Community-based AIDS prevention and care in Africa: Case studies from five African countries

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Community-Based AIDS Prevention and Care in Africa
Building on Local Initiatives

Case Studies from Five African Countries

Supported by The Wellcome Foundation Ltd. as part of Positive Action - the company’s international programme of HIV education, care and community support

THE POPULATION COUNCIL
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The Population Council, an international, nonprofit organisation established in 1952, undertakes social and health science programmes and research relevant to developing countries and conducts biomedical research to develop and improve contraceptive technology. The Council provides advice and technical assistance to governments, international agencies, and nongovernmental organisations, and disseminates information on population issues through publications, conferences, seminars and workshops.

The Wellcome Foundation Limited is an international pharmaceutical company dedicated to the discovery and marketing of products which promote human health and quality of life. The company has been at the centre of the medical response to HIV and AIDS since its development in the mid 1980s of zidovudine (AZT) for the management of HIV infection.

Through its “Positive Action” programme, Wellcome is committing funds, expertise and facilities in support of its fundamental belief that its activities in the field of HIV and AIDS should go beyond the traditional roles and responsibilities of commercial organisations. Positive Action is an international programme of HIV education, care and community support, and comprises a series of different initiatives, each focusing on a different area where there is most need. There are currently five main initiatives: HIV Community Support, Children and Young People, Developing Country, The Workplace, and Information and Policy.
In sub-Saharan Africa, people have faced calamities brought about by disease, famine, drought, civil strife and the like for generations. But somehow the strong extended family and kinship networks that are the backbone of the African social structure have been able to cope with these catastrophes. AIDS, however, is a different matter. As Barnett and Blaikie note in their recent book *AIDS in Africa*, "...AIDS threatens all the major expectations of people's lives—from sexual fulfillment, to marriage and having children, to being cared for in one's old age by one's children, through to having a proper burial and being remembered in the community's consciousness after death." With almost two-thirds of all estimated cases of AIDS to date thought to have occurred in the region, the potential social and economic devastation faced by the people of sub-Saharan Africa is enormous.

What makes the situation even more difficult is that the AIDS epidemic has struck at a time of economic downturn when most African governments are faced with implementation of economic structural adjustment policies that reduce, rather than support, their ability to provide health care and social services to their citizens. Per capita health spending in many African countries is currently less than the cost of a single HIV blood test!

Yet despite the magnitude of the crisis and the paucity of resources at their disposal, Africans are responding to the challenge of AIDS with unyielding courage and creativity. Building on the inherent strengths of family and community, people at the local level are getting involved in the fight to stop the spread of the disease and to support and care for those who have been affected—not just those who are infected with the virus, but their families as well.

**DESCRIPTION OF THE PROJECT**

With the support of The Wellcome Foundation Limited's "Positive Action" Programme, the Population Council is carrying out a three-year project entitled "Community-Based AIDS Prevention and Care in Africa: Building on Local Initiatives."

Given the constraints faced by the health care infrastructure in responding to the immensity of the crisis and the growing awareness of the limitations of traditional educational approaches in motivating people to modify their sexual behaviour, it has become apparent that in the African context, community-based AIDS prevention and care of those affected are, in the first line of defence against the disease.

A project was therefore developed to: 1) explore the range of efforts by organisations in Africa that are dealing directly with the consequences of AIDS, 2) understand the essential components of effective community-based efforts for AIDS prevention and the care of persons living with HIV infection, and 3) determine how best to build upon these local initiatives. It also sought to examine the potential for integrating concerns for both prevention and care of people living with AIDS as part of the same project.

The project has chosen to focus on five countries in East and Southern Africa: Kenya, Tanzania, Uganda, Zambia, and Zimbabwe. They were selected because the AIDS pandemic has already reached serious proportions in these nations and because, in most instances, they are countries where the Population Council has established working relationships with a variety of local institutions.

**THE SURVEY**

As an initial step in identifying the range of community-based initiatives undertaken to date, the Population Council carried out a survey of organisations involved in HIV/AIDS prevention and care in the five selected countries. In each country a consultant (or consultants) with expertise in community-based health care was identified to assist Council staff in carrying out a survey of local organisations providing these services. Due to time and logistical constraints, most organisations surveyed were either operating within or had offices located in the capital city. In total, representatives of 65 organisations (13 in Kenya, 14 in Tanzania, 11 in Uganda, 15 in Zambia, and 12 in Zimbabwe) completed a questionnaire.
that included information on the type of services
provided, clients served, composition of staff,
sources of support, and the like. (Lists of participat­ing
organisations and consultants are included as
appendices to this report.)

THE CASE STUDIES

From an analysis of the survey responses, four
broad themes of were identified: 1) the role of
counselling in HIV and AIDS prevention and care
programmes; 2) an exploration of home and com­
munity-based care; 3) the reorganization of trad­
tional institutions within the community to meet
the need for HIV and AIDS prevention and care;
and 4) the impact of a changing socio-economic
environment of HIV and AIDS on women and
children. Eight of the projects that participated in
the survey and were specifically addressing one or
more of these themes were then identified to be the
subjects of case study reports. Again, consultants
were identified to visit each of the project sites.
They administered questionnaires and, in some
cases, conducted focus group discussions among
administrators, staff and clients. Where possible,
board members and/or representatives of donor
agencies were also interviewed. This process was
designed to yield a description of the local commu­
nity and an understanding of the project's operation
within this context. It also sought to identify both
the achievements of the projects to date and con­
straints being faced. In addition, the consultants
made recommendations as to how the work of each
organisation might be improved and facilitated.

In June, 1993 a special workshop, sponsored by
the Population Council and the Wellcome Positive
Action Programme, was held just prior to the IXth
International Conference on AIDS in Berlin. The
aim was to share the preliminary findings of the case
studies with representatives of governmental, non­
governmental and donor organisations, technical
assistance agencies, and national and international
AIDS prevention programmes.

This report presents case studies of the eight pro­
jects. To keep the report to a readable length, pro­
jects are grouped by country rather than theme so
that background information about the AIDS epi­
demic in each country can be summarized in an
introductory profile. This format was also adopted
because most of the projects actually carry out a
variety of activities that encompass more than one
theme; therefore, in order for readers to fully under­
stand the important role such organisations are play­
ing at the community level, we felt it was important
to report on the full extent of their endeavours.

The eight projects range from ad hoc activities
that began as the response of concerned community
members to the devastation of AIDS to national
organisations that recognized the importance of
working at the community level to develop effective
mechanisms for helping those affected by the epi­
demic and culturally appropriate means of encour­
aging behaviour modification. While some of the
organisations work primarily with specific groups of
people (e.g., industrial workers, children, traditional
 healers, prostitutes), all of the projects ultimately
contribute to the well-being of entire communities.

It should be emphasized that this report is in no
way seeking to define all-purpose models for com­
munity-based AIDS prevention and care. Rather,
we are attempting to identify and understand the
elements that make for successful projects in the
hope that this information will prove helpful to
other groups trying to meet a similar challenge in
their own communities. At the same time—and of
equal importance—the case studies clearly highlight
common constraints that these organisations are fac­
ing in trying to meet the rapidly increasing need for
knowledge, care and compassion in the face of the
AIDS pandemic. It is our hope that their stories
will encourage governments, donors and a broad
spectrum of development agencies to find better
ways of supporting local initiatives such as these in
their efforts to unite families and communities in
meeting the challenge of AIDS.

Notes
   (New York: The Guilford Press)
2. World Health Organization (June 1993), "World Health Organization Global Aids
THE PROBLEM OF HIV INFECTION AND AIDS IN ZIMBABWE

AIDS was first recognized in Zimbabwe in 1985, but at the time its significance as a major public health threat was not fully understood. For the most part, the disease was attributed to runyoka—a local term for a form of punishment contracted after adultery—or to witchcraft. However, it has now become clear that AIDS is one of the main health issues affecting Zimbabwe today.

In 1987, 119 cases of AIDS were diagnosed according to statistics compiled by the National Public Health Laboratory. By 1989, the total had risen to 1,632 and by the end of 1992, there were 14,032 cases. However, in the opinion of doctors and researchers, many more people have died of AIDS-related complications without having been accurately diagnosed. It is estimated that, in reality, close to 40,000 people have died of AIDS since the disease was first recognized a decade ago. Presently, the number of people infected with HIV is approximately 644,000. The majority of AIDS patients (60 percent) are between 20-29 years of age, 17 percent are under four years old and around 12 percent are between 40-49 years old. Additionally, despite the absence of accurate information on sexually transmitted diseases (STDs), reports from public health institutions indicate that more than 50 percent of patients in urban STD clinics are also HIV-positive.

In a country that is struggling economically, like Zimbabwe, AIDS has created enormous social and ethical dilemmas that defy simple solutions. AIDS is a prolonged illness that involves great suffering for patients, families and friends. Further, the financial burden AIDS places on families and the primary health care system makes provision of quality health care more difficult than ever. The consequences of the situation are and will continue to be increased deaths, especially among children and young adults; increased numbers of orphans, single parents, and child-headed households; disruption of family income and productivity; mounting psychological and economic pressure on individuals and families; increased absenteeism from work and reduced productivity; increased use of health facilities and cost of medical care; increased morbidity; and greater demand for health care and social services.

