different levels, because the epidemic does not affect an older woman in the same way it affects a younger woman.

The other thing we need to appreciate better is that because women have been socialised to think they are subordinate or second class citizens, they lack assertiveness and self esteem – they look on themselves with pity. We need a lot of education and exposure for women at a very young age so that they begin to appreciate who and what they are in society. We continue to think that the people who develop our countries are men but, in my opinion, the male form of leadership in Africa has failed. In addition to that, we must mobilise women to become an increasing part of the decision making process. We can use HIV as an opportunity to deliver these messages. When you look at the National AIDS Councils all over the world, they are run by men and they don't create enough programmes that address women's issues per se.

The economic empowerment of women is vital; with respect to HIV, education is not enough. I work with one of the most vulnerable groups in the world – sex workers – and they are

one of the most organised groups of women. They will tell you they know in detail about HIV because they have nursed their friends through it. Yet, they will go on the streets the next day because they have to. We need to empower them with skills so that they will start earning money and will not be on the street and exposed to HIV. At the centre of any HIV programme must be income generation and entrepreneurship. Educational campaigns alone are a waste of money because women know about HIV, but they will still expose themselves because they have no alternative.

The role of the government in relation to HIV and AIDS is crucially in the areas of policy and law, in addition to funding. What is sad about Africa is that too many of our governments have decided they have no money. But if there was an election tomorrow, they would find money for the election. So they need to rethink their priorities; we need to mobilise our governments to put money on the table. The government needs to wake up to the reality and know what the priorities are. One of these priorities is to reduce HIV infections in our nation and to reduce the burden of disease among the people, and also to reduce the impact HIV is having on people, households and families. It is time to move from rhetoric to action.

A former Zambian Minister of Health, Professor Luo is President of the Society for Women and AIDS in Zambia. She is well known for her project - TASINTHA which was designed to support and protect sex workers in a variety of ways.



Clementine Mumba

Chelstone, Lusaka

FOUNDER MEMBER TALC, SINGLE, CAREGIVER, SUPPORT WORKER, ADVOCATE

it will take **all of us** to stand up and speak one word ”

Clementine is a single parent with one child and four dependents. She is HIV positive having found out about her status in 1998. She had contracted TB in that year and, as those who have TB are also suspected to be HIV positive (TB is known to be a co-infection or opportunistic infection of HIV), a friend encouraged her to have a test for the virus. At that time, there was no VCT as counselling was not available. Nonetheless she went for a test. When she learned she was positive, Clementine was devastated and could not sleep for two days but soon realised that if she continued in that way she would not survive for long. Since then she has lived positively.

As Clementine had been stigmatised by her office supervisor over the TB, she decided not to inform anyone of her HIV positive status but her boss called meetings which excluded her. They discussed how to deal with Clementine as they thought she would infect them all, however fortunately for her, the rest of the staff were very supportive. When she was tested for TB, she was told that it was non-infectious, so she continued working. Her boss did not believe that she was not infectious, and arranged for everyone in the office to go for TB screening. Nobody went for

this screening except her boss. But Clementine was psychologically affected by all of this.

Her boss then asked the Administrator to tell Clementine not to touch any of the office tea cups, plates or spoons in the staff room. Despite this action, Clementine felt relieved because she thought she was going to lose her job. But Clementine now has a new boss, and things have improved greatly.

Clementine is very open about her status but thinks people do not believe her some times because of how healthy she looks. Despite the cost, Clementine began taking ARVs in 2000 having bought them from Botswana as ARVs were more expensive at that time in Zambia. However, she could still not afford to continue with the treatment as they still proved to be expensive. And so, Clementine only took the ARVs for three months, but later with the help of friends she resumed medication.

As time passed, subsidised ARVs were made available in public institutions though there was still bureaucracy to access them. Clementine realised that some doctors did not inform patients that they were subsidised ARVs and continued buying from Drug Stores at a full cost. In 2005, the Late President, Levy Patrick Mwanawasa, SC. announced that ARVs should be provided for free to all those who required them.

The side affects of ARVs are challenging, having to take the drugs every day for life, Clementine has lost fats in her face, her stomach has grown big and her legs become small (like sticks).

But the greatest challenge arises from the attitude of friends who, once they hear of her status, disappear from her life. This, she comments, makes you wonder whether you should tell people or not. You can get very lonely, but you don't have anyone close to you. Once she opens up, she feels better.

Clementine feels that people have become complacent because of the introduction of

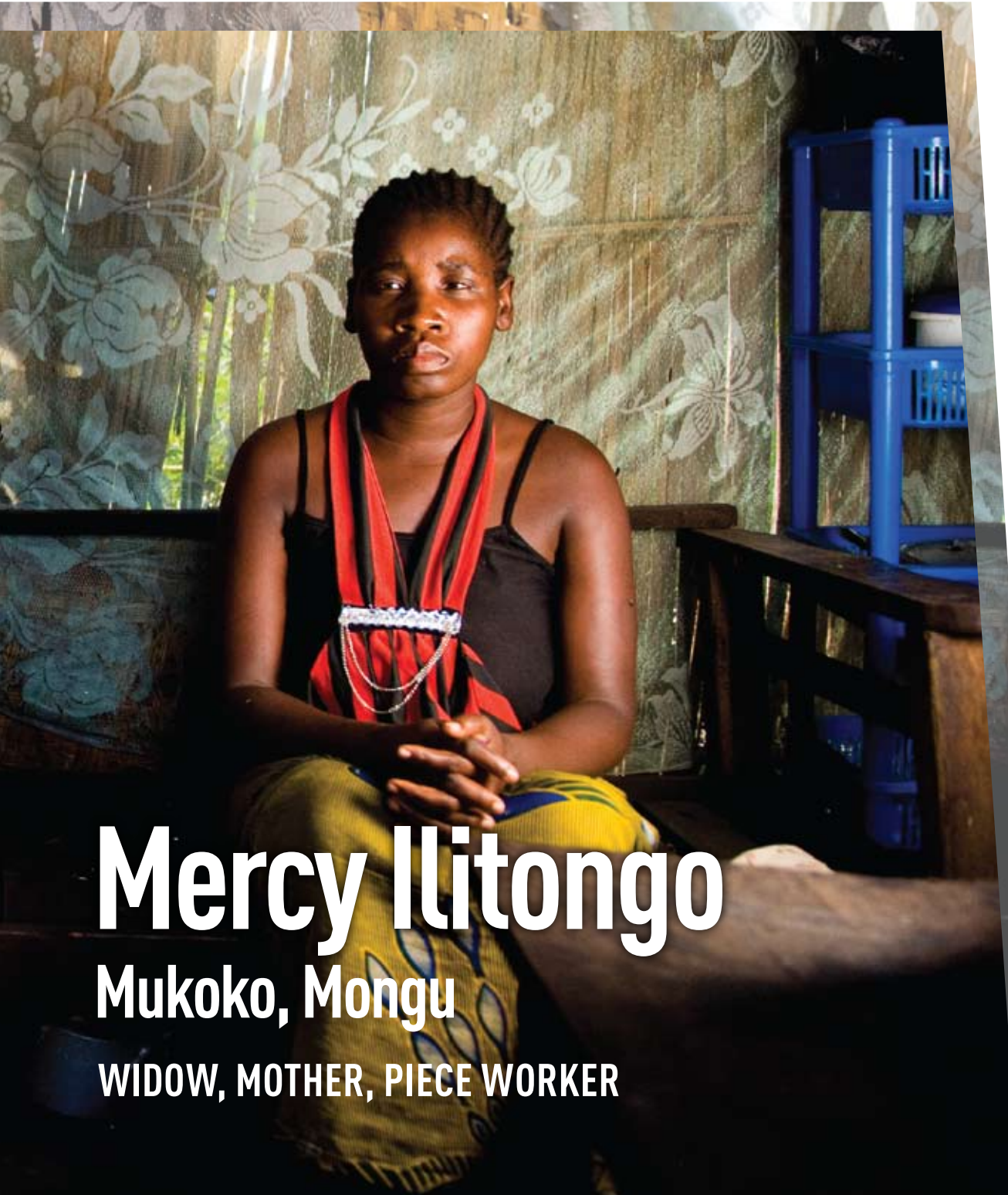
ARVs and insists that the emphasis needs to firmly remain on prevention and on sensitising people about HIV, speaking about what is happening 'on the ground'. *'We need to use role models more because some people still dont think the virus is real. If the public can see how others have living a positive and productive lives , it will help remove stigma and will also help reduce discrimination. There are many who cannot read or write, especially in English, it would also help if information was simplified and also made available in at least the seven main local languages'*.

Clementine insists that leadership is key in the fight against HIV and AIDS. She would like to see the President taking a key role say, for example, going for VCT - leaders are supposed to lead by example.

She believes that it will also take a few brave women going into the communities, encouraging other women to stand up and speak. *'Women have to learn to stand up and defend ourselves because no one will do that for us. You have to stand up and be assertive because there are very few women who will stand up and say no. Women need to tell men enough is enough, but this will take time – it will take all of us to stand up and speak one word, otherwise we are going have a big battle to win. Not many people are taking the lead especially leaders'*.

Losing people to HIV related illnesses has made Clementine strong. She lost two young sisters. It has given her a vision of where she needs to go in life, what she needs to do. It has affected her in that she cares for the dependents of her loved ones, two of whom are HIV positive; one of the children has cerebral palsy, and needs a lot of care as she cannot do most of the things on her own. *'Most households in Zambia have a number of orphans and it takes a lot to care for them, feeding them, clothing them, taking them to school, helping them have a normal life. You have to provide for everything, not just shelter'*.

“ It is more difficult for the children because **they do not understand** ”



Mercy Ilitongo

Mukoko, Mongu

WIDOW, MOTHER, PIECE WORKER

Mercy's husband died in October 2009 and she is now a widow with four children, all of whom have been tested. They are aged twelve, nine, seven and two years. The youngest is positive and on medication. She was a twin, but the other twin died at age two. Mercy is not working and survives doing some washing and cleaning in houses in the community in exchange for some money and food. Mercy is illiterate. She rents her house for K30,000 per month but it is very hard for her especially in the rainy season as the rain enters her house.

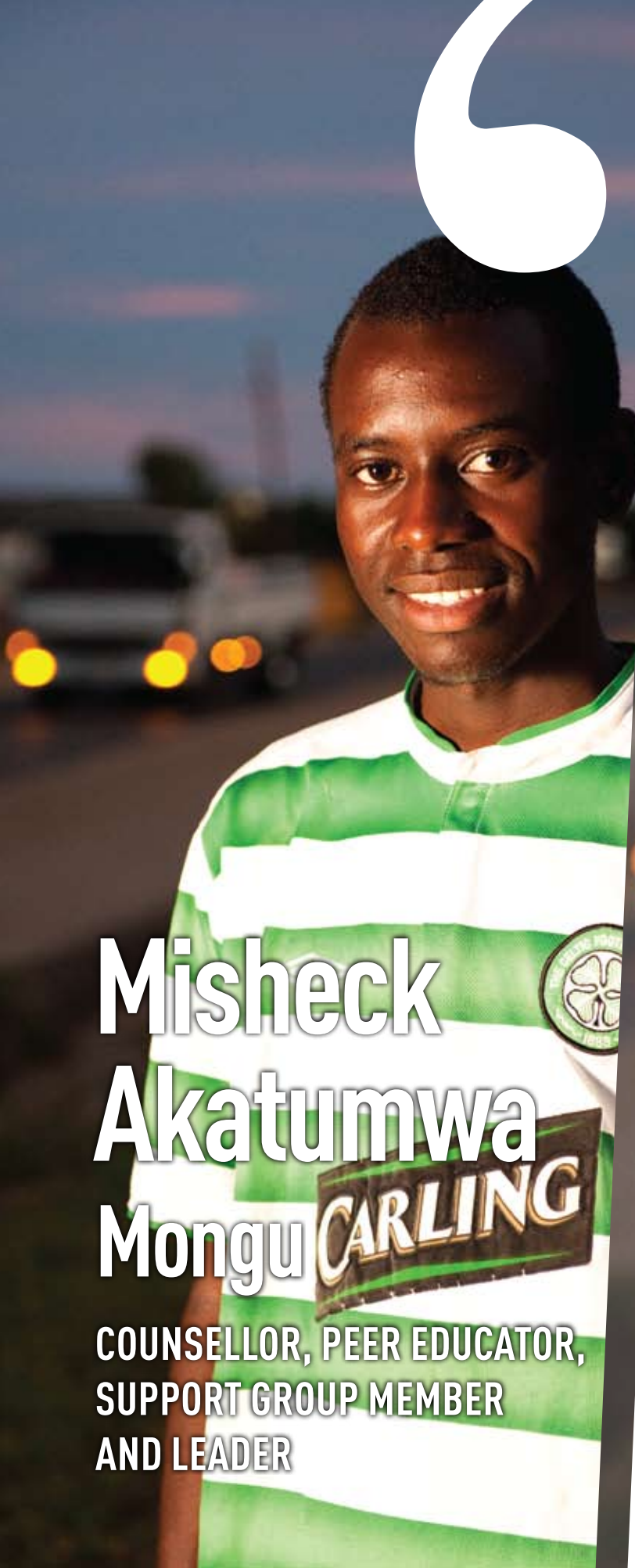
As her husband died, Mercy went for VCT and after a month she was diagnosed positive but was not too scared as she knew she could get medication to help her so she could be alive with her children. Her child was also tested at the same time and started medication also. It takes about an hour for her to walk to get their medication and she usually has to queue for a couple of hours. Mercy and her daughter take their medication at 07:00 and 19:00 but, they have problems getting adequate food. Mercy does not mind not eating herself but it is more difficult for the children because they do not understand.

Mercy suffers a bit from discrimination and stigma in her community, for example, sometimes if they are sharing food, or eating together, people will not eat from her plate if she has left some food because they are afraid they will become infected. She thinks that it is just from ignorance that they do this. It annoys her, but she tries not to pay too much attention because she does not want to get upset and depressed as this will make her weaker.

If something were to happen to Mercy, she is not sure who would look after her children because her relatives are very far away. She is the only one left of fifteen siblings. Her mother has passed away, and her father is still in her village and pays no attention to her. She has to remain strong so she can care for her children because no one else will if something happened.

Mercy thinks HIV is spreading because so many people in her community have it. People continue to drink too much and this makes them more susceptible to becoming infected. She insists that people should not sleep around and even in a stable relationship, condoms should be used because there are other STIs to worry about.

Mercy is thankful for the free medication because, due to the levels of poverty around her, she would not have been able to afford the medication otherwise. Mercy would be dead without it. She thinks parents need to be very careful and look after themselves so that they can care for their children, to stop children living on the streets.



Misheck Akatumwa Mongu

**COUNSELLOR, PEER EDUCATOR,
SUPPORT GROUP MEMBER
AND LEADER**

“
Once
people know
their status,
then they can
know how they
need to live.”

Born into a family of five boys and two girls, Misheck is a counsellor by profession and started working with ARHA while he was in school. This experience encouraged him to continue and to study counselling. He began work in Lewanika General Hospital in Mongu, where he delivered VCT services. He then began doing home-based care after completing his studies. He enjoyed this work because he met and supported a lot of different people, some negative, some positive. He also found it hard because he found it difficult to give people the results when they tested positive.

But with time, he got used to this and now enjoys the relationships he is able to build with his clients. He says that after counselling, the relationship with the client does not end there. He makes follow up calls to find out how people are doing, if they are having any

difficulties in terms of medication or any other challenges such as stigma or discrimination. He developed his interest for this work after attending a workshop on behaviour change. He admired the work people were doing and first wanted to work as a nurse or a doctor, but that did not work out. He knew he wanted to help people, so he decided on counselling.

Misheck argues that HIV and AIDS are definitely spreading among young people. If someone has a girlfriend, that girl may have another boyfriend also, sometimes an older man. The pandemic is spreading because people lack access to effective and appropriate information. Even those educating on the issue often do not have accurate information. Sometimes, Misheck argues, those very HIV and AIDS educators leading workshops go in search of girls after they finish and, as a result, people lose trust in them because of their behaviour.

Misheck feels he has achieved a lot with those he has helped. Before they were tested, they were very sick, some could not even walk, but now that they are on medication and have been supported they can walk again. They are much healthier and some are working with other support groups. Around 20 support groups have been set up for about 200 young people living with HIV and AIDS in Mongu. Previously, they were living with stigma and discrimination but this is now beginning to change.

Misheck goes for VCT frequently, every 3 months. People think the only way to become infected is by having unprotected sex but this is not true. On one occasion, while doing home-based care, he was splattered with blood from a person who is HIV positive. He waited 3 months to do a test, but it came out negative. He was quite scared when this happened, so now he goes every 3 months to be tested.

Misheck's girlfriend is also a counsellor and works at the Lewanika General Hospital in Mongu. They go for VCT together.

He lives in the same community as Kahilu (an ex-sex worker). She knew him as a counsellor but did not approach him to seek help until very sick. He encouraged her, by counselling her on HIV and AIDS (he carries out door-to-door education in the community). After that, she went for VCT with her friend and they both got tested and were found to be positive. After being hospitalised for over a month, Kahilu began taking ARVs.

Misheck has worked with a number of sex-workers, helping them to get tested and to access ARVs if necessary. Misheck has supported sex workers in becoming peer educators to get different work and cease selling themselves for sex.

It is difficult to support people like Kahilu now because there is not enough funding anymore to discourage them from going into town. If there is no support, they will most probably go back to sex work. Misheck feels like he has failed when things like this happen, because he has not been able to help them as much as he should.

People need to know their status. Sexual intercourse is not the only way you can become infected, there are many ways. Once people know their status, then they can know how they need to live.

Misheck argues that the government needs to be more serious about rural people. Urban areas have a lot of information, but the information does not spread effectively. Some people don't even know about condoms or do not have access to them. More education is needed and Zambian leaders need to be role models.

LEGAL AND POLITICAL VULNERABILITY

“Zambia’s constitution prohibits the enactment of any law that is discriminatory on the basis of sex or has such discriminatory effect. But it also recognizes a “dual legal system”, which allows local courts to administer customary laws, some of which discriminate against women.”

Human Rights Watch, 2007

Most cultures in sub-Saharan Africa are patrilineal, so when a woman marries through customary law, she will then be a part of her husband’s family or tribe and therefore any property will be passed along through the males in the family. Women can often only access land or property through their fathers, brothers, husbands or male relatives and cannot legally own land. If a relationship ends between a woman and her husband, there is a good chance that the woman will lose her home, land, livestock, household goods, money and any other property. These violations thus perpetuate women’s dependence on men and undercut their social and economic status. Women, therefore, have little or no access to property or reproductive rights.

Although equality, reproductive and sexual rights are supposed to be guaranteed under international and regional human rights treaties, unless they are recognised and enforced by national-level courts, they are of little or no value. This situation is exacerbated by the fact that in much of rural sub-Saharan Africa, there is limited access to legal information or to African

national courts in particular when it comes to the rights of women.

In Zambia, there are two ‘legal systems’ – the ‘civil’ court system and the ‘traditional’ court system and, depending on location and practice, these systems do not view issues identically with the traditional system being predominant. Women, and especially rural women, are routinely at the mercy of traditional courts because of the patriarchal nature of traditional practices. This can greatly affect women especially in terms of finance, and specifically in relation to owning property.

Poor educational capacity is often further compounded by lack of access to even basic information on, for example, ‘property grabbing’ by the family of a deceased husband or partner and what the law allows – this increases the vulnerability of women when faced with the economic realities of HIV and AIDS. The link between powerlessness and the risk of HIV infection is key to understanding the sources of women’s vulnerability.

“There is one factor more than any other that drives me crazy in doing the Envoy job: it’s the ferocious assault of the virus on women. We’re paying a dreadful and inconsolable price for the refusal of the international community, every member of the community without exception, to embrace gender equality. And in so many parts of the world, gender inequality and AIDS is a preordained equation of death.”

Former UN Special Envoy Stephen Lewis, 2004

COMMENTARY BY JOYCE MACMILLAN

I began practicing as a legal practitioner in a private law firm, then moved to corporate law as legal counsel and company secretary. Later I moved into the field of women's rights where I worked for 8 years before coming to the Zambia Law Development Commission. The Commission is a Statutory Body empowered to research and make recommendations on the socio-political values of the Zambian people that should be incorporated into legislation, the anomalies that should be eliminated on the statute book and the removal of archaic pieces of legislation from the statute book, among other things.

The legal vulnerability of women in Zambia stems from the fact that discrimination against women has been legalised and that, as a result, women are restrained in exercising their right to self-determination, to autonomy and to physical integrity. Zambia has a non-discrimination clause in the Constitution, but that clause does not apply to customary law and yet everybody lives their daily lives governed by customary law because we are born into it and we are socialised by it. By failing, reusing or neglecting to exclude non-discrimination under customary law, we have effectively left the door wide open to discrimination against women.

There are certain things that a woman can and cannot do. As a married woman there are do's and don'ts, there are norms. Women are forced or coerced, threatened and made to comply with those norms in daily life. This approach has permeated our laws because the people who enact the legislation are socialised in the same manner they have the same values as do our judges. There are also silent, unspoken and



intangible methods of control that force women to comply, and if you are not complying, then you risk becoming an outcast and because you have to comply, you are vulnerable to HIV and AIDS.

With customary law, from the time of puberty, you go through initiation and are taught how to be a woman and what is expected of you. Some customary practices during the initiation into womanhood also expose women to HIV infection. For example, in the Eastern Province of Zambia there is a practice where a sexually experienced older man has sexual intercourse with the girl before the coming out ceremony (the practice is called *'kungenesa fisi'* and is practiced among the Chewa). The initiation makes young girls often below 18 years think they are now women and the coming out ceremony (called *'chinamwali'* among the Chewa, the *'Nkolola'* among the Tonga and the *'ichisungu'* among the Bemba) is a public announcement that the girl irrespective of her age is ready for marriage and sexual activity.