In response to the crisis, Zimbabwe has developed approaches to AIDS prevention and care as part of its primary health care (PHC) strategy because, while AIDS is an incurable disease, HIV transmission is preventable. With this in mind, the Government of Zimbabwe has urged community health workers, including traditional healers, to join together to help reduce the personal and social consequences of AIDS, minimize the socio-economic destruction caused by the disease and increase awareness about HIV-prevention.
A CASE STUDY OF THE ZIMBABWE NATIONAL TRADITIONAL HEALERS ASSOCIATION (ZINATHA)

Consultant: Dr. James Jijide

The Zimbabwe National Traditional Healers Association (ZINATHA) represents most of the traditional healers practising in Zimbabwe. Although ZINATHA covers all of Zimbabwe, this case study was carried out in ten suburban districts of Harare, Zimbabwe’s capital: Mufakose, Glen-View, Glen Norah, Highfield, Mbare, Mabvuku, Tafara, Chitungwiza, Epworth, and Kuwadzana.

PROFILE OF THE PROJECT COMMUNITY

The 1992 census estimated the population of Zimbabwe at 10.4 million and the growth rate (from 1982-1992) at 3.1 percent. In 1992, 47 percent of the population was below 15 years of age, while 3 percent was 65 years or older, creating a high child-dependency ratio. Between 1969 and 1992, Zimbabwe’s crude birth rate decreased from 48 to 39.5 per thousand while the crude death rate was lowered from 15 to 10.8 per thousand, and the infant mortality rate from 101 to 83 per thousand.

In Zimbabwe, health services are provided through five institutionalised systems: the Ministry of Health (MOH), local governments, mission hospitals, employer-sponsored medical services, and private practice. All categories of health professionals, including physicians, paramedics and trained community health workers, can be found in these institutions. In order to develop a health infrastructure that reaches the entire population of Zimbabwe, the MOH has placed emphasis on preventive measures by adopting a Primary Health Care (PHC) strategy. Community health workers are the core element in this approach. These individuals are selected from the community and trained at district health centres. They then return to work in their communities. Community health workers thus serve as a link between the government health facilities and the community.

PROJECT DESCRIPTION

ZINATHA was formed in July, 1980, at a meeting of traditional healers organised by Dr. H.S.M. Ushewokunze, the first Minister of Health in the new government of independent Zimbabwe. About 100 healers attended this meeting. Many were already leaders of small associations that had existed before independence. The result of the meeting was the establishment of a single national organisation that includes all Zimbabwe’s traditional healers, operating under the auspices of the Ministry of Health (MOH). Legislation was passed in parliament that gave ZINATHA and the traditional health sector legal status.

Professor G.L. Chavunduka of the University of Harare became the organisation’s first president. Traditional healers—also referred to as traditional medical practitioners—including herbalists, spirit mediums, faith healers, and traditional midwives, in Zimbabwe, they are white, black, Asian, and of mixed race. While traditional healers are found throughout Africa, the recognition they have gained in Zimbabwe is unique. One reason this has come about is that the first Minister of Health for independent Zimbabwe was, in addition to being a medical doctor, a traditional healer. He recognized the value of traditional practices and the importance of involving practitioners in meeting the health needs of the new nation.

ZINATHA'S stated objectives are to:

- Unite all traditional healers into one organisation;
- Promote the practice of traditional medicine;
- Promote research into the effectiveness of traditional medicine and methods of healing;
- Promote training in the art of herbal and spiritual healing;
- Supervise the practice of traditional medicine and prevent abuse and false practice;
• Cooperate with the MOH and other institutions involved in public health; and,
• Preserve and promote African culture.

ZINATHA currently has 11 offices nationwide and the number of registered traditional medical practitioners is presently 45,000. In Zimbabwe today, it is estimated that approximately 90 percent of the population receives therapeutic services from traditional healers. Given their numerical advantage—45,000 healers as compared to 1,400 medical doctors, or a ratio of one practitioner to 226 patients as compared to one doctor per 7,286 patients—a traditional healer is more likely to be accessible and, therefore, able to give his/her patients individual attention.

The only qualification for becoming a ZINATHA member is a primary school education. There is no training programme or certification for traditional healers. In most cases, the ability to be a healer is considered a gift that is conveyed to a person by ancestral spirits and not something that can be learned. In the case of some herbalists, knowledge is passed down orally from one generation to another.

The majority of traditional medical practitioners in Zimbabwe are women, at a ratio of 5:2. They are listed in a directory called The Register of Traditional Medical Practitioners of Zimbabwe produced and continuously updated by ZINATHA.

ZINATHA'S HIV/AIDS Project

Because of its affiliation with the MOH, ZINATHA maintains a close association with the National AIDS Control Programme (NACP). Under the auspices of the NACP, it has developed a national HIV/AIDS prevention project using traditional care systems. The HIV/AIDS project has the following objectives:

• To provide moral, psychological, social, economic, and cultural support to individuals, families and communities affected by HIV/AIDS;
• To develop traditional methods aimed at reducing HIV/AIDS transmission, increase awareness of HIV/AIDS for prevention and care of people with AIDS, and create a supportive environment for those living with the disease;
• To define priority areas, devise interventions and develop resources needed for effective management and implementation of HIV/AIDS prevention and control activities;
• To increase collaboration between traditional healers in order for them to share experiences and skills among themselves and with other organisations involved in AIDS prevention.

Training in HIV/AIDS Prevention and Care

In 1989, ZINATHA conducted a Knowledge, Attitudes and Practices (KAP) survey among traditional healers. The results revealed that most did not know much about HIV infection and/or AIDS. Therefore, later the same year, the organisation held a series of national workshops, funded by the MOH, to inform healers about AIDS and to define their role in dealing with the disease.

By January 1990, ZINATHA had shifted its emphasis to the community level by establishing a community-based health education project. Ten additional training workshops on HIV/AIDS for practitioners were held that year in different parts of the country. A follow-up study of these workshops indicated that knowledge about AIDS—in terms of prevention, safe medical practices, counselling, and care—had become very high among those participating. In 1993, 26 workshops, for about 90 participants each, were held and the Association hopes to offer as many as 50 in 1994.

The content of ZINATHA workshops includes modes of HIV transmission, prevention of HIV transmission, symptoms and diagnosis of AIDS, and counselling and care of people living with HIV infection. Specific instruction is also provided on safe medical practices, such as avoiding contact with contaminated blood products and instruments, and maintaining aseptic conditions, including sterilization of traditional equipment and the use of gloves, when appropriate, during treatment.
In particular, the Association seeks to ensure that sterile procedures are being used during invasive surgical procedures often used to administer traditional medicines and that used razor blades are disposed of properly. ZINATHA is also seeking to make both its members and their clients aware of the advantages of oral medications, as compared to those administered through incisions.

ZINATHA holds seminars and workshops for healers on the clinical care of persons with HIV/AIDS and is developing disease management guidelines that will be distributed to members. The relationship between HIV/AIDS and other sexually-transmitted diseases (STDs) is stressed in all ZINATHA training activities. In turn, healers are instructing community groups, families and sexual partners to seek early detection and prompt treatment of STDs.

Dr. J. Toto Tangwena is a traditional healer who is also the chairman of ZINATHA’s Disciplinary Council. He operates his own clinic in a residential area of Harare. He usually sees between 60 and 100 patients a day. Because he sometimes keeps patients at his clinic if they are weak and have traveled a long distance, or if they need to receive specially prepared foods, Dr. Tangwena employs three assistants who help feed patients and provide them transport home or to make bus or rail connections.

Dr. Tangwena’s specialty is epilepsy but he also does a lot of treatment of infertility and eye problems. He is attempting to treat AIDS patients as well. Right now he is trying to understand how antibodies work and how their function can be strengthened in people with AIDS. While he doesn’t consider himself an expert, he has had some success in suppressing symptoms and is currently working with nine AIDS patients. He applies this treatment only to those who have already tested HIV positive and, if he sees no success after two weeks, he refers the patient to another healer or to the hospital.

Home-Based Care and Treatment

In Zimbabwe, when someone leaves the hospital and returns home, a traditional practitioner usually becomes the caregiver. Most of the healers interviewed for this study emphasised that they are mainly treating opportunistic infections related to AIDS such as diarrhoea, cough, or skin conditions. When AIDS patients visit a healer, they usually receive a “cleansing treatment,” which typically consists of a series of herbal remedies that must be taken under the healer’s supervision.

According to traditional beliefs, the “cleansing” product weakens the body. Consequently, another set of remedies is administered to fortify the body. These “body-building” remedies are to be accompanied by a nutritious diet and a recommendation to refrain from sexual activities. The whole process varies in length, lasting up to three months. The patient is then provided with a third set of remedies to take at home for an additional period of time—anywhere from two weeks to one month. At the end of this period, the patient returns to the healer for a check-up.
HIV/AIDS Counselling and Family Planning Services

Because of the high degree of respect they are accorded due to their understanding of ancestral, social and cultural values, traditional healers can be very influential in modification of sexual behaviour. The ZINATHA HIV/AIDS project makes use of diverse counselling methods to support adoption of safer sexual practices and has had some success in promoting condom use. For example, in their education and counselling, healers are taught to avoid being judgmental. Rather, they are encouraged to stress that condom use offers a different way of attaining sexual pleasure and is not an inhibition to achieving satisfaction. And instead of discouraging herbalists from selling aphrodisiacs (which are very profitable items), ZINATHA suggests that they emphasise to their clients the value of using these compounds to enhance sexual relations with their wife or regular partner.