From there, you go into marriage and it is from there that the danger of infection really takes hold because at least outside marriage women have some power to say no or 'use a condom'. But for married women, we are socialised to, once you say "I do" – you say yes to sex, at his convenience, even though you know he may be interacting with other people sexually. There is further a lot of pressure to stay married and as many women remain economically disempowered, they cannot get out of marriage and then there is also the pressure to have children.

There is a multitude of reasons why women stay in a bad relationship – the social stigma, the economic implications – "what will I do, how will I eat?" and then divorce courts usually side with the man when dividing the property. We are now trying to change this legally.

The courts do not use the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) or other international conventions because they are not very self-effective. Zambia ratifies them but we then have to domesticate them and instead of doing so, we copy and paste, pick out what we like and paste it into law.

We have a programme for women who are pregnant to access prophylaxis to prevent Mother to Child Transmission - we call it **mother** to child transmission, women are blamed and this has consequences. When a woman goes into an antenatal clinic and is tested positive, she has to sit down and

think, should I tell him, or keep it to myself. Sometimes women who have told have suffered consequences and this discourages others from telling their partners.

Sexual harassment in the workplace is not a criminal offence; it is in schools when it involves children, but not in the workplace. A lot of women become infected because of sexual harassment in the workplace. A man just comes onto you and they are literally raping you or coercing you into having the sexual interaction because they have the power over you to fire you, discipline you or make life in the workplace extremely difficult for you. It is

difficult to prove because it happens in private and it is your word against his, and he is often a more powerful, highly respected person than you.

Inheritance law excludes customary land, so if you and your husband are married, you build your home or your house on land held under customary tenure, you cannot inherit that land or the house. Because of this it allows the man's family to come and take away that land or you can be inherited by his family. If you refuse, you have to go back to your pre-marital home.

But what strikes me the most is that the younger women should be allowed to stay to keep their children there. However the head man sometimes says 'I do not want an infected woman who is young, who will infect other men in my village, so she must go!' So he will influence the family to tell these women to leave.

So you will find a lot of women moving to the urban areas. In Monze, there is a compound, Zambia compound – if you go there, you will see a lot of widows and their children there. Out of every 5 houses, 4 are widows. We found that they are mostly all young women who have been dispossessed of land, and had no where to go back to, so they move to town, either build a place or rent one or two rooms in the compound. They become commercial sex workers during the night, and during the day maybe they sell some tomatoes or cabbages to provide for their family. Sometimes those women become very sick also, and it is the children who have to care for them.

A lot of children are then being trafficked because they are trying to fend for their family. Some young girls are worked to the bone, sometimes paid with only one meal. You see young girls being taken from Monze to Chirundu or Livingstone to be used in the sex trade, and often getting infected. It is a vicious circle, it is so difficult.

There are a lot of Zambian women who do not opt for divorce but for judicial separation thinking that this order will separate them from the man and, as a result, they are protected from this man. But that separation order does not end conjugal rights, so at night, the man can come for sex, drunk or sober and the woman can do nothing. Women who apply for judicial separation now need to make an accompanying application for an injunction for restraining these conjugal rights.

Under customary law, women do not marry men, men marry women. Customarily the woman cannot divorce the man, it is the man that must divorce. So the woman will go to the court and explain and the court will say, you must make an application for something else (such as reconciliation) rather than divorce especially in rural areas and only if the court is satisfied that the couple cannot reconcile will an order for divorce be made. We need to move away from a lot of customary laws, but there is a lot of resistance, even from the women themselves. Some traditional leaders see the need for change but many others do not.

Under customary law, women do not marry men, men marry women. Customarily the woman cannot divorce the man, it is the man that must divorce.

Joyce MacMillan is a legal practitioner and analyst with the Zambian Law Development Commission.



Susan Kekelwa

Livingstone

VOLUNTEER, PRISON VISITOR, WIFE

“ Know what you think, know what you do - you will **live longer** ”

Susan Kekelwa is 36, married and her husband has three children from his previous wife who died. Susan does not yet have children.

Right now I am a volunteer with the Network of Zambian People living with HIV (NZP+), and with the IEC (Information Education Communication) Advocacy programme also where I do advocacy work. I have been with NZP+ for seven years; I joined just after I discovered my HIV status. Since joining I have received some skills training in advocacy work and human rights for people living with HIV.

After I was tested and was found to be positive, I went for over a year without telling anyone about my status but later on when I began to get involved in the work and saw how people would not go for testing and I decided to disclose my HIV status to some people. Even now some people do not believe that I am positive, because I have managed to look after myself so well.

I think I know how I became infected. I am not a person who had very many boyfriends, but I know one of them cheated on me. The other way I may have become infected is through being raped by a neighbour. It is only now that I realise how common it is that people violate other's rights but the victim is too scared to do anything about it. We went to the police but they argued that maybe we had an arrangement with that man - the blame was being transferred to me. I have met the man since, his wife has divorced him and he is miserable. After this, it was very difficult for me to have a boyfriend because I couldn't cope with it all. Now I'm not on any treatment. I just take good care of myself.

I met my husband through an organisation that visits prisons; he was in prison but very much willing to learn through the peer educators there. When he came out of prison, it was a while before I saw him, but eventually we did and he came to me and said 'You are going to be my wife!' I said, 'I don't think so!' but I was wrong as we got married on the 22nd December 2007. When I told him my status, we decided to go for VCT together because he did not know his. We both tested positive so I took him through the process of accepting his status and caring for himself.

Now we live a very happy life, he is not sick nor is he on treatment. We are planning to have a child because with PMTCT it is possible. But I want to take my time and prepare and look at all the options of breastfeeding or not and things like this. When my husband came out of prison, he found it very difficult to get a job. We have an uncle who gave him a car to use as a taxi so we can manage life. So when we look at our situation to have another child right now, it would be a problem for us, we have to raise some money first. Now he has a job so we hope there will be a baby soon!

Women are more vulnerable to HIV; it is always the women who take the blame. If they are pregnant, get tested and are positive, the men say 'you have brought the virus, you have been having affairs.' When you see the statistics of NZP+, there are more women in our support groups than men - they are very, very vulnerable.

For Zambian women, they need to know it is a virus that lives in you, it is not going anywhere; what you are doing, it also does, you need to accept it. If I sleep, it is sleeping, if I eat, it is eating. If I am having a lot of sexual partners, it is also interacting with them because it is in me. We need to remember that what I am doing, the virus is also doing it. Only when you die, it will stop. People think that it is

only when you are misbehaving that you will transmit the virus to someone else, which is not the case. This makes stigma worse because you think everyone is looking at you, everyone is watching you. If I look in Livingstone, I can be like a role model for the people because when they see me, they do not see the virus. I am open. I am not shy about it. If you do not open up and disclose it, it will eat you up! Women need to be strong and disclose their status, then you can survive.

For men, it is important for them to do couple counselling, they need to change their attitudes towards sex. They need to change their attitudes and behaviours or else it will continue. There are too many multiple concurrent partnerships.

My work in the prisons involves peer education, those in prison need to be cared for if they are HIV positive, food supplements are needed if a person is taking ARVs; they need to know how to care for themselves. For example, my husband is advocating for something to be done about sanitation, things are improving but diseases are still there though - TB, HIV, STIs.

Although people don't want to talk about it, every person deserves a second chance. Not everyone accepted my husband at first but I told them he deserved a second chance. He knows God now, is active in the church and is a very happy person. He is just a man. Some people think ex-prisoners need to be condemned. Not me, no.

I hope other people will learn from me. Positive living is something you need to do and can do. Know what you think, know what you do - you will live longer.



Godfrey Malembeka

Lusaka

EX-PRISONER,
PRISON REFORM ACTIVIST,
CARE WORKER, TEACHER



Women are in effect serving three sentences ”

Prisons Care and Counselling Association is a Prison Cell NGO formed in 2000 by ex-prisoners which deals with male and female remandees and convicts as well as illegal immigrants to assist in the rehabilitation of both prisons and prisoners. It focuses on the improvement of the physical conditions in prisons – improving cells, building schools etc. – and on education - running classes on a broad range of topics including HIV and AIDS, human rights, drugs, mental health etc. Most of the prisoners, especially the female prisoners are illiterate and this makes them vulnerable. Most of the current female prisoners are divorced because once a male partner realises the woman is going into prison, he will divorce her – *‘Men in Zambia are not ready to wait for their wives, but the wives wait for the husbands. We are trying to balance that scale.’*

We look at the plight of women with their children in prisons - they are known as circumstantial children – born and brought up in prisons. We are building nursery schools and we want children to go to school with prison officers’ children and other inmates children because they are free but inside. Zambian society is not ready to look after a prisoner’s child.

We approach the issue of HIV and AIDS from, for example, the drug abuse angle. When you look at modes of transmission, you cannot separate it from drug abuse. We focus on drug abuse sensitisation; we want inmates to know the long and short term effects of drug abuse. We know that drugs give them courage to commit sodomy and many of the other things they are involved in. The hottest or quickest mode of transmission is actually sodomy and

homosexual activity in the prisons because condoms are not allowed!

We also focus on human rights, natural rights, which prisoners have even if they are incarcerated. They have rights to eat three times a day, to adequate shelter, to decent clothing, health treatment – these are not privileges. The Zambian prison system is designed to accommodate 5,500 prisoners but actually has about 16,000 plus at the moment, so serious congestion is a big problem. So when we talk about blood and air-borne diseases such as TB, HIV and AIDS, the prison environment is very conducive to these diseases.

We want the justice system to respond by resorting to non-custodial sentencing, there are a lot of people in prison today for petty offences and these people should be outside, they should be given fines, suspended sentences, they should be given community based sentences. We are also looking at empowering women in prison, we want to help them so that by the time they are leaving prison they have some capital and the possibility of a new life, perhaps with their partner.

The main contributing factor to the vulnerability of our women is the Prisons Act itself which empowers the officer in charge to select who should be treated at the hospital on any particular day (even if a doctor has already recommended treatment). The officers have the final say on who may be allowed to go for treatment – this is creating a lot of problems for women as these officers or wardens in charge are not medical officers. It should be a basic right for women that they are attended to by a doctor.

We have 86 prisons countrywide but only 15 prison based clinics. 33 of these 86 prisons are open air prisons, these are a little bit better

because prisoners are allowed to walk, to go all over, there is less security – but the 53 penal prisons **must** have clinics.

The vulnerability of our mothers, our women, is higher than that of our male convicts; if a person who is not expectant is finding it difficult to access treatment, what about the expectant mothers, who have to deliver in prison? The current situation does not cover the babies born adequately, in terms of basic provision. So you will find that expectant mothers are incarcerated twice - they are incarcerated mentally because they are thinking of the baby, and their actual incarceration. So looking at mental health, you will find that the level of disturbance among female prisoners is higher than among men. Another problem under the Prisons Act is that wardens can transfer prisoners and often when they are transferred their files are not transferred with them, causing medical and other difficulties. There are considerable problems associated with medical records which are constantly lost impacting directly on treatment for HIV and AIDS.