ZINATHA and the Zimbabwe National Family Planning Council (ZNFPC) are coordinating efforts aimed at procuring and distributing condoms for the prevention of sexually transmitted diseases, including HIV/AIDS, and unwanted pregnancies. They are targeting work places and commercial centres along highways (where considerable high risk sexual activity takes place). ZINATHA also collaborates with ZNFPC to disseminate information on the use of oral contraceptives, traditional methods of birth control and the risks of unsafe abortion. In addition, ZINATHA is promoting both traditional and modern family planning methods, especially for persons with HIV and those at risk of acquiring HIV infection.

Community Participation

As the epidemic continues, an increasing burden is falling not only on the health sector but also on families and communities as well. ZINATHA has adopted a very interesting approach in their community education programme. They work closely with chiefs and other opinion leaders in an attempt to get them to encourage the modification of traditional practices that promulgate the spread of AIDS, such as certain initiation rites or the inheritance/cleansing of widows by male relatives. They seek the support of these influential leaders in sanctioning the substitution of other rituals that will maintain tradition but not put people at risk of HIV infection.

ZINATHA also supports development of community-based peer counselling groups within clubs, unions, councils, and other organisations. Political party leaders, heads of educational, religious and traditional institutions and groups are being mobilised to influence behaviour change, especially among youth and young adults. For example, in many African cultures, aunts and uncles traditionally educate young people about sexual matters. ZINATHA is trying to capitalize on this cultural practice to create an AIDS prevention programme within schools. An "aunt" or "uncle" selected from the community makes regular visits to an assigned school to talk to young people about various aspects of "family life," including HIV/AIDS.

As part of its community participation plan, ZINATHA involves Zimbabwe's trained community health counsellors, employed by the MOH, in the promotion, development and implementation of information, education and communication (IEC) activities in their communities. These community health counsellors receive a small allowance from ZINATHA for this additional work. ZINATHA also seeks to make welfare services more accessible for people with AIDS and their families by disseminating information on what social services are available, who is eligible and how to apply.

The ZINATHA HIV/AIDS project seeks to unite all community-based health providers to carry out home visits to people with AIDS. Some healers report that they have been able to persuade families to care for AIDS patients by explaining to them that to do otherwise would contradict traditional values and provoke the displeasure of the ancestors. Practitioners thus encourage their communities to respect the important role of the extended family in meeting the material, social and psychological needs of all those directly and indirectly affected by AIDS.
Information, Education and Communication

Using different forms of communication—such as radio, television in local languages, lectures, and diverse formats including mass media, drama and dance—ZINATHA carries out IEC activities in both urban and rural areas. Consequently, the Association has been able to raise HIV/AIDS awareness not only among practitioners, but in the general public as well.

Elements of ZINATHA's traditional approach to HIV/AIDS prevention has been incorporated in the curriculum of various primary and secondary schools. The HIV/AIDS project offers talks to medical students at the University of Zimbabwe, at the school of social work and at associate colleges and institutes. ZINATHA also gives lectures to teachers on safer sexual behaviour and prevention of STDs.

The Association has recently completed a booklet on traditional AIDS education in Shona, the most widely spoken language in Zimbabwe, focusing on culturally controversial issues, stigmatisation, and misconceptions surrounding AIDS. They hope to be able to produce translations in English and in Ndebele, the country's other major language.

Participation in Clinical Trials

In recognition of the potential contribution of traditional medicine in the fight against AIDS, a government policy was established to encourage investigation of the effectiveness of traditional treatment. Two wards of Parirenyatwa Hospital, Zimbabwe's largest public hospital, now offer the option of treatment for AIDS-related illnesses by traditional medical practitioners. In addition, ZINATHA encourages healers to register to participate in clinical trials to test their traditional medicines in the treatment of AIDS-related conditions. These trials are being carried out under the auspices of the MOH.

Four healers, nominated by ZINATHA, are currently participating in one such trial. The initial phase will last for six months. People with AIDS are referred by the hospital to the healers and are monitored by an MOH physician. Participating patients must be between 18 and 45 years of age and have restricted symptoms—that is, be in reasonably good health. If they develop severe problems, they are withdrawn from the trial. Counselling of participants is done by hospital staff and the patients meet regularly with representatives of both the MOH and ZINATHA to review their progress.

Mrs. Muganiwa is one of the traditional healers nominated by ZINATHA to participate in the clinical trial being conducted by the MOH. Currently she has 20 participating AIDS patients (she has other AIDS patients not in the trial). She prescribes herbal remedies and sees her patients at least once per month. Some of her clients have experienced a 10-15 kg weight gain since beginning treatment. Mrs. Muganiwa says her main problem is that some clients will not take her advice—for example, they don't want to stop drinking beer while taking the medication although alcohol impedes the effectiveness of the herbs.
ZINATHA is eager to test all possible remedies that might be helpful in treating the symptoms of AIDS. Therefore, the organisation has taken a strong stand in rejecting claims by a few practitioners who claim that HIV/AIDS has existed from time immemorial and that traditional healers can successfully cure the disease. They urge any healer who believes his or her remedies to be useful in the treatment of AIDS patients to join the clinical trials. For example, Dr. Grace Chihuri is a healer who says she has been successful in suppressing the symptoms of opportunistic infections related to AIDS. From 1990-1991, she treated 81 patients; five have since died, but 76 are still alive and their symptoms have been suppressed. Seven of the herbal medicines she used for treating these patients have been sent to the United States for further investigation.

MANAGEMENT

ZINATHA’s supreme policy-making body is its Medical Council, made up of 12 members of whom seven, including the Chairman and Vice Chairman, are appointed by the Minister for Health after consultation with ZINATHA. The other five members are elected by the organisation. All those appointed or elected to the Council are registered traditional healers who have been practicing for five years or more.

The National Executive Committee, consisting of 15 elected ZINATHA members, reports to the Medical Council. Implementation of programmes and policies is then carried out by District Executive Committees and Branch Executive Committees which operate at the provincial, district and local levels. Within ZINATHA there are four departments—Administration, Finance, Research and Education, and Legal Affairs—that operate under the direction of the Secretary who executes ZINATHA’s project activities.

ZINATHA also has a Management Board consisting of five members who meet monthly and a Planning Committee made up of six officials. Because it operates throughout the country, ZINATHA has decentralized its activities for implementation by district and branch committees. In the case of the HIV/AIDS project, this allows innovative approaches to treatment and technical support to be developed at the local level and ensures better utilization of human, as well as material and financial resources.

Licensed inspectors regularly monitor the implementation of the HIV/AIDS project by making field visits and writing progress reports. ZINATHA is an advocate of patients’ rights and encourages them to approach the organization if they feel they have not been properly treated. The Association maintains a Disciplinary Council and, if there is a complaint, a committee member will talk to both the healer and the patient. If warranted, a suspension of the healer from the organisation can be recommended or a fine levied.

ZINATHA is accountable to the MOH, the NACP and local authorities and acts as the NACP Secretariat in coordinating, implementing and evaluating traditional medical approaches to STD/HIV/AIDS prevention, control and care activities.

RESOURCES

The HIV/AIDS project is managed from ZINATHA headquarters in Harare with the assistance of eight support staff who complement the work of 15,000 non-salaried healers nationwide, all specialising in various aspects of STD/HIV/AIDS prevention and care. In addition, the HIV/AIDS project is served by 28 volunteers who are active at the community level. Volunteers organise presentations on HIV/AIDS as part of meetings of various clubs and organisations. Healers and volunteers receive allowances of Z$20-50 (apx. US$3-8) each when they attend workshops. Traditional healers are not salaried but charge their clients fees for services. There is no standard fee, but consultations generally average around Z$10-15 (US$1.50-2.50).

As a membership organisation, ZINATHA has a yearly operating budget of Z$350,000 (US$53,929) which comes from annual membership subscriptions of Z$25 (US$3.86). The HIV/AIDS project does not have its own budget or separate staff, but it is able to make use of ZINATHA facilities such as vehicles, office space, furniture, and equipment. When workshops or other activities are organised,
funds must be obtained from the NACP, MOH or other donor agencies. For example, DANIDA currently provides support for ZINATHA’s AIDS education activities. To maximize the use of its existing resources, the HIV/AIDS project seeks to coordinate its efforts and share materials, experience and technical assistance with other organisations working in this field. Some of these include: the Zimbabwe AIDS Network; the Southern Africa Network of AIDS Service Organisations; the Zimbabwe Health Association; The World Health Organisation; UNICEF; the Red Cross; Save The Children-UK; the Swedish International Development Authority; the Canadian International Development Agency; and the Zimbabwe National Family Planning Council.

ZINATHA is also working closely with the ruling party, the Zimbabwe National Union, and maintains working relationships with City Health Departments and the Harare City Health Awareness Planning Committee. Finally, ZINATHA collaborates with clubs, societies, unions, and various religious organisations.

EXPERIENCE TO DATE

ZINATHA’s overall project activities are helping to bring about a change in high risk behaviour such as unprotected sex, multiple partners and unsafe medical practices which could lead to HIV infection. They have also helped to create a more supportive environment for those living with HIV infection. The Association promotes community home-based care initiatives aimed at reducing the medical, economic and psychosocial burdens of AIDS. Advocacy for quality institutional care of people with AIDS and their families has enhanced collaboration and information exchange between ZINATHA, community-based organisations, and individuals involved in HIV/AIDS prevention activities. Although more needs to be done in this area, ZINATHA’s HIV/AIDS project has also enhanced the rights of people with AIDS.

The main strength of the HIV/AIDS project is its counselling and care components. It is common in African cultures for illness to be equated with punishment, directly or indirectly, from an angered/frustrated ancestral spirit for some wrongdoing or transgression. ZINATHA, therefore, seeks to stress the positive side by encouraging clients to adopt positive behavior—such as faithfulness, sobriety, hygiene, and care for the sick—which will be rewarded by happy ancestral spirits.