Obtaining CD4 counts is also problematic as the system does not have CD4 count machines; people can be tested, but if the viral load is not known, they cannot be put on drugs unless they are escorted to a bigger hospital. We need to attend to our women quicker and more effectively. They are in a worse condition than men, especially because they don't have people

who will visit them to support them. The men in the prisons always have their wives, mothers, sisters – there is always a queue.

There is also an issue of food supplements. We are given strong drugs but not fed three times a day and the food is not balanced. People are given 350 grams of food a day and it is always the same food. 350 grams of rice, or of maize meal. There is nothing else: no oil, no ground nuts. We work with prisoners to develop their own gardens so vegetables can be available.

The law that governs prisons was made so long ago it is actually outdated; it does not take account of international law or standards. If you examine the law you will see that women are not even allowed to go into prison with their underwear! How are women supposed to survive like this?

And then there is the issue of drugs. One of the main reasons why women are in prison is because they are used as drug mules; they are asked by wealthy men to transport drugs from one country to another, or even within the country. Some of them are in because they were selling marijuana, some for selling game meat, some are in because they were fighting; some are in for armed robbery. We have people remanded in prisons sometimes for 5, 6, 7 years, while they are waiting for their case to be heard; their records are gone, the arresting officers don't turn up etc. These things can drive you to drugs.

Women are in effect serving three sentences:

- as their husbands have divorced them

- because they are worried about their babies because they cannot feed them properly or care for them properly

- then the years that they are actually serving.

We have opened up 'site clubs' in prisons - for example Lusaka Central Prison has a PRISCCA Site Club with a full committee of officers, trustees, teachers, lawyers (some of whom have been incarcerated) – they are designing lessons on issues such as HIV at the level of the prisoners and in languages they can understand. Some prisoners are trained as Peer Educators, so that when they are in the cells at night time, they can teach and talk about the issues.

Stigma is still a problem, and there is stigma within the stigmatised community. Prisoners are stigmatised by the outside community and then, those who are on ARVs in prison are also stigmatised.

Women are in effect serving three sentences:

- because their husbands have divorced them
- as they are worried about their babies because they cannot feed them properly or care for them properly
- then the years that they are actually serving.

It is always the women who support these women in the prisons, I go on the radio to talk about this and the response from men is *'why do you support these women, they are harlots! Why should you make the environment in prisons better for these women'*. But the response from women is different *'Any person can land in prison; continue the work you are doing. Where can I find you because I have these shoes.'*

The rural areas are worse for the women. In the rural prisons, there are no lawyers, they follow the judges. Judges need to be sent to the provinces, we advocated for that and luckily the government listened. They are sending judges to the provinces next year, and the lawyers will follow. In rural areas, some women have to deliver in prisons with no water, no electricity. We have to supply them and their babies with clothes.

I suffered heavily in the congested prisons. Most of the things that go on in prisons are not seen or heard of outside. It was very bad, especially when there was cholera. I saw my friends wrapping themselves in newspaper and plastics to try and stop the infection... you are supposed to be fed three times a day in prison. For four years, I was fed only once a day; sometimes you just feed on bean soup... you would not believe how bad it was. But still I survived. I was bitter with the justice system after this.

EDUCATIONAL VULNERABILITY

“As it has become increasingly clear that keeping girls in school is protective against HIV, achieving Education for All (EFA) would be a critical contribution to HIV prevention ... Focusing EFA efforts on the poor, who are the least likely to attend school, will have particular benefits in the fight against HIV. Poverty and HIV are intertwined issues in southern Africa ... While increasing levels of general education can be effective, tailored HIV prevention curriculum also has a role to play...”

Matthew Jukesa, Stephanie Simmonsa and Donald Bundy, 2008

The educational challenge of HIV and AIDS in Africa is deeply rooted in the pervasive gender inequalities in African societies and the subordinate status of women and girls. For economic, social, family, health and cultural reasons, many young girls are forced to leave school early. This reality contributes greatly to lowering female literacy rates and to generally poor educational attainment. The lack of effective education and poor literacy contributes to the disempowerment of women. In the context of women's health and HIV and AIDS, it puts them at serious risk, not only prior to infection, but also post-infection. Poor education attainment generally reinforces gender inequalities leaving many women uneducated or ill-informed as regards issues such as the transmission of HIV and on how to protect themselves from becoming infected.

There are a number of key issues which must be highlighted and addressed with regards to girls and women's education. The main focus points are the threat HIV and AIDS poses to the progress already made in girls access to and completion of basic primary education; how education is a 'critical mitigating force' for developing life skills and knowledge in terms of supporting themselves and their families; and that

by assisting girls in overcoming the effects of HIV and AIDS and supporting them in gaining access to education, they become more empowered to support themselves, their families and communities and also contribute to national development.

“In the longer term, and more generically, education plays a key role in establishing conditions that render the transmission of HIV and AIDS less likely—conditions such as poverty reduction, personal empowerment, gender equity. It also reduces vulnerability to a variety of factors, such as streetism, prostitution, or the dependence of women on men, which are a breeding ground for HIV infection.”

Michael J Kelly, 2000

COMMENTARY BY EDITH NG'OMA

In terms of access to education, the situation has greatly improved but the problem now is with retention and completion; girls are able to go to school, but they are not able to stay in school. In terms of the quality of education, improvement is badly needed. We now need to try and ensure everyone gets as far as grade 8 and 9. Not all schools have grade 8 and 9, so some children have to walk long distances. Then they arrive in school tired and cannot concentrate. Sometimes they start renting closer to the school and go home at the weekends to get food and so on but if they run out of food during the week, they must return home and so miss school time. In certain cases, we have schools without proper toilet facilities for girls, so most of the time when they have their periods they would prefer to stay at home. Many, they don't have sanitary towels as these are considered a luxury. So you find that while education may be improving because the Ministry of Education is active, the quality of education is not what it should be. Girls have to sit the same exams and often they are not prepared and so don't turn up for exams. We have examples of classes of more than 40 students where only 5 might come for the exam.

FAWEZA has sensitised communities and formed committees to try to monitor the schools. Students keep a record and mark how many times a teacher comes to class. Some teachers just tell the children to read specific pages and stay in the staff room, so the children are on their own in class. There are still all sorts of problems and issues with schools.



FAWEZA has two major programmes, advocacy and lobbying and interventions designed to increase female participation in education. We have worked on a 're-entry policy' which has brought a number of girls back into school after pregnancy; now when a girl gets pregnant, she is allowed to go on leave and come back about 6 months after delivery – this is major breakthrough. We are also working on the issue of preventing, managing and eliminating violence against children in schools. We also have scholarship schemes where we support girls and boys in basic schools, high schools and as well as tertiary level. We do not support students up to grade 7 because this is supposed to be free although uniforms etc. still need to be bought. We are supporting 70% girls and 30% boys in the scholarships programme.

The other programme is focused on SMT interventions – Science, Maths and Technology. In the past it was believed that tough subjects such as these were for boys only, and girls were not allowed to take them. We have introduced

a competition where the best 4 students of each province are brought to Lusaka for a quiz. This encourages the girls to participate in these subjects. In this current year the overall national winner was a girl and in the teacher's competition (which looks at methodologies for teaching these subjects), a female teacher was also the national winner.

There are many other interventions such as reading circles (with books supplied by UNICEF) and what we call SAFE clubs - Student Alliance for Equity; they are designed to help students help each other to study and where they also learn life skills.

Traditionally, girls cannot have boys as friends, they cannot mingle but in these groups this can happen. We have overseers and peer educators trained to lead these groups. So they talk about different life skills, how to be assertive, HIV and AIDS issues, how to prevent infection

etc. We also have what we call Back-to-Back where women in the community who have a skill (knitting, sewing etc.), come together and help each other learn. Then we try to give them a seed fund so that they can start projects and raise funds. 70% of the profits usually go to the women, and the rest goes to the children who are out of school. This runs hand in hand with 'transit schools' in most communities where children who drop out of school are encouraged back. We also have a security and safety project as some girls have to walk a long way to and from school and run the risk of abuse or even rape. We now have 'safe houses' with matrons who care for the girls; we now have about 6 of these houses; we also have mobile libraries as most schools do not have adequate amounts of books. Ultimately, the challenge is about building real access to education.

In the past it was believed that tough subjects such as these were for boys only, girls were not allowed to take them.

Lack of education has a big impact on the kind of decisions women make e.g. how they defend themselves because they may not understand their rights. We have a lot of women who find themselves in positions where they say *'If I stand up to my husband and say this, what happens if he kicks me out, where will I go, how will I care for my children?'* This affects the country as a whole. When a child goes to school, they come home with homework and may not understand it or how to do it. If the mother is educated then they will be able to help but if the mother is not educated, the children may fall behind, and may even eventually drop out.

Most schools have HIV and AIDS clubs, but not everyone belongs to them, and that's one disadvantage. The only time a whole school would benefit is if the HIV and AIDS club decides to do a presentation at assembly or something like that. Then everyone will hear.

So to a certain extent, it is filtering into schools but not really fully; it needs to be included more in the curriculum for all ages. Some people are ok with their children learning about condoms and sex. But others feel that by teaching them about these things we are giving permission to have sex and culturally, some people are not comfortable talking about sex and reproductive health at all.

There is so much excitement when you go to a community and the women have learned to write their name - it brings a lot of pride. Traditionally, when a girl comes of age she is sent to her grandmother to be taught about womanhood and marriage. But if the grandmother is unable to read or write, she will only teach the girl about the more traditional aspects of marriage, and nothing about the danger of HIV and AIDS. If those women are taught how to read and write, and have information about HIV and

AIDS that is the time they can teach girls about protecting themselves. Sometimes the children just have to depend on what they learn from television, radio and their friends.

HIV and AIDS education needs to be better represented within the school curriculum, and it also needs to be more integrated into teacher training colleges because teachers need to have this information. In this context, we are trying to use a gender responsive pedagogy where teachers are being responsive to gender. The way we are approaching this pedagogy is the way we need to approach HIV and AIDS, through a gender focus. Through the colleges, we can reach the teachers. Through the teachers, the students. Through the students, the homes.

Right now, women have little say in terms of bedroom issues. They go by what the man says. But if they are given information about how they can share this information with their husbands, what their rights are, perhaps a lot of issues could be resolved.

We need to have mobile schools in rural areas where even just once a week in the really remote areas, we have teachers coming to see the women, teaching them something, leaving them homework for the following lesson. If we were to bring the school to the communities where they could spend a few hours, women would be very willing and maybe then, women in really rural areas can have access to education.

Some cultures believe that the earlier the girl gets married, especially if she is a virgin, then the better it is in terms of the dowry; this is a major issue. There are cultural traditions where if a woman dies, her sister takes her place without finding out why someone has died. Such cultural practices are hindering women.

Through the colleges, we can reach the teachers. Through the teachers, the students. Through the students, the homes.

The situation for women is now improving even in rural areas where there are groups of women who take part in these clubs and where they teach each other skills and reading and writing. They are making an effort on their own. In the past people chose to send the boy to school but for a girl, she would be married off. Now many have realised that it is not always the case that a girl should get married. The value placed on education is also changing. People are becoming sensitised and we now hear more about abuse etc. In the past we would have been told not to embarrass the family by talking about this. Sometimes we would only hear about it after a woman has died; now it is

different, women can talk about it more. They also have the courage to report cases of abuse, although they still fear not being protected. Education is positive because people now know they have rights and women know where they can go to be kept safe. Women also now realise how important being educated is along with having work, so that they become self-reliant instead of just depending on their husband. This is what is happening, tradition is changing.

Edith Ng'oma is Programmes Manager at FAWWEZA – the Forum for African Women Educationalists of Zambia, an NGO advocating for change in the Zambian education system and more broadly on the needs of girls and women.



Patricia Pumulo

Mukoko, Mongu

**BUSINESS WOMAN,
MOTHER, WIFE**

**SUNTRUST**



this can **happen to anyone**
at any time ”

Patricia was born in 1976 and has given birth to nine children but five of them died. She is married to Kayama who is 31 years old and works as a security guard in Mongu.

Patricia is a small scale business woman selling roasted casava and ground nuts at the market in Mongu, which she buys from farmers in Kaoma. She rents her house in Mukoko for K25,000 per month. Life is tough in her community and most people survive through small business activity.

When she went for testing in 2007, she was four months pregnant; hearing that she was positive, she was very scared, but got advice on what to do next. She did not know anything about mother to child transmission, she delivered the baby at home because she did not realise she could infect the child during delivery and the child became infected as a result. After four months her child became sick, tested positive and was given medication and was then put on ARVs because both her and the child were very sick. Patricia and her baby were in hospital for 2 months but sadly her baby died at eight months; Patricia has now been on ARVs for 4 years and one of her two sons is negative and the other has not yet been tested.

Her husband, Kayama, was tested last year in the local health kiosk and was found to be positive having earlier being tested negative. They have been together for three years and he insists he did not know Patricia's status until he tested positive.

There is stigma in the community and many people point at Patricia because she is on medication. Because of her counselling, she has learned to ignore it because it would only contribute to her sickness. She knows this can happen to anyone at any time, so it is best to ignore them.

Patricia thinks women are more vulnerable because of the different modes of transmission giving birth and helping deliver babies and using razor blades.



MORE WOMEN GO AND FIND OUT ABOUT THEIR STATUS THAN MEN WHO WOULD RATHER CARRY ON AND NOT KNOW THAT IS WHY OUR WOMEN ARE DYING AT A TENDER AGE, BECAUSE OF OUR CARELESSNESS WE WERE NOT WANTED BY OUR FAMILY SO, WHEN DAD DIED, WE HAD NOWHERE TO GO





EVEN THOSE WHO ARE MARRIED DO PROSTITUTION BECAUSE THEIR HUSBAND DOES NOT GIVE THEM ANY MONEY
MY MESSAGE TO THE WHOLE WORLD IS THAT YOU SHOULD NOT BE DISCOURAGED IF YOU MAKE A MISTAKE



CIVIL SOCIETY IN ZAMBIA: A RESPONSE

THE VIEW OF
WOMEN FOR CHANGE
ON THE PANDEMIC

“The fight against HIV and AIDS can only be undertaken successfully when there is a clear focus on women, putting them at the centre of the whole pandemic and ensuring that women take full control of their own bodies. For WfC, the fight is against gender imbalances and cultural practices that perpetuate power relations inimical to women’s health. HIV and AIDS in Zambia is a power relation issue and it is also a class issue. Unless we break these barriers, we will not succeed in fighting the HIV and AIDS scourge. WfC will therefore concentrate on the above-mentioned issues in a practical way in the communities”

As an organisation, WfC considers the following as urgent priorities in the fight against HIV and AIDS in Zambia and particularly in its operational areas:

- Support interventions aimed at enhancing the quality of life for orphans and vulnerable children and this includes:
 - Facilitating support to orphans by providing them with school needs
 - Facilitating capacity building for out of school orphans to enable them look after themselves
 - Facilitating the attainment of food security for families caring for orphans
- Working towards poverty eradication in the communities where WfC works because of the link between poverty and HIV infection
- Intensifying advocacy on the plight of HIV and AIDS orphans and vulnerable children including social support for orphans and widows in HIV and AIDS prevention
- Continuing to campaign for policies and practices that are gender-sensitive, just and effective in responding to the plight of the poor and those affected and or infected by HIV and AIDS
- Creating public awareness on rights of people living with HIV and AIDS
- Intensifying activities in gender analysis and awareness raising to ensure both women and men are sufficiently gender sensitive and able to act on gender issues that perpetuate contracting the virus and its transmission. Through gender-focused programmes, power relations that perpetuate the spread of HIV and AIDS infection such as sexual cleansing, sexual violence, abuse and rape in homes should also be challenged
- Working with traditional leaders to advocate for the banning of negative cultural practices that put women and men at risk of contracting the virus

THE OFFICIAL GOVERNMENT RESPONSE

HIV and AIDS became a public health issue in the early 1980s in Zambia. In 1986 the Government of the Republic of Zambia initiated its first response to this in the form of the National AIDS and Prevention Control Programme (NAPCP). As with other government responses at the time, it became apparent that the initial response to HIV from the Zambian Government was insufficient as it focused only on the biomedical aspect, with very little, if any, focus on the social aspects of the disease. Throughout the 1990s, non-governmental organisations, community based organisations and faith based organisations partnered with the government to attempt to address the gaps in the response to HIV. This then led to the formation of the National HIV and AIDS/STD/TB Council (NAC) to effectively control, co-ordinate and manage all government and civil society interventions.

Since its establishment in 2000, NAC has overseen the development of a number of initiatives to address the issue of HIV and AIDS such as the National HIV and

AIDS Intervention Strategic Plan (NAISP) 2002-2005, the National Monitoring and Evaluation Plan, the National Decentralisation Policy 2003-2012, the 2005 National HIV and AIDS Policy, the National HIV and AIDS Strategic Framework 2006-2010 and the Fifth National Development Plan among a number of other policies, plans and laws. The Sixth National Development Plan is in the process of being agreed and implemented.

It has been argued that the most important of these initiatives is the National Decentralisation Policy 2003-2010. The policy's main aim is to devolve responsibilities for resource allocation, human resource management and accountability to the provincial, district and community level. This includes Provincial AIDS Task Forces (PATFs), District AIDS Task Forces (DATFs) and Community AIDS Task Forces (CATFs), which are then all part of the Provincial Development Co-ordination Committees, the District Development Co-ordination Committees and Neighbourhood Health Committees respectively. At the international level, Zambia

has also ratified a number of key instruments in order to further address the issue of HIV and AIDS including the Maseru Declaration on HIV and AIDS which, once translated into national practice through the HIV and AIDS strategic framework, has promoted the access to care, treatment and support and, most importantly, free Anti-Retrovirals (ARVs).

One of the main areas of focus in the National HIV and AIDS Strategic Framework (NASF) 2006-2010 is to intensify prevention of infection. As a result of the Zambian Mid-term Review of the NASF, four priority prevention areas were identified:

1. Prevention of sexual transmission of HIV
2. Prevention of mother-to-child transmission (PMTCT) of HIV
3. Counselling and testing
4. HIV prevention in health care setting, including post-exposure prophylaxis (PEP)

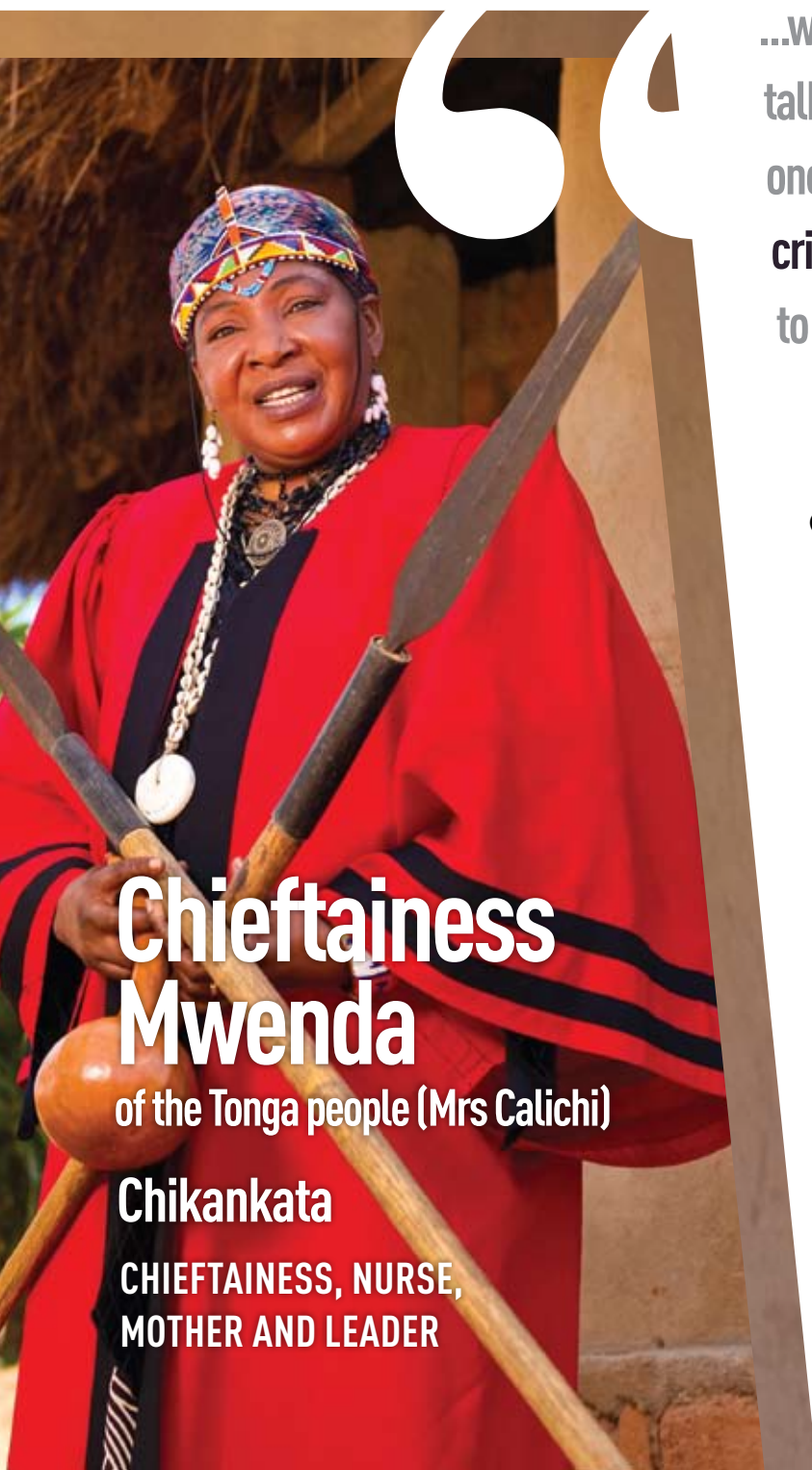
Policy areas covered by the NASF include:

1. Protection and human rights (including the protection of vulnerable groups such as women, young people, prison inmates and migrants. This, however, does not include protection of people living with HIV and AIDS)

2. Universal access (to prevention, treatment, care and support for men and women)
3. HIV testing (the national policy on HIV counselling and testing stipulates that this service should be provided free of cost to all users)
4. HIV education in school (and that each curriculum should be responsive to local culture)
5. Sectoral and workplace policies and strategies
6. Ethics in research (A Research Ethics Committee reviews and approves any HIV and AIDS research protocols involving human subjects)

As is mentioned in the vulnerabilities section of this report, HIV and AIDS is a ferocious attack on women. While women display a number of common vulnerabilities with men, it is apparent from the evidence illustrated in this report that women also display a number of significant and unique vulnerabilities which must be recognised, understood and addressed with specific, focused and 'gendered' interventions if they are to be effective. However, this is not reflected in the policies, plans and strategic frameworks listed above. Although women are identified as being a vulnerable group, this does not address the severity of the issue for women in Zambia.