The HIV/AIDS project’s biggest weakness is its lack of financial resources and insufficient number of trained staff. Training efforts are also exacerbated by the low rate of literacy among traditional healers.

In addition, many ZINATHA members feel that there is still a need for greater acceptance and recognition of their work by their colleagues in the formal health sector. As one healer, who is also a Western-trained medical doctor, commented, “Modern health practitioners who discount the efforts of traditional healers in effect impede medical progress in the search for a cure against AIDS.”

LOOKING AHEAD

ZINATHA hopes to expand its training efforts so that all 45,000 members will have the opportunity to participate in the HIV/AIDS project. To do this, however, they will need to raise additional funds to cover project expenses. One idea they are mulling over is to develop an African village as a tourist attraction. The village would serve to raise money for the Association while, at the same time, provide information on traditional medicine to a broader audience.

ZINATHA has found that to be effective at the local level, practitioners require pictorial means of conveying information rather than relying on imported, written material that may not be culturally sensitive. Thus, they would like to develop additional materials of this type in the future.

Lastly, as the only government affiliated association of traditional healers in Africa, ZINATHA is hoping to organise a conference in 1995 that will bring practitioners from other African countries to Harare to discuss AIDS prevention and promotion of traditional medicine. They are now contacting potential donors to seek support for this event.
THE PROBLEM OF HIV INFECTION AND AIDS IN ZAMBIA

The first case of AIDS in Zambia was diagnosed in 1985, and since then the cumulative total number of persons known to be HIV-positive or to have AIDS has increased to 26,625 of which 1,649 were reported to have died by September 1992. However, there is considerable under-reporting of HIV/AIDS cases due mainly to inconsistency in case-reporting among the major hospitals and a lack of HIV testing kits. HIV sentinel sero-surveillance in Zambia shows HIV prevalence rates of 25 percent among pregnant women in urban Lusaka, and 10 percent and 25 percent, respectively, among students and company workers who donated blood at the Central Hospital in Ndola (capital of the Copperbelt Province) between 1991 and mid-1992. Current figures show major differences between urban and rural sentinel centres. In urban centres, about 25 percent of women coming for ante-natal care are testing positive while in rural centres, rates are running at 7 percent.

When the HIV/AIDS pandemic first surfaced in Africa in the early 1980s, it was largely viewed as a "health problem" in most African countries, including Zambia. Its management, therefore, rested primarily with ministries of health. But, the Government of Zambia soon began to realize the socio-economic as well as health consequences of HIV/AIDS. Limited means of addressing the situation could no longer suffice because most government sectors had come to realize that the HIV/AIDS pandemic has serious consequences and implications extending far beyond the responsibilities and capabilities of the Ministry of Health. As a result, non-governmental organizations (NGOs), private institutions, communities, and other government ministries are now cooperating with the Ministry of Health and/or taking a leading role in promoting AIDS prevention and care measures.

THE NATIONAL AIDS CONTROL PROGRAMME

As a result, in early 1987, with the support of WHO, the Ministry of Health in Zambia created the National AIDS Control Programme (NACP) and, shortly thereafter, set up a Short Term Program (STP) to ensure a safe blood supply. In July 1987, a Medium Term Plan (MTP) was developed that stipulated priority strategies, interventions and activities over the next five years. The objectives of the NACP were set out as follows:

- Epidemiological monitoring;
- Prevention of sexual transmission of HIV through information, education and communication (IEC) activities;
- Promotion of safer sex;
- Prevention of perinatal transmission;
- Provision of safe blood and blood products;
- Promotion of sterile conditions for blood letting and injection;
- Development and coordination of research; and,
- Improved management of HIV-infected individuals and clinical AIDS patients.

The NACP in Zambia has been widely recognized as one of the more successful organisations of this type in responding to the AIDS crisis. For example, it is one of the few such programmes to have actually channeled the full percent of resources recommended by the World Health Organisation to non-governmental organisations.
A CASE STUDY OF INDENI: A PETROLEUM REFINERY COMPANY IN NDOLA COPPERBELT PROVINCE, ZAMBIA

EMPLOYER RESPONSE TO LABOUR SHORTAGES DUE TO HIV/AIDS IN THE WORK PLACE

Consultant: Dr. Mubiana Macwan'gi

The INDENI Petroleum Refinery Company, located in Zambia’s Copperbelt Province, is one of the 65 companies participating in a Ministry of Labour and Social Security (MLSS) effort to promote AIDS education and prevention in the workplace. It was selected as a case study because it is considered to be one of the best examples of the institutionalisation of the MLSS initiative in an industrial setting.

PROFILE OF THE PROJECT COMMUNITY

The Copperbelt Province, in northern Zambia, is the most populous in the country. It has a population of 1.6 million, of which 176,339 people live in the city of Ndola where the INDENI petroleum refinery is located. As Zambia’s leading industrial province, there is a high concentration of skilled labour in the area. The main industries are mining, manufacturing and ranching.

The Copperbelt Province is the most urbanized in Zambia and attracts both young nationals and expatriates seeking employment. Thus, the province has a higher growth rate (4 percent) than the country as a whole (3.2 percent). The province has 17 hospitals supported by 138 clinics.

Due to the intense influx of rural youth to urban areas, high mobility and high cost of living in the area, which results in a breakdown of traditional values, the population of the Copperbelt Province is prone to some of the high risk behaviour associated with HIV/AIDS transmission. For example, out of 5,803 AIDS cases reported to the World Health Organisation (WHO) in 1991, about 1,250 were recorded in the Copperbelt Province.

However, these figures underestimate the problem as sentinel surveys carried out in Zambia show that one in four women attending ante-natal clinics in large urban areas, such as in the Copperbelt, are already infected with HIV.

PROJECT DESCRIPTION

The Ministry of Labour and Social Security’s Work Place Initiative

In Zambia formally employed workers represent a large, accessible population who are directly experiencing the impact of AIDS. The economic, social and personal devastation of the epidemic affects not only workers, their partners and families, but also the productivity and income of their employers. Companies want to maintain a healthy and productive workforce in order to contribute to the economic stability of the country. For them, AIDS represents an economic as well as a health and social concern.

Because the workplace is an organized community, it offers important opportunities for HIV/AIDS education and prevention. Workers are easy to reach through both their employers and through trade-unions; trade-union leaders are also opinion leaders who are in a position to influence behaviour change.

The origins of the work place HIV/AIDS project goes back to 1979, when the Ministry of Labour and Social Security (MLSS)—with support from the United Nations Population Fund (UNFPA)—initiated a project to introduce family planning information and services in the workplace. The family planning project aimed to: 1) make the management of large companies aware of the relationship between population growth and labour welfare and its implications for national development; and 2) to help individual workers and their families make positive decisions about parental responsibility and family size.
By the early 1980s, the MLSS recognized the need to introduce a component dealing with sexually transmitted diseases (STDs) into the family planning project. It was logical, therefore, that when AIDS became recognized as a health concern in Zambia, the project was further expanded to include HIV/AIDS prevention and care activities.

To carry out this initiative, a permanent unit has been established within the MLSS. Twenty-four labour department officials, located in different sites throughout the country, have been trained to provide assistance to companies in establishing and carrying out family planning and HIV/AIDS activities within their organizations. These officials incorporate support for the project as part of their regular labour inspections, as well as when they go out to help settle individual or collective disputes.

The MLSS HIV/AIDS project concentrates on training personnel from participating industries to serve as HIV/AIDS educators, motivators, and counsellors. Specifically, its objectives are to: 1) create awareness about and prevention of HIV/AIDS among employees; 2) promote adoption of risk reducing behaviours, such as condom use; and 3) encourage positive living among those infected with HIV.

The MLSS is currently working with 65 diverse companies throughout Zambia that provide health services to their employees (5 in Kabwe, 10 in Kitwe, 7 in Luanshya, 27 in Lusaka [the capital city] and 16 in Ndola). Since most of these companies also cover health costs for workers' families, the MLSS would like to expand HIV/AIDS activities to reach dependents as well. While the MLSS is pleased with the progress made thus far, they would also like to expand the project to other companies. However, since the project is currently supported entirely by the government, they are finding it difficult to continue providing support to the companies already participating let alone attempting to initiate projects at new sites.

Despite limited resources, the MLSS intends to continue to support the current company projects in at least two ways: to train more local labour officers so that they can provide support within their areas and to revive their newsletter. The newsletter would offer an opportunity for companies throughout Zambia to share experiences and highlight various activities they could undertake on their own.

**HIV/AIDS Prevention and Care Activities at the INDENI Petroleum Refinery**

The INDENI Petroleum Refinery Company, situated in the city of Ndola in the Copperbelt Province, was established in 1968 as a parastatal company equally owned by the Zambian and Italian governments. INDENI refines crude oil pumped through a pipeline, over a distance of 1,700 km, from the port of Dar-es-Salaam, Tanzania.

INDENI has a total labour force of 403 workers; 377 men and 26 women between 21 and 55 years of age—the preponderance of men due to the technical nature of most jobs at INDENI which few Zambian women have as yet been trained to fill. Workers come from all nine provinces of Zambia and neighbouring countries. There is also a small proportion of expatriates from Italy and India.