A TRADITIONAL LEADER RESPONDS



Chieftainess Mwenda

of the Tonga people (Mrs Calichi)

Chikankata

**CHIEFTAINESS, NURSE,
MOTHER AND LEADER**

“...we need to talk business, not talk rubbish. We need to accept one another. **We need to stop criticising one another.** We need to bring development, not gossip.

”

Chieftainess Mwenda is fifty five. She is married with four children, all of them girls. Professionally she is a nurse, but she is now a chief of the Tonga people. She is the ‘umbrella’ for the Tonga people, a ‘roof’ for their house, a role given to her by God. There have been chiefs in Zambia historically and when the British arrived in Zambia, there were already many tribal structures and laws. Her tribe has powers of rainmaking – they would pray for rain and God would bring that rain.

She is the ninth chief since records began while there have been many chiefs, there has not been a woman. Chieftainess Mwenda is the first female chief. Historically, they used to send women to the ancestral shrines to be sacrificed

to appease ancestors. At that time, women were never involved in decision making or in giving orders or involved in the administration of the people. They had to struggle in a court of law for her to become chief. They had to get a court to rule that a woman could be chief as there is still a lot of stigma where women leaders are concerned. While she has stood strong as a chief for her people, even now, many struggle with the reality of being ruled by a woman. People call her names, and tell her she cannot rule them because she does not have hair on her chest. She understands this, but insists they will eventually have to accept her. She wants to bring change for her people but it is the people who can bring real changes, with the help of the international community.

HIV and AIDS have affected her personally because she has lost many of her people to it. As a Home Based Care (HBC) nurse, she lost many, many friends, including educated people within her family. She says it has driven her family backwards and that even now, it is difficult sometimes to care for her family and people. She has seen people die and they are still dying. She regularly thinks that if this person or that person was still alive, they would have made a big change in the area. She needs men in her community as they are supposed to be builders and pillars of the community. Men have a lot of knowledge, but they need to change. She feels HIV has impacted hugely on her life – she has a great interest in it because of this.

The two most important things that need to be done – education, we need to share what we know and learn, we need to educate young people. The second is empowerment in order to fight poverty.

She believes men are more affected but then they infect women *‘Initially we lost a lot of men, but now we are losing their wives. This means they leave a lot of orphans’*. She cares for a large number of orphans and is trying to educate them. If the women were still there, they would care for the children. If men were still there, they could also care for their children. She is also the mother to the children of her brothers. She feels there is a lot of pressure on her as a chief because people believe she can care for all of these children, but it is a huge strain on her.

In Chieftainess Mwenda’s view, the practice of sexual cleansing contributes a lot to the spread of HIV and AIDS. It has been practiced for a long time within the tribe. In order to remove the ghost of a husband who has died before he is buried, the pants of the husband are exchanged with those of the wife. She must wear them while he wears hers and is buried in them. After five days of mourning, she has to remove the pants, take a bath, and then a man would be brought from her late husband’s tribe to have sexual intercourse with her. If she refuses, then people will come and force her to have sex. It is then assumed that that man can have sex with the woman whenever he wants after this.

There needs to be a law prohibiting sexual cleansing because it is dangerous, especially if you do not know if the husband died from HIV-related illnesses. If the husband was HIV positive, then this would mean that the

woman brings HIV to this new man and his other wife/wives. Once he has 'cleansed' her, this means the HIV will spread.

There is also a strong tradition of witchcraft and she believes people have tried to bewitch her. In order to protect themselves from such bewitching, people believe that they need to get protective tattoos, which are done by people who are not educated, using the same razor blades on different people often promoting infection.

Within the tribal meetings, when they are discussing developmental issues, HIV is always included. She believes that education about HIV is very important, especially within schools. What worries her the most, however, is the need to change people's lifestyle. Despite the fact that people have knowledge, people do not want to change their lifestyle. They still want 2, 3, 4 or 5 wives. They are still having sex with many partners, before and during marriage. The Chieftainess says there is knowledge that if someone is HIV positive, you cannot sleep with them, but you must take care of them. If you inherit an HIV positive wife, you can care for her, but not have sex with her.

As a Christian, the Chieftainess promotes abstinence. She argues that people need to open their eyes as *'we are living in a changing*

world. My children do not even believe the same things I believe. So I do promote the use of condoms, but also for people to stick to one person, one sexual partner at a time. You cannot have sex with lots of people – you will become immoral. As a HBC nurse, and a Christian, I used to carry condoms to give to my patients. When I worked as a nurse,

people would ask 'Aunty, do you have anything for me?' and people would be happy because I gave them condoms'.

Men have too much power. We have been taught to submit to men – we have been told, we cannot say no to sex. If your husband approaches you, whether you are ready or not ready, you have to say yes to sex. Women have no control over their bodies. You do not know how a man is using his body. You do not know how many partners he is meeting. But when he goes to his wife, she cannot refuse him. You have to let him do what he wants. He can bruise you, but you cannot cry out. It is like women are being bought to be sex machines.

refuse him. You have to let him do what he wants. He can bruise you, but you cannot cry out. It is like women are being bought to be sex machines.

The Chieftainess focuses on widows in the community, on empowering them and helping them educate the community. She finds it is difficult to work with the women in her community as they try to intimidate each other, and there is too much gossiping. A change our mindset is needed in order to become proper leaders – *'we need to talk business, not talk rubbish. We need to accept one*

another. We need to stop criticising one another. We need to bring development, not gossip'.

She feels HIV is becoming static now as there have been so many deaths in the young age groups. Changes in the living style of men are badly needed. Men's behaviour is a huge issue.

The two most important things that need to be done. Firstly, education. We need to share what we know and learn, we need to educate young people. The second is empowerment in order to fight poverty. If people have something to eat, they do not need to sell their bodies in order to feed their family.

We need more honesty in the aid that is given to Zambia. There needs to be a 'down up' approach as we need to feed the roots to empower the leaves. If you feed the leaves, everything becomes dry. The government needs to not enrich themselves, but enrich the roots.

The Chieftainess would like young women to be taught that they do not need to submit to men. When they say no, it should mean no.

A 'no' must be said. We need to have rights, just like men. If a man finds a woman in a relationship outside of marriage, they can sue them. But women cannot if they find a man is doing the same. Men need to be punished for this also. Proper practical equal rights are needed between men and women, not theoretical ones. Practical ones. If we continue to crawl in front of men, they will continue to look down on us. Stand up and show them that we are making a change. Raise your head and tell them that we are teaching men to make a change. Change has to begin with me, you and him and her, so that others can also change.

In Africa, there are no laws to prevent polygamy and affairs like there is in the rest of the world.

As easy as we are breathing the air now, a man can live how he wants to live, and no one will say anything. There is too much freedom. We need to harness this. If the government would give us more power to set rules for our people, I would change things. If you found your husband was having an affair, you should be able to sue him, because he is bringing HIV to your family. We need to strengthen our government set up and rules. We can play a better game.

Let us talk about things that are supposed to be taboo in our custom. Let us talk about sex. Let us be open so people can learn. That way we will be able to fight HIV. There is no way that we will begin to develop if we lose young people from our area. We need to be empowered. We need to keep the family circle tight in order to fight HIV and AIDS.

IRISH AID RESPONDS

BY NICOLA BRENNAN

For Irish Aid, it was clearly evident that HIV and AIDS was having a huge impact on people's daily lives. There were many teachers, health workers and ordinary members of the community dying. People were phenomenally affected and very little was being done. This was the development challenge to which Irish Aid responded.

Irish Aid was among one of the first bilateral donor countries to develop an organisational strategy in response to this HIV and AIDS crisis. It was developed in 2000 as a direct response to the impact of HIV and AIDS on people in the areas where Irish Aid was working – particularly in Sub-Saharan Africa including Zambia. The strategy identified women and children as being disproportionately vulnerable to HIV and AIDS and also looked at the impact of the virus and its consequences on women and children in particular.

Women were identified as being more susceptible than men biologically but also culturally where in terms of sexual relations, women could not always demand protection,



leaving them particularly vulnerable. Another area in which women were identified as being particularly vulnerable was in the burden of care. Women and particularly young girls take on the role as care-givers when someone becomes ill within the family.

Men, it is clear, are the decision makers in families and there is a lot of work to be done in working with both men and women to address unequal power relations especially in relation to sex. Irish Aid has a strong gender based approach in its work to reduce poverty and address the impact of the HIV and AIDS pandemic.

The prevention of further HIV infection is at the core of Irish Aid's approach which also addresses issues of treatment access and care for those living with HIV and AIDS. Prevention is still central to our work. There is no magic bullet when it comes to HIV prevention and Irish Aid looks to a range of strategies including Behaviour Change Communication.

EDUCATION AND PREVENTION

Irish Aid invests a lot in education prevention campaigns and education for girls – in Zambia this is the largest component of the aid programme. Access to education for girls is vital and research has shown that education in itself is a preventative mechanism so it is critical that girls get access to education and the longer they stay in formal education the better – this is critical.

Irish Aid also supports direct HIV prevention education, working with teachers in terms of building their skills and capacity to teach about the virus etc. We also support peer education and youth groups as a method of educating young people about HIV and AIDS. In Zambia, Irish Aid has a particular focus on supporting community schools where education is accessed by the most vulnerable children, many of whom have been orphaned and whose vulnerability has increased as a result. Statistics would suggest that the majority of those orphaned are often as a result of HIV and AIDS. Irish Aid also supports schools through working with civil society organisations and government to reduce child abuse in schools and provides bursaries for very vulnerable children to ensure that they can go to school. In addition, we support country wide HIV campaign prevention campaigns, access to voluntary counselling and testing, and the prevention of HIV being transmitted from mother to child during and after birth.