Recognition of HIV/AIDS as a problem at INDENI can be traced back to 1984, when two staff members became ill and died from causes related to AIDS. Gradually, other employees developed similar symptoms. By 1985, the company physician had become concerned about the increase in the number of employees falling ill with what looked like the new ailment being talked about in medical circles, “AIDS.” He sent 12 blood samples from workers he suspected might be HIV-positive for testing in Italy. Four of these samples were reported to be positive. Shortly thereafter, the Tropical Disease Research Centre (TDRC) at Ndola Central Hospital started screening blood for HIV. The doctor seized this opportunity to retest the blood of the 12 employees. The same four blood specimens were reconfirmed to be HIV-positive.

At that time, INDENI’s clinic personnel were not equipped with the knowledge or skills to deal with this unknown disease. As a result, the four
affected employees received no HIV/AID specific health care services or support. Three subsequently died while at INDENI; one opted to leave the company for fear of being stigmatized and died at home three years later.

Concerned about the increasing number of AIDS-related deaths, the Managing Director cabled Italy in 1987 to alert the Board of Directors about the medical problem facing the company. AGIP Petroli, the Italian parent company, sent their chief medical officer, who was knowledgeable about AIDS, to Ndola. While at INDENI, he held consultations with senior management, informing them about the new syndrome (AIDS) and the need for HIV/AIDS prevention and care initiatives.

All of this was taking place at about the same time that the MLSS began including HIV/AIDS prevention and care activities as part of its work place project.

Rosemary Mutemwa joined INDENI 12 years ago as the nursing sister in charge of the company’s clinic facilities. At that time, employees interested in family planning had to go to the hospital for services. This didn’t make sense to Sister Mutemwa, so she approached the district medical officer in Ndola and got support to offer family planning counselling and services at INDENI. Family planning methods available at INDENI include pills and barrier methods such as condoms and foaming tablets. IUDs are also available but have to be inserted at the hospital.

Then representatives from the MLSS visited, asking her to complete a survey about what family planning services were being offered by the company. Subsequently, INDENI was invited to be one of the first companies to participate in the UNFPA-sponsored work place family planning project. It is not surprising, therefore, that INDENI was also one of the first companies to offer an HIV/AIDS prevention project for its employees and that the HIV/AIDS project has become an integral part of the company’s occupational health programme.

INDENI’s HIV/AIDS prevention and care services are offered to all its employees. Activities include information, education and communication (IEC) to increase AIDS awareness, promotion and provision of condoms, counselling, nursing and medical care for in and out-patients, and community outreach services targeted at employees’ families, particularly spouses and sexual partners. People with AIDS receive medical care for opportunistic infections such as tuberculosis and dermatological conditions. Within INDENI’s clinic, international standards for aseptic care are observed in all relevant procedures, including disposing of syringes and needles after one use. Other instruments, such as dressing materials, are disinfected as recommended by manufacturers.

The HIV/AIDS project fits into the broader health education programme at INDENI that offers health talks once a week on various subjects, including AIDS. Special events take place in the staff canteen or training centre; some are open to anyone who wants to come, while in other cases the head of each section nominates two employees per shift to attend, in order not to disrupt productivity.

HIV prevention activities include lectures, group discussions, debates, and film and video shows. A recent debate was entitled: “HIV Status: would you like to be told or not?” More than 90 employees attended and were still asking questions when the time for the event was up. Committee members also visit AIDS patients in the hospital and then
follow-up with home visits to provide emotional support, check on the patient's progress, and provide drugs and other essential commodities that may be needed.

Initially, HIV/AIDS services were intended only for the workers. However, since 1990, the HIV/AIDS Committee has been attempting to provide outreach services designed to reach the families of INDENI employees. INDENI provides housing for its workers (which it leases from the Ndola City Council). This means that most employees and their families live within company compounds and are thus relatively easy to reach.

The impetus for the outreach programme was due to recognition that employees do not live in isolation; rather, they are very much affected by the behaviour of the people they live and interact with outside INDENI everyday. In fact, during interviews and group discussions, workers said that they were finding it difficult to act upon the knowledge they had acquired from the IEC and prevention activities at work because they lacked support from their families or associates at home.

Initial attempts to reach workers’ families at home were frustrated by a lack of transport, time and resources. Further, Sister Mutemwa found that the women got bored listening to her giving the same lectures about family planning and AIDS all the time, so she has adopted a new strategy. She has recently formed a women’s group among the wives of employees in Ndeke, a residential area of about 200 people. Most of the women in Ndeke do not work outside of the home and so are accessible during the day. Sister Mutemwa has brought 25 of them together to form a women’s group.

The group meets monthly at the home of one of the clinic staff members. The women themselves have discussed the kind of activities they would like to undertake to help their families and the community. The project takes advantage of their meetings to offer health talks on different subjects, such as oral rehydration therapy and preparation of nutritional foods as well as on family planning and AIDS. In this way the women don’t get bored by hearing the same thing over and over. Child weighing is a regular part of the meetings too, in order to detect early signs of malnutrition. At times, films are shown to the group. For such special events, members spread the word and attendance reaches more than 50.

Sister Mutemwa hopes that once the group becomes well established, INDENI may consider renting a building within the community where they can hold meetings and carry out income-generating activities. Similar projects might then be established in other residential areas where employees live.

Impact of HIV/AIDS on INDENI Staff and Productivity

Because there is no compulsory blood screening at INDENI, and HIV infected staff often will not admit their status, the cause of death is usually
reported as an AIDS-related illness such as tuberculosis and diarrhoea. Thus the full impact of HIV/AIDS on the work force is difficult to determine. However, a review of mortality statistics maintained at INDENI shows a high concentration of staff deaths in the most productive age group: out of the 32 deceased staff between 1987 and 1992, 53 percent (17) were in the 34-39 year age group. Furthermore, records indicate that mortality rates doubled in the same period, and that a large proportion (84 percent) of deaths at INDENI have been due to AIDS-related causes.

AIDS is a terminal illness, often of long duration. Although it was beyond the scope of this case study to document the company's financial outlay for HIV and AIDS related illnesses, the medical costs to the company are substantial. For example, medical care for one AIDS patient between 1985 and 1993 was approximately K140,820 (US $352 at the 1993 exchange rate), and this did not include medical absences or transport and hospital costs.

In addition to medical care, INDENI expends a substantial amount of money for paid sick leave for personnel suffering from AIDS. For example, costs of medication and clinical care for one worker cost the company more than K150,000 (U.S. $375). In addition, this employee received 95 days paid sick leave, 50 days of hospitalization, and 10 compassionate leave days due to the death of her husband and brother (both died from AIDS-related conditions) on separate occasions. This was a total of 155 days (five months) of paid absences between 1987 and when she died in 1993.

When an employee, his/her spouse, children and/or immediate family members (parents and siblings) die, INDENI pays funeral expenses as well as providing a coffin and transport for burial. During 1992, employees lost a total of 70 close family members. Hence, the time lost to attend funerals was quite significant. At the time of the survey, the company also provided a grant of K10,000 to an employee upon the death of a child or parent, and K5,000 when a sibling dies. INDENI, therefore, paid out a total of K223,200 (US $558) in funeral grants.

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<tr>
<th>CHARACTERISTICS OF DEATHS WHICH OCCURRED AT INDENI: 1987-1993</th>
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<td>Male</td>
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<td><strong>Age in years</strong></td>
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<td>40-44</td>
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<td>&gt;45</td>
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<td><strong>TOTAL:</strong></td>
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<tr>
<td><strong>Occupation</strong></td>
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<td>Managers/Engineers</td>
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<td>Plant Operators</td>
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<td>Secretaries</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>TOTAL:</strong></td>
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<tr>
<td><strong>Causes of death</strong></td>
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<tr>
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<td>1993</td>
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<td><strong>TOTAL:</strong></td>
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MANAGEMENT

The MLSS encourages each participating company to form a working committee to plan and carry out HIV/AIDS prevention and care activities. At INDENI a committee has been formed consisting of 25 voluntary members (including clinic staff, secretaries, trade union representatives, managers, and workers at large). Of this group, about 10 are really actively involved in the project. The Committee members then elect their own officers, including a chairperson and secretary.

The project is based in the company clinic, which offers services to employees 24 hours a day (due to the nature of the refinery business, employees work on rotating shifts around the clock). The clinic has a total of eight paid staff: one public health nurse, five clinical officers, one laboratory technician, and one visiting doctor who is in attendance for two hours daily, Monday through Friday, and on call 24 hours a day. While all clinic staff participate in the project, overall responsibility lies with the HIV/AIDS committee.

RESOURCES

While the MLSS work site project was originally funded by the UNFPA, it is currently financed entirely by the Government of Zambia through the Ministry of Labour and Social Security.

The HIV/AIDS prevention and care project at INDENI is one facet of the company’s overall occupational health services (OHS) and thus has no operating budget of its own. It therefore must compete with other OHS activities for resources and funding. Sister Mutemwa has included a specific item for purchase of HIV/AIDS educational materials in her budget for next year, but she doesn’t know yet if it will be approved by management. If it is, it will be the first time money will be specifically earmarked for AIDS activities.

The MLSS provides no direct financial support to any company participating in its family planning and HIV/AIDS project. Rather, it provides training, supervision and assistance by putting companies in touch with other organizations that can help with provision of condoms and educational materials (pamphlets, posters, and calendars), technical assistance, moral support, and resources such as providing sites for meetings and seminars. In INDENI’s case, these include: the Ministries of Health, Education, and Local Government, as well as the local health departments, other parastatal institutions, Zambia’s Flying Doctor Service, and non-governmental organisations such as the Copperbelt Health Education Project (CHEP), the Planned

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<tr>
<th>受益者</th>
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<tr>
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<td>父亲</td>
<td>25,800</td>
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To help individual company projects raise funds, the MLSS has supported inter-company competitions such as football matches and drama competitions on family planning and HIV/AIDS. In 1991 and 1992, INDENI won trophies for good performance in both drama and football.