INTERNATIONALLY

Irish Aid invests in long-term research and development with the objective of identifying a suitable HIV preventative vaccine. Some but slow progress is now being made in this area. The identification of such a vaccine could provide immediate protection against HIV

infection. We need to continue this investment if we are going to have a long term impact on this pandemic. Irish Aid has also invested in the development of microbicides¹ and was among the first bilateral donors to fund such which includes the public sector donors who provide the funding and the pharmaceutical industry who provide the science and research. There are different types of microbicides currently being tested in clinical trials with varying levels of progress. Trials are taking place in South Africa, West Africa, India etc. A fully effective result has not yet been discovered but when it is, the benefit to women will be great. It will mean they will be able to access microbicides as an individual and determine their use. Studies have shown that many women are excited because they will be able to take control themselves while others are less optimistic and a little concerned about the reaction by their male partners.

NUTRITION AND CARE

Nutrition plays a key role in relation to HIV and AIDS. People who have adequate access to food can stave off infection initially and if HIV positive, can halt the spread of the disease to AIDS if their access to food is good and consistent. Irish Aid works to ensure that people infected and affected by HIV and

¹ Although there are many approaches to preventing sexually transmitted diseases in general and HIV in particular, current methods have not been sufficient to halt the spread of these diseases — particularly among women and people who live in less-developed nations. Sexual abstinence is not a realistic option for women who want to bear children or who are at risk of sexual violence. In such situations, use of microbicides could offer both primary protection in the absence of condoms and secondary protection if a condom breaks or slips off during intercourse. Microbicides may eventually prove to be safe and effective in reducing the risk of HIV transmission during sexual activity with an infected partner

AIDS have adequate and consistent access to a stable and nutritious diet. In the area of care, we work at a number of different levels.

As regards policy and advocacy, we support government to respond to the vulnerability of HIV and also provide advocacy support to civil society so that they can represent the voices and reality from community level in their dialogue with government and in influencing policy and programming. Irish Aid provides significant support to civil society organisations in their work on HIV and AIDS – both direct service delivery - particularly in relation to education on HIV, support to women's groups, support to children and people living with HIV and AIDS.

For example, in Northern Province in Zambia, there is a women's group outside Kasama who were given a small grant of about 10,000 euros. They developed a support group within the community and gave direct support and home based care kits to those affected by HIV and AIDS. They encouraged people to deal with opportunistic infections and supported people in terms of access voluntary counselling and testing and getting to the clinic. As a general strategy, Irish Aid supports civil society organisations to deliver services. Block grants are given to a number of community-based organisations.

Irish Aid also supports cash transfers given by the Zambian government to communities as a social protection measure in order to tackle vulnerability. While Zambia as an economy has been doing very well, the gap between rich and poor is ever increasing. Cash transfers and direct funding of food vouchers are for people who are extremely vulnerable. The child grants scheme covers children up to the age of 5 years old.

These transfers are provided in a number of districts – a small amount of money is given to the poorest people on a monthly basis. Among the criteria determining who receives the

transfer is being chronically ill (TB, repetitive malaria, etc). Community groups come together and identify those most vulnerable in their community and they get cash in hand on a monthly basis. Irish Aid has contributed to this but we also monitor the programme to see what people do with the money they receive and how it affects their livelihoods such as building up household assets, seeding and planting, buying livestock, children in school, spending on local healthcare, etc. At the moment, the evidence is that this approach is producing considerable impact. Because HIV is a driver of vulnerability especially among the poor, anyone who is HIV infected has increased vulnerability. If they have resources then they have options. If they don't have resources, then their options are limited.

Throughout all of this work, the emphasis is on building the resilience of the people who are most vulnerable, especially women and children.

HIV TREATMENT

Irish Aid also does considerable work on access to HIV Treatment where the main approach has been to strengthen health systems overall. It is important that health workers are trained, laboratory services are functional and support services are in place for people to access HIV treatment. Irish Aid was one of the founding members of the Global Fund to fight AIDS, TB and Malaria in 2001/02 and I sat on the Board of the Fund for 6 years. Zambia is a key recipient of the Global Fund where they have been able to extend HIV treatment to all 72 districts and ensure that over 50% of people who need HIV treatment now get access to it.

Treatment is not just the delivery of drugs but also having systems in place, training health workers, providing laboratory support services, follow up, treatment education and support to people on treatment. Irish Aid also supports services relating to PMTCT.

Irish Aid has a specific focus on Northern Province in Zambia. Irish Aid supports four districts as well as the province itself where NGOs have over the years, been funded to provide a range of services as well as care and support in the community. In certain areas, Irish Aid has supported improved water and sanitation access. Through their work, Irish Aid has been monitoring the impact access to water has for care givers, vulnerable households as well as monitoring impact on water charges on female headed households.

Irish Aid has supported a home based care programme in Northern Province; originally we worked with a large number of NGOs and now we are working to ensure that the district council's strategic plans take into consideration the needs of people living with HIV and AIDS.

WORK WITH NATIONAL AIDS COUNCIL (NAC)

It is essential to develop and strengthen institutional structures in Zambia, building the government's capacity to deliver services to the people. In this regard, the National AIDS Council (NAC) is a critical body in the national response to HIV and AIDS and works across a wide range of sectors within government itself as well as in society more broadly. The Council is mandated to coordinate national HIV-related policy and strategy in Zambia and NAC also supports district level structures – Provincial AIDS Task Forces and District AIDS Task Forces to ensure planning at provincial and district level is taking HIV and AIDS adequately into account.

Research and analysis must be strong and accurate and this is a key determinant of HIV and AIDS approaches within the country, informing policy and planning. Irish Aid continues to engage directly with the Zambian Government in areas such as the Sixth National Development Plan (SNDP) to ensure that HIV was informing and shaping priorities.

STIGMA

It is unacceptable that the disease is hidden as a result of stigma and discrimination. It is heartbreaking to think about what many people have gone through without being able to talk about being infected and the impact of the disease on them and their families. There is still too much silence around HIV and AIDS.

In 2006, Irish Aid launched a National HIV stigma campaign in Ireland. Known as Stamp Out Stigma the implementation of this campaign was linked into the overseas development programme to ensure that the reality of people's lives both in Ireland and in sub-Saharan Africa helped to inform and shape education about HIV and policy responses to HIV.

Irish Aid has a progressive HIV workplace policy; it supports its staff on prevention, treatment and care. We have regular discussions on HIV with staff in the workplace and we provide HIV treatment for staff and their dependents if they need it.

THE LEGAL DIMENSION

Irish Aid is playing a role in trying to get a Gender Based Violence Bill in Zambia passed by Parliament and we support community and civil society organisations to assist in developing the Bill and in ensuring that it gets a hearing in Parliament. This is an important piece of legislation which is about protecting and empowering women.

Nicola Brennan is a Development Specialist currently working with Irish Aid in Zambia.

KEY FINDINGS FROM THE STORIES

“There is no one to blame here, we are all the same, whether man, whether woman, whether married, we are all spreading the virus. You cannot just blame sex workers for the spread. Even married men and women are spreading the disease.”

Miriam Mushetu, Lusaka

“We need to talk business, not rubbish.”

Chieftainess Mwenda

THE VIRUS CONTINUES TO HAVE A DEVASTATING IMPACT IN HUMAN TERMS

The stories presented here compellingly describe the devastating impact of the virus on individual women and men, the fear and denial at the initial stages; the consequences for relationships and for family life; the negative responses from many people and communities who fear those diagnosed positively; the challenge of revealing one's status; the very significant fears around children and their futures and the continuing problem of 'self-stigma' which many Zambians have to tackle.

In contrast there are also stories of considerable courage, of family support and care, from mothers, fathers, siblings, care workers and support groups. There is growing evidence of a positive and proactive approach from many individuals and groups and considerable self confidence amongst those living positively.

"I told my parents about my status three days after the results. It was more difficult for my mother to accept. She was very upset. As time went by, she gave me her support."

Eve Lifuti, Livingstone

"Everyone is at risk to HIV, especially those who are married. They are more at risk than any person. As for us who are not married, who just have sex with men, it is easier for us to tell a man to use a condom. In our culture, women have to submit to their husband. They cannot ask their husband to use a condom. If you are his girlfriend, you can say more, and you can tell him no!"

Theresa Mwansa, Lusaka

BEING TESTED POSITIVE POSES IMMENSE CHALLENGES TO INDIVIDUALS, FAMILIES AND COMMUNITIES

Many of those interviewed highlighted the importance of publicly acknowledging their status and encouraging others to do likewise. They stressed the importance of getting others to go for VCT, the need to stand up and challenge stigma and discrimination and, in short, they exhibited the leadership so crucial to the effective tackling of the pandemic in future years.

HIV and AIDS concerns our own lives and those of our families, children and relatives lives. As soon as we don't take it seriously, it affects the country as a whole.

Chiku Zulu, Chikankata

"In the past, I used to fear HIV and AIDS. We all did. Now it is better that we go for testing. We did not know about it as there was no information. But now we know and we are not afraid any longer."

Janet Ngoma, Lusaka

"I found it very hard to interact with some people because they would say, 'she is taking medication', 'she is positive', 'she cannot mix with us'. I stopped meeting with people for a while because I was afraid of what they might say."

Milambo Mugela, Mazabuka

KNOWING YOUR STATUS AND LIVING POSITIVELY IS AN IMPORTANT STARTING POINT

One strong message from the stories to whom almost everyone interviewed attached great importance was ‘knowing one’s status; going for VCT and dealing with its outcomes in terms of living positively, taking ARVs and looking after one’s health. They stressed the importance of peer education in this regard and the need to proactively encourage others to take up the services on offer. Some of those interviewed noted that telling others of their status provided considerable ‘relief’ and hope for the future.

They also stressed the crucial importance of early intervention and the significant danger of delaying seeking help.

“People need to be open with their status. You will live freely. Being a leader, our president should go for VCT. He needs to lead. We as Zambians should not stigmatise ourselves.”

Beauty Sialwinde, Mazabuka

“Go right away to know your status. If you do not know your status, you are killing yourself. ARVs prolong your life. My daughter said to me that she heard people who are on ARVs will live another thirty years, so you will live until you are almost ninety!”

Juliana Meleki, Livingstone

“I did not feel too bad when I was diagnosed, because I knew people got better once they started taking ARVs. I was relieved because it gave me a solution to my problem.”

Mate Imenda, Senanga

MANY CULTURAL AND SOCIAL BELIEFS AND PRACTICES REMAIN HUGELY PROBLEMATIC

Those interviewed made constant reference to continuing traditional practices and beliefs that impact negatively on HIV and AIDS. While women’s sexuality continues to be, in many respects, an issue surrounded by taboos and myths, practices such as Lobola, sexual cleansing, attitudes inculcated into young girls about men’s sexual ‘needs’ during initiation, ‘dry sex’, wife inheritance, etc. compound and extend the subordination of women.

However, many of the stories also highlight how this situation is being challenged by many including traditional leaders and that such practices are changing or being reduced in occurrence especially in some areas and provinces.