EXPERIENCE TO DATE

One major strength of INDENI's HIV/AIDS project is the active collaboration between the National AIDS Control Programme (NACP), the MLSS, and INDENI management. For example, INDENI allows the workers time off to participate in HIV/AIDS prevention and care activities and there is no discrimination against employees known to be HIV-positive or who have AIDS—they do not lose either their jobs or company benefits. Employees who participate on the HIV/AIDS Committee and clinic staff have full mandate to carry out HIV/AIDS activities as part of their job responsibilities.

A primary achievement has been increased awareness and knowledge about HIV/AIDS among INDENI employees. Most of the employees interviewed in the case study said they were aware that AIDS is a major social problem and health threat. They also knew the main symptoms of AIDS and that the primary mode of transmission in Zambia was through heterosexual intercourse. And while project staff still feel that there remains a large gap between knowledge and behaviour change, there is some evidence of positive change. When the project began, workers were reluctant to use condoms—on occasion, a few would come to the clinic to request them. Now, whenever there is a project-sponsored event, staff have to bring boxes of condoms because "they are going like hotcakes."

Also, there has been a significant change in workers' understanding of how the virus is transmitted. This is reflected in the fact that when the project began, those who were known to be positive or have AIDS were shunned by their colleagues—left to eat alone and not involved in other activities. Today there appears to be no discrimination because everyone understands how you get AIDS and that there is no danger involved in associating with those who are infected.

However, the project experiences some constraints. For example, although the project is intended for all employees at all levels, it has been observed that top management personnel do not participate directly in project activities (e.g., attend meetings and educational activities). This has a negative effect on other workers as they look up to the top management personnel as role models. Workers will often say, "why should I change my behavior when I know the bosses haven't changed theirs."

Specific obstacles facing the project include lack of transportation. The HIV/AIDS project must depend on sharing a van with the personnel department which means that it is not always available for their use. This can cause cancellation of events or neglect of many follow-up activities. Lack of educational materials in local languages is another problem. Many materials, especially films and videos, are only in English and thus of limited use, especially for outreach activities with family members, few of whom speak or understand English.

Although INDENI's HIV/AIDS activities have not been evaluated, reports from the clients, clinic staff, and management indicate that the project's community outreach initiative is still in its infancy and that family involvement is still minimal. In addition, despite greater understanding, there is still much denial about HIV/AIDS infection on the part of individuals. Many who suspect they are ill due to AIDS, are reluctant to go for testing. Rather, they say that they are ill due to the chemicals they work with at INDENI.

LOOKING AHEAD

It is important to note that not all clinic staff have received adequate training in proper management of HIV/AIDS patients and that none have
been trained specifically in how to counsel HIV/AIDS clients. This is considered to be a major weakness in the current project.

Project staff also reported that MLSS representatives never visit INDENI any more. In the first year, they came a lot, organizing the football and drama competitions mentioned earlier. The local MLSS office has told project staff that they don’t come any more because they lack transportation and because they feel INDENI is already doing a good job. But personnel at INDENI indicated that technical support from the MLSS is important because it generates greater interest both on the part of employees and management, and boosts their morale.

A valuable role that the MLSS could play would be to bring together HIV/AIDS project staff from different companies in the region to share experiences and learn from one another. They could also help the various projects establish links with other organisations in the area that could function as collaborators with their HIV/AIDS projects.

The following are recommendations for how workplace initiatives might play a more vital role in alleviating the social, economic and epidemiological consequences of the AIDS epidemic:

- Community outreach activities need to be expanded and strengthened as a supportive link between employees and their families, and to the community in general. There is a need to determine the most effective ways of reaching families and sexual partners of the workers, especially women.
- Collaboration between INDENI and other institutions, such as the MOH, need to be improved and institutionalized.
- As the HIV/AIDS project currently has no trained counsellors, the training of HIV/AIDS counsellors is crucial to improve the quality of services.
- Currently most available IEC materials are in English, thus most of INDENI’s staff and their families find it hard to effectively assimilate the messages they contain. This underscores the importance of producing and/or translating appropriate IEC materials into local languages.
- There is a need to more actively involve senior management personnel in project activities as their support and commitment are vital for the project’s success.
A CASE STUDY OF
KWASHA MUKWENU:
A CINDI PROGRAMME
IN URBAN LUSAKA, ZAMBIA

Consultant: Ms. Patricia Kamanga

Kwasha Mukwenu is a Children in Distress (or CINDI) project located in Matero, a small suburban area of Lusaka, the capital of Zambia. It is affiliated with the Society for Women and AIDS in Zambia (SWAAZ).

THE CINDI APPROACH

To meet the growing need for local alternative forms of care for people with AIDS that utilize local human and material resources more efficiently, a community-based approach, known as Children in Distress (CINDI), was initiated in Zambia in 1989 and became operational in May 1991. The CINDI concept grew out of deliberations between doctors from the Chainama Mental Hospital and the University Teaching Hospital, and representatives from SWAAZ, UNICEF, and Christian Children's Fund, concerned with the need to provide alternative care for HIV/AIDS patients. This was done in coordination with the National AIDS Control Programme. The CINDI approach was designed to:

- Ensure that HIV-infected people and people with AIDS receive understanding and compassion;
- Care for orphaned children whose parents have died of AIDS and/or children living with HIV-positive parents;
- Mobilize the community to obtain funds for purchasing medicines to treat opportunistic infections related to STDs and AIDS;
- Advise those infected with STDs and HIV about where to obtain health care services, including referrals to local clinics.

CINDI activities are being carried out under the auspices of two organisations, SWAAZ and the Family Health Trust. This case study is on Kwasha Mukwenu, the SWAAZ-affiliated CINDI project.

PROFILE OF THE PROJECT COMMUNITY

Matero is an old and rather well-established peri-urban section of Lusaka with a population of about 60,000. The area is relatively well-developed in terms of the number of schools, the extent of communications, and the existence of a variety of local industries. Most residents earn a living from civil services, artisan trades, or marketing and vending, but there is also a high degree of unemployment. Three government health clinics are located in the area, but medicines tend to be in short supply. Many people in Matero find it difficult to pay for medical care which causes individuals to frequently delay treatment and thus further compromise their health and well-being.

STDs and HIV infection are serious problems in Matero, particularly in the case of the many local inhabitants who frequent the approximately 200 beer drinking establishments scattered throughout the area. Some men are known for not being able to maintain steady sexual partnerships or marriages because they cannot support them. In addition, as there is a lack of employment opportunities for women, many have been forced to resort to prostitution to support their families. Discotheques located in the area attract young people and are felt to offer opportunities for sexual liaisons.

PROJECT DESCRIPTION

Kwasha Mukwenu, which means “help your friend” in the local language, was founded in December 1991 in Matero. It was formed initially by members of the women’s group at St. Mary’s Catholic Church after one member returned from a trip to Uganda and shared with the group what she had learned about how orphans are being cared for in that country. The women had already begun to experience deaths in their own compounds that were leaving children without parents to care for them. Based on what they learned about what was being done in Uganda, they decided to take action.

First, the women from St. Mary’s visited other churches and women’s groups in the area to enlist
ever possible, for orphans to remain in their own homes and for Kwasha Mukwenu members to look after them there. Since the organisation draws members from different parts of Matero each member is responsible for identifying children in need in her area.

Care of Orphans and People with AIDS

On average, each woman looks after from three to five families of orphans. They call these children their "caretaker families" and they become the "caretaker parent." It is each caretaker parent's responsibility to ensure that the orphans under her care attend school and that they have food, medical care, clothes, shelter, and the attention of a caring adult. Because the women live nearby, they see the children every day, and the children understand that they can go to their caretaker parent if they have problems. Currently Kwasha Mukwenu members are looking after 65 orphans who are in secondary school, 80 who are attending skills training (these are youth over 15 who have been thrown out of school), 240 in primary school, and 138 are pre-schoolers (under seven years of age).

Whenever they learn that orphaned children have been thrown out by relatives (not an uncommon occurrence in such a resource-poor environment), members try to get the family to take them back. In addition, members are aware of families where one or both parents are affected by AIDS and keep Kwasha Mukwenu informed of their circumstances. They provide assistance to these families to the extent possible, even if it is just moral support and the knowledge that someone is concerned with their welfare and that of their children.

Kwasha Mukwenu members regularly visit about 50 people with AIDS in Matero. They provide food, bathe patients, offer counselling and, when necessary, provide some financial help to cover the cost of medicines.

Income-Generating Activities

There are currently about 35 active members who come to the centre every day to participate in the group's three major income-generating activities: cooking, sewing and tie and dye. The cooking project has contracts with several local schools and provides these institutions with biscuits and bread each day. Clothes and uniforms made by the sewing group, and cloth produced by the tie and dye project, are sold through local retail shops, as well as at conferences and special events. In addition to earning income through the tie and dye project, the organisation's youth wing is helping 10 orphaned adolescents to both support themselves and their siblings and learn a trade by working as apprentices in this business.

Educating the Community

Kwasha Mukwenu provides counselling for groups of orphans, mostly girls, and attempts to educate the community about HIV/AIDS. The organisation tries to encourage support for the Zambian tradition that children belong not just to their parents but to the whole family. They want to help re-establish this spirit of the extended family which often erodes in an urban environment. Kwasha Mukwenu members have produced a play which they use to educate people about the situation of orphans in their community. Last year they presented their play at a meeting on the International
Year of the Family which was attended by representatives of UNICEF. UNICEF staff were so impressed that they arranged for the group to receive the five sewing machines their income-generating project.