THE ATTITUDES AND BEHAVIOURS OF TOO MANY ZAMBIAN MEN POSE AN IMMENSE CHALLENGE – TO ZAMBIAN WOMEN AND SOCIETY

The vast majority of the case studies included here highlight what is perhaps **the** core issue as regards HIV and AIDS in Zambia – the continuing negative attitudes and behaviours of men as regards sexuality and sexual relationships in a HIV and AIDS context. Too many Zambian men, from all walks of life and location, consider it perfectly acceptable to have multiple sexual partners inside and outside marriage and stable relationships. They continue to practice behaviour which insists on their sexual ‘rights’ inside a relationship whilst also reserving the right to engage sexually outside that relationship. They continue to view, and treat, women as subordinate even when this threatens the latter’s health and well-being. Zambian society and aspects of its ‘traditional culture’ all too often views this situation as ‘normal’ and acceptable even though it continues to undermine Zambian society. The consequence of this situation for women is graphically illustrated in the stories presented.

“Men have too much power. We have been taught to submit to men – we have been told, we cannot say no to sex. If your husband approaches you, whether you are ready or not ready, you have to say yes to sex. Women have no control over their bodies. You do not know how a man is using his body. You do not know how many partners he is meeting. But when he goes to his wife, she cannot refuse him. You have to let him do what he wants. He can bruise you, but you cannot cry out. It is like women are being bought to be sex machines.”

Chieftainess Mwenda, Chikankata

“Men come with two things, love and infection.”

Regina Najandwe, Mazabuka

THE SUBORDINATE STATUS OF WOMEN IS THE CENTRAL ISSUE

It is impossible to avoid one central conclusion from this and other research and documentation projects undertaken – the continuing subordinate status of women in Zambian society is a major and over-arching problem in Zambia. It is difficult to see how effective intervention as regards the pandemic can be realised while women remain abused and oppressed in the bedroom, the household and the community.

“Women do not have the power to say no to unprotected sex. Then the woman becomes pregnant, and the child becomes infected also. The burden of care falls on the woman. If a woman is found to be positive, and the husband is negative, he will leave. But if the man is positive, and the woman negative, she will stay.”

Annie Matala, Choma

THERE IS EVIDENCE OF POSITIVE PROGRESS, ESPECIALLY IN MORE RECENT YEARS

Those interviewed made it clear, in many different ways, that progress is being made as regards the pandemic. The availability of VCT and ARVs has improved. Attitudes and behaviour towards those who are infected have begun to change significantly. Support networks and groups are on the increase. Brave individuals and groups are willing to acknowledge their status publicly and in this way provide crucial leadership and as a result, more and more Zambians recognise that being tested positive is ‘not a death sentence’.

“...the consequences of HIV and AIDS are not as bad as before when there was much less information and little or no medication. Now, local people do not suffer as much and the death rate has been reduced. But, there are still those who do not wish to take drugs with inevitable consequences.”

Namakau Mubiana Liwanga, Senanga

“...the Zambian government has given life. Previously people had to go long distances and pay for the drugs, but now they are free.”

Sheela Hagila, Mazabuka

THE AVAILABILITY OF FREE ARVs IS CRUCIAL BUT THERE ARE SIGNIFICANT CONTINUING ISSUES

Person after person spoke of the life saving and enhancing importance of ARVs and how their appropriate use literally saved lives and significantly improved health and general well-being. Many spoke in graphic terms of the impact of ARVs on weight, rashes and infections, sickness and strength as well as the importance of overcoming initial difficulties in adapting to the medication.

However, many also spoke consistently of the significant difficulties in accessing ARVs. The costs associated with travel and transport, accommodation, availability at clinics and of the length of queues and waiting for access. They spoke of the difficulties for those who are sick or bedridden and of the need for improved outreach.

“There are big challenges trying to reach people who are far away and stigma is still there in small communities, so people are not going for testing. They lack information. They need to be mobilised better for this.”

Mutonga Muketukwa, Senanga

SUPPORT GROUPS AND NETWORKS PLAY AN IMPORTANT POSITIVE ROLE

It is evident from the case studies that peer support groups and networks play a hugely positive role throughout Zambia. Many spoke of how they were encouraged, supported and accompanied by others from such groups especially as regards the initial steps associated with deciding to go for testing or to initiate an ARV programme. Some of those interviewed spoke of how they subsequently began support groups themselves to assist and encourage others.

And, again, women remain at the forefront as care givers, support workers and leaders. Their inner strength and forbearance are clearly illustrated in many of the case studies.

HIV AND AIDS IS A QUESTION OF SIMPLE JUSTICE (AND INJUSTICE)

Cumulatively, the stories gathered here illustrate the immensely heavy burden Zambian women carry in the context of HIV and AIDS. Any genuine 'reading' of these stories must conclude that the issue is one

of existing injustice and the need for greater focus on the justice demands and needs of the issue. This question cannot be avoided.



HUMAN DEVELOPMENT IN ZAMBIA

HUMAN DEVELOPMENT INDEX (SEE DEFINITION BELOW)

- Zambia is classified as having low human development (23rd of 42 such countries)
- It is ranked 150 from 169 countries in 2010 (in the bottom 11%)
- While the HDI increased between 2008 and 2010, Zambia is one of only 3 countries with a lower HDI today than in 1970
- During the 1990's all three dimensions of the Index – health, knowledge and income – deteriorated but since 2000, all three have improved

COMPARING 1980 AND 2010

- Life expectancy at birth decreased by almost 5 years
- Mean years of schooling increased by over 3 years and expected years of schooling decreased by less than 1 year
- Gross National Income per person decreased by 11%
- While the HDI increased between 2008 and 2010, Zambia is one of only 3 countries with a lower HDI today than in 1970
- According to the UNDP, most Zambian households lack basic conditions such as safe drinking water, basic health or clean energy sources and half of the time, these deprivations are severe

HUMAN DEVELOPMENT INDEX

This Index was developed by the United Nations Development Programme 30 years ago to measure the levels of human development in countries worldwide. It challenged the view that human development could be measured by simply looking at economic indicators alone. The HDI measures 3 key indicators – life expectancy (in years), education (adult literacy levels and combined enrolment rates for primary, secondary and third level education) and standard of living (gross domestic product per person adjusted for parity).

LIFE EXPECTANCY AT BIRTH

- 44.5 years in 2007 (44 years for men and 45 years for women)

ADULT LITERACY RATE

- In 2007, 70.6% of Zambians aged 15+ were literate (men 80.8%, women 60.7%)

GNI PER CAPITA 2008

- \$1,359 (estimated earned income for men \$1,740, women \$980)

POPULATION NOT USING IMPROVED WATER - 42%

CHILDREN UNDER WEIGHT FOR AGE

- 25% aged under 5 (2000 – 2006)

POPULATION BELOW INCOME POVERTY LINE

- At a poverty line of 1.25 per day or less – 64.3%
- At a poverty line of \$2 per day or less – 81.5%

DISTRIBUTION OF WEALTH

- Poorest 10% shared 1.3%
- Richest 10% shared 38.9%

PUBLIC EXPENDITURE ON HEALTH AND EDUCATION, 2006

- \$29 per person equal to 10.8% of budget spending on health
- \$55 per person equal to 14.8% of budget spending on education

UNDER FIVE MORTALITY RATE

- 192 per 1000 in lowest quintile and 92 in the highest



WOMEN AND HUMAN DEVELOPMENT IN ZAMBIA

GENDER-RELATED DEVELOPMENT INDEX (GDI – SEE DEFINITION BELOW)

- Zambia is ranked 124th of 137 countries on the GDI (in the bottom 10%)
- 26% of women have secondary or higher education as against 44% of men and female labour market participation is 60% against 79% for men
- The GDI in 2009 was higher than that of 1995

GENDER EMPOWERMENT MEASURE (GEM – SEE DEFINITION BELOW)

- Only 15% of seats in the National Assembly (17% of Ministerial positions) are held by women (Botswana 11%, South Africa 34%)
- Only 19% of senior legislators, officials and managers are women
- Women make up 31% of professional and technical workers

MATERNAL MORTALITY RATE

- 830 (per 100,000 live births), below the regional average of 900

BIRTHS ATTENDED BY SKILLED PERSONNEL

- In rural areas, the rate is 31% against 83% in urban areas
- The rate among the poorest 20% of women is 27% and for the richest 20% of women 91%
- Amongst the least educated women, the rate is 24% whereas it is 73% for the most educated

VIOLENCE AGAINST WOMEN

- Official figures indicate that as many as 27% of women who have been married reported being beaten by their partner; the rate increases to 33% for 15 to 19 year old women and 35% for 20 to 24 year old women
- 59% of Zambian women have experienced violence from someone since the age of 15
- 57% of those living with HIV and AIDS are women
- Among young women aged 15-24 years, the prevalence rate for HIV is nearly four times that of men in the same age group

GENDER-RELATED DEVELOPMENT INDEX (GDI)

The Gender-related Development Index measures human development from the perspective of the inequalities that exist between men and women in the following areas: a long and healthy life, education and a decent standard of living.

GENDER EMPOWERMENT MEASURE (GEM)

The Gender Empowerment Measure measures existing inequalities between men and women as regards power and opportunities. It measures these in three ways – political participation and decision making, economic participation and decision making, and power over economic resources (ratio of female to male estimated earnings).



WOMEN, HIV AND AIDS IN ZAMBIA

THE FEMINISATION OF HIV AND AIDS

- 14.3% of the Zambian adult population is estimated to be infected with the HIV virus
- It is estimated that 1.6% (82,681 people) of the Zambian adult population are newly infected with HIV each year
- For every two people who start antiretroviral therapy, an estimated five more become newly infected with the virus
- The prevalence rate for women is 16.1% and 12.3% for men
- The feminisation of HIV and AIDS is perpetuated by GBV, failure to negotiate condom use and limited economic opportunities for women

AIDS or no AIDS, women and men are essentially equal. Making that equality a lived reality is a major challenge for every individual, community, institution and country. The epidemic has highlighted the tragedies that gender inequality can bring in its wake. But it also points to the need for wholesale transformation of the social, economic, legal and political structures of society to put an end to practices and attitudes that offend the dignity of women and men alike. Here, as in the sphere of poverty, the epidemic acts as a catalyst, calling on people and institutions across the world to create a more just society, characterised by respect for the basic principle that “all human beings are born free and equal in dignity and rights”

Michael J. Kelly SJ (2010)

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HIV and AIDS, women and vulnerability in Zambia

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARHA	Adolescent Reproductive Health Advocates
ATAAZ	Anti-AIDS Teachers Association of Zambia
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
CATF	Community AIDS Task Force
CIDRZ	Centre for Infectious Disease Research in Zambia
CD4	Cluster of Differentiation 4
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CPT	Care and Prevention Team
DAPP	Development Aid from People to People
DATF	District AIDS Task Forces
EFA	Education For All
FAWEZA	Forum for African Women Educationalists of Zambia
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
NAC	National AIDS Council
NAPCD	National AIDS Prevention and Control Programme
NASF	National HIV and AIDS Strategic Framework
NGO	Non-Governmental Organisation
NZP+	Network of Zambian People living with HIV and AIDS
PATF	Provincial AIDS Task Forces
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PRISSCA	Prison Care and Counselling Association
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAAZ	Society for Women and AIDS in Zambia
TALC	Treatment Advocacy and Literacy Campaign
TB	Tuberculosis
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNZA	University of Zambia
VCT	Voluntary Counselling and Testing
WfC	Women for Change