Kwasha Mukwenu members also distribute educational booklets about STDs and HIV/AIDS, in local languages and English, which they receive from the Family Health Trust, a Zambian NGO, and the Health Education Unit of the Ministry of Health (MOH). Despite not having formal training, Kwasha Mukwenu members do their best to provide counselling and health education not only to HIV-positive individuals and people with AIDS, but to their partners and families as well. In addition, classes/discussions on topics such as family health, HIV/AIDS prevention and care, and STDs, are frequently held at the centre. They are conducted by local officials from the Ministry of Education, medical staff from government clinics, religious leaders, and community health workers.

MANAGEMENT

Kwasha Mukwenu is a registered, interdenominational, community-based NGO with 120 registered members. It is an affiliate of the Zambia branch of the Society for Women and AIDS in Africa (SWAAZ). All Kwasha Mukwenu members are volunteers; there are no paid staff. Members who have professional training (in education, health care or social services) serve as committee heads and help to train other members on the job. The entire group meets monthly to review current work and plan future activities.

Kwasha Mukwenu has a governing body composed of a Chairperson and Vice-Chairperson, Secretary and Vice-Secretary, Treasurer and Vice-Treasurer, all elected by the membership. Members themselves serve on various committees that include: health care, education, counselling, income generation, finance department and youth wing. Kwasha Mukwenu has recently formed a Board of Directors—at the suggestion of visitors from a sister organisation in Malawi—which they hope will help them in their fund raising efforts. Currently their Board includes representatives from UNICEF, USAID, KARA Counselling, the Family Health Trust, the YWCA, and the parish priest.

RESOURCES

The spirit and determination of Kwasha Mukwenu's volunteer members remain the project's primary source of support and most of the organisation's resources come from its own fund raising activities. Kwasha Mukwenu staff are volunteer members who donate four hours per day to work at the centre, baking, sewing, and participating in other activities to raise money for the project. This is in addition to their work in the community caring for orphans and people with AIDS. St. Mary's parish provides space for the centre and has donated the stove used for the baking project. As noted above, UNICEF donated five sewing machines for the sewing project, replacing the three the group had been using which were on loan from individual members. In addition, the individual members make financial contributions to support the organisation.

To date, outside financial assistance has come primarily from SWAAZ, which has provided funds to furnish the centre and to expand the tie and dye project to include an apprenticeship programme for AIDS orphans, as well as for general support. SWAAZ is also planning to begin gathering old
clothes which Kwasha Mukwenu can give to the orphans. The organisation also receives support from individual donors.

In terms of liaison and cooperation with other institutions and NGOs, Kwasha Mukwenu works with local churches, the Family Health Trust's Anti-AIDS project, SWAAZ, the MOH and other local organisations that provide assistance to the project in terms of supplying educational materials, resource people, and training opportunities. The support of local government authorities helps to publicise and legitimise the group's activities and to mobilise community support.

EXPERIENCE TO DATE

Historically, in situations of illness or death, Africans have relied upon the mutual assistance provided by the extended family. But in the face of AIDS, the family support network alone cannot meet the growing need for care. Neighbours must also collaborate with one another to provide the necessary social support within the community. Particularly, there is a need for alternative means to care for children whose circumstances have become precarious as a result of AIDS. Kwasha Mukwenu attempts to establish such alternative forms of support by helping—at least to the extent possible—individuals, families, and the community cope with the epidemic and support children orphaned by AIDS.

Kwasha Mukwenu members believe that the primary strength of their project is the caretaker parent arrangement. Not only does this system directly provide care for orphans and people with AIDS, but it ensures that the group members are always aware of the health status of the community and thus are a valuable resource within the community. Kwasha Mukwenu maintains positive relationships with religious groups and community opinion leaders. These collaborative efforts have increased community awareness of the problems faced by children at risk and has encouraged various local institutions to come forward to offer education and counselling to Kwasha Mukwenu's caretaker families.

By integrating its activities with existing local institutions (schools, clinics, churches, etc.) the programme is building a new relationship between these institutions and the community conducive to the promotion of HIV prevention and care of those afflicted by AIDS.

Despite being aware of the implications of HIV infection, most people in Matero have not changed their sexual behaviour considerably. While Kwasha Mukwenu members have been actively involved in the dissemination of educational materials, they now believe that they need to adopt more aggressive counselling about prevention.

LOOKING AHEAD

If Kwasha Mukwenu is to serve more children, it must earn more income. To do this it needs additional volunteers able to participate regularly in income-generating activities, serve as caretaker parents, and do community outreach. The organisation would like to be able to offer members a modest form of compensation for the time they devote to this work. Without some material benefit to offer, they believe it will not be possible to attract enough volunteers to meet the growing need.

In terms of developing new sources of income, one suggestion is to begin making coffins. The cost of the increasing number of funerals in Matero is becoming hard for families to bear. Kwasha Mukwenu members believe that if they could con-
struct coffins that are reasonably priced, this would be helping the community as well as providing the group with another source of income. They could also offer coffins at no charge to their own members as a benefit of membership. The parish priest has already agreed to give them the land needed to expand their activities.

A major concern of Kwasha Mukwenu members, and families affected by AIDS, is how to keep children in school. School fees, uniforms, shoes, and textbooks all must be supplied before children are allowed to attend either public or private schools. For families devastated by AIDS, particularly where children are orphaned, money to meet these expenses is difficult if not impossible to come by. Liaison with a wide variety of organisations, including schools and churches, could begin to address this issue and thus greatly benefit the large numbers of young people facing a questionable future. As an initial step in helping these young people, Kwasha Mukwenu would like to provide training in English, mathematics, and religious education to out-of-school youth.

Kwasha Mukwenu would also like to learn more about the legal rights of orphans and how to protect them, because right now they are just working spontaneously. The Child Adoption Society in Zambia has guidelines regarding adoption but this is a different situation than their own, where they are helping orphans in the community who are either living with relatives or on their own.

To increase their effectiveness in meeting the needs of the people they serve, Kwasha Mukwenu members would like more of their members to receive training in counselling skills. The project would also like to be in a position to acquire the various drugs needed by families under its care for the treatment of STDs, HIV infection, and related conditions. Local government clinics rarely have drugs available and people often lack the funds needed to secure medications on their own.

In Zambian society extended family networks have been used for generations to care for the sick. Strengthening this indigenous system can help meet the increasing need for care of people affected by the AIDS epidemic within the community, rather than relying on hospital-based facilities that will be hard-pressed to meet the increasing demands of those in need of care and support.

Kwasha Mukwenu members believe that the work they are doing can be replicated in any community where neighbours can be encouraged to cooperate and care for one another, where community members are willing to volunteer time and services in support of local initiatives, and where some social infrastructure, such as medical and education facilities, are available. It is also important that at least a small percentage of the community be willing to take on the responsibility of being caretaker parents.
THE PROBLEM OF HIV/AIDS IN UGANDA

AIDS is a major crisis in Uganda and its impact on society and the national economy is enormous. The first cases were reported in 1982 at Kasensero and Lukunyu on Lake Victoria. Since then, the disease has spread throughout the country. The government soon recognised that the AIDS epidemic posed a serious threat to the economic and social development of the country and, in 1986, established the National AIDS Control Programme (NACP), located within the Ministry of Health (MOH). The NACP coordinates technical and operational activities related to AIDS.

As of December 31, 1992, a cumulative total of 38,552 clinical cases of AIDS in adults and children had been reported to the NACP Surveillance Unit. Of these, 35,486 (92%) were adults and children aged 12 years and above; 3,066 (8%) were children under eleven. The overall mean age of those affected is 30 years and the mean age for males and females is 32 and 28, respectively. The NACP estimated that by mid-1991, 1.5 million people, or nearly 10 percent of the population or 20 percent of the sexually active population, were HIV positive. Every district in Uganda has now reported at least one clinical case of AIDS.

By the time the current government came to power in 1986, Uganda’s health infrastructure had been all but decimated by years of civil strife. So, while in principal public health services are available, in most instances facilities (especially in the rural areas) have returned to only the minimal standard of care or have remained closed. In an effort to speed up the restoration of services, while recognizing current economic constraints, Uganda is gradually introducing cost sharing in the delivery of public health services. In areas where cost sharing has gone into effect, there is already a noticeable improvement in terms of availability of services and drug supplies, provided patients are able to afford their share of the cost.

UGANDA NATIONAL AIDS CONTROL PROGRAMME

Since its inception in 1986, the NACP has made developing strategies to prevent and control HIV infection a priority. Information, education, and communication (IEC) activities play a fundamental role in this strategy. Other units such as surveillance/epidemiology, patient care, and blood transfusion complement the IEC unit. A National Committee for the Prevention of AIDS, a multi-disciplinary and multi-sectoral body, was created to play an advisory role and helped to formulate policy. It has since been replaced by the Uganda AIDS Commission, which now coordinates and guides policy formulation and multi-sectoral collaboration for the prevention of AIDS.

A review of NACP activities in 1988 led to a strategy of decentralization of AIDS prevention and control activities to the district level in order to increase the coverage and effectiveness of the national effort. District medical officers were given the responsibility and resources to plan and implement day-to-day activities. Local AIDS committees made up of non-governmental organizations (NGOs), religious groups, Resistance Councils (the unit of local government in Uganda), and other local bodies were formed to mobilize and/or support community-level AIDS education activities. The NACP also seeks to establish links between the community and the most accessible health care facility in each area. It is hoped that when properly utilized, such links will streamline the referral process and will directly involve community members in the treatment of opportunistic infections related to HIV/AIDS and the care of people with AIDS.
A CASE STUDY OF COMMUNITY-BASED COUNSELLING IN AIDS PREVENTION AND CARE IN UGANDA

Consultant: Ms. Mary Amanyire

This study focuses on the Community-Based Counselling (CBC) project of the Information, Education and Communication (IEC) Section of the Uganda National AIDS Control Programme (NACP). While the project has now expanded to nine districts, this study took place in Pakanyi Subcounty, in Masindi District, one of two initial project sites.

It is high time we took up the challenge of AIDS in our own hands. It is too much work for the AIDS Control Programme alone to educate everyone everywhere and AIDS will not wait. Go out and educate your people where you live. Start up local drama to educate the undisciplined. Take charge every Friday or Sunday and devote five minutes to remind your friends and neighbours about AIDS. Maybe if we all participate and seriously talk to our children, it could be the beginning of change in behaviour.

NACP Director, at the launch of the CBC Programme

PROFILE OF THE PROJECT COMMUNITY

Pakanyi is one of the twelve subcounties that make up the Masindi District in Western Uganda. The subcounty has a population of 23,945, living in 51 villages under the jurisdiction of Resistance Councils, the unit of local government in Uganda. Approximately 53 different languages/dialects are spoken in the area although some basic Swahili is understood and spoken by most people. Most residents are peasant farmers who come from a variety of cultural backgrounds.

Pakanyi has eight primary schools and one secondary school. A health centre, recently renovated by the Minister of Health (MOH), is staffed by a medical assistant, nurses, and midwives. Three other health posts are distributed throughout the subcounty; however, these facilities are often closed due to shortages of staff and supplies.

PROJECT DESCRIPTION

In 1991, the NACP carried out an evaluation of its IEC efforts. As the programme manager stated, “Not only is the AIDS Control Programme keen to evaluate and learn from what has been done in the field of AIDS/IEC but we need to know where to go from here.” The evaluation made clear that while the level of awareness about HIV/AIDS was high, this was not leading to significant change in behaviour. The evaluation also revealed a high degree of misconceptions about the transmission of HIV that was impeding efforts to prevent the spread of infection and inhibiting efforts to care for people with AIDS in the community.

Today in Uganda the subject of AIDS is incorporated into almost every type of community activity. Therefore, the NACP decided to redirect its IEC efforts beyond awareness to a type of education that would enable communities to actively promote behavioural change. They saw a need to engage individuals, families, and communities in dialogue—through counselling—in order to motivate them to adopt safer sexual behaviour.

Therefore, among the new approaches implemented was Community-Based Counselling (CBC). This approach focuses on encouraging local communities to take the initiative in carrying out AIDS education and providing basic nursing care through the deployment of a cadre of trained, voluntary Community Counseling Aides (CCAs). It is designed to promote better living conditions for the whole community while at the same time reducing dependency on external sources of support.
Establishment of the CBC Programme

The NACP began drafting training and project guidelines for the CBC project in 1991. Two districts were selected for the initial intervention: the urban district of Jinja, east of Kampala, and the rural district of Masindi, northwest of the capital. Communities within each district were selected based on: 1) the availability of Resistance Council officials willing to support the project, 2) the existence of a health centre and medical assistant, and 3) accessibility to the other parts of the district.

In the field, the NACP team first organized a meeting of officials working at the district level. These included the medical officer, the Resistance Council chairperson, a representative from the district administrator’s office, a health educator, a senior nursing officer, a health inspector, a medical superintendent, a representative from a women’s development group, representatives of local NGOs, a community district officer, and a youth officer. Their response to the seriousness of the problem and the need to take action was immediate. As the subcounty chief of Pakanyi noted when commenting on the increased number of deaths in his area: “We need a constant reminder among us. Someone to answer many of our questions, including (about) condom use.”

Discussion at the meeting centered on how to introduce the project in the district, identification of local resources, solicitation of support from other government ministries with community level extension workers and from district level non-governmental organisations (NGOs), selection of trainers and a member of the district health team to serve as the focal person for the project in the community.

Next, working with local MOH staff, 15 district trainers were selected on the basis of their previous training experience, fluency in the local language(s), familiarity with the culture, permanent residency in the area, interest and knowledge about HIV/AIDS and health education, ability to combine training of counselling aides with their other duties, having established links with extension workers at the community level, and possessing the ability to supervise the work of the counselling aides. Some of the district trainers were MOH staff while others were drawn from different government ministries or from NGOs, such as the Red Cross.

The district trainers then participated in a seven-day training programme conducted by the NACP. Over time, the project has found that trainers recruited from other agencies have tended to lose interest once the initial training has been completed. As there is a continuing role for the district trainers in terms of sensitising the community and encouraging local support (such as giving talks to local organisations), as new districts are added, the CBC project is now selecting trainers primarily from among MOH personnel. MOH medical staff serve as resource persons for the project.

Once the course was completed, the district trainers then trained a cadre of coordinators who oversee the day-to-day activities of the counselling aides. The coordinators also work with health centre personnel to set up a two-way referral system between the community and local health care facilities.

Next, seminars designed to introduce the CBC project to the subcounty and to gain and solidify local support were held for 50 community leaders. The intention was to get them involved in formulating possible community and individual level strategies to prevent the further spread of HIV/AIDS and provide support to those who are infected, as well as to seek their help in determining what would constitute appropriate educational and communication techniques for use in their area.

By the end of this two-day seminar, general criteria for the selection of the community counselling aides also had been developed. It was decided that CCAs would be men or women, 25 years or older, who are permanent residents in the area, willing to work voluntarily, trusted by their community, understand the issues involved, belong to a religious denomination, and are already active members of the community. Personal experience in nursing or
having cared for a close relative with AIDS is considered useful but is not necessary.

While both men and women are working successfully as CCAs, the district health education officer in Pakanyi believes that older women make the best counselors because they are more readily available, more compassionate, and are usually well established and respected within the community. He has found that the educational level of a person does not seem to have any effect on whether or not she or he is good at the job.

Subsequently, 30 CCAs were selected and participated in two weeks of daily training sessions conducted in Pakanyi by the district trainers, with the assistance of facilitators from the NACP. The curriculum included: facts about AIDS, understanding common perceptions about AIDS, communications skills, essential elements of providing home care, counselling skills, referral mechanisms to utilise existing health care services, and some information about good nutritional practices for people with AIDS.

Saida Ismael is a woman with grown children who makes the long trek each day between her home and the nearest trading center where she sells prepared foods. However, she devotes a portion of each day to her work as a community counseling aide (CCA), because she believes her work can save lives. Carrying the posters and other IEC materials provided by the project, and a supply of condoms, she tries to visit at least a few of the more than 300 families living in the two villages that she covers.

Saida says she has no problem talking with either men or women about AIDS and safer sexual practices, but that it is not possible to talk to a mixed group. Her biggest problem is lack of transport, as the houses in her villages are quite spread out. When she was informed that she was one of six CCAs selected to receive a bicycle from the project she was overjoyed. "This will be a great help to me in my work and I will continue to teach and counsel until my death!"

Activities of the Community Counselling Aides (CCAs)

The CCAs are the backbone of the CBC project. Each CCA usually represents one village but in Pakanyi, where dwellings tend to be spread out, one aide may cover only a portion of a larger village. The training programme has been designed to equip CCAs not only with knowledge about HIV/AIDS prevention, but with basic counselling skills so they can provide AIDS education and care at the grassroots level. A primary goal is to enable the CCAs to strengthen the level of family and community support to people with HIV/AIDS. They also serve as a two-way referral system between the community and local health care facilities.

The project's emphasis on home-based care evolved because in Uganda the increasing number of AIDS cases is overburdening a health care system already weakened by years of civil strife. Further, it has become clear that, like most Ugandans, people with AIDS usually prefer to die at home. Home-
based care thus builds upon the African tradition of relying upon the extended family in a time of need. Further, many AIDS patients simply could not afford the cost of drugs or an extended stay in the hospital even if these options were available.

According to the design of the CBC, when AIDS patients are discharged from the hospital they are followed up by a CCA under the supervision of the district health team. The CCA provides ongoing, supportive counselling in the patients' homes. CCAs also refer people to the health clinics for HIV testing and then keep in touch with them when they return home. Currently most CCAs have five or less clients with AIDS (or sick people who the CCAs believe have AIDS even if they are unwilling to admit it because of fear of stigmatisation) who they visit regularly. But this is only one part of their work.

Adopting a strategy to help control the spread of HIV and provide home-based care has required not only counselling for patients, but also for spouses, immediate family members, and others in the community. Thus, CCAs make sure that family members have the correct information about HIV/AIDS. In Africa, illness traditionally is a family matter and everyone wants to help the patient and her/his family. But AIDS is beginning to challenge the ability of the extended family system to cope without outside assistance. In many cases family members may be ignorant about the disease and fear having an infected person in the home. Others fear the reaction of neighbours if it becomes known that there is someone with AIDS in their midst. This calls for considerable discretion on the part of the CCAs when they provide home-based care and underscores the important role they play in educating family members and the community about AIDS. So in addition to making home visits, CCAs work with groups of students, participate in local meetings, and generally serve as an educational resource for the entire community.

Asaba Nebba is a CCA who covers two villages that include almost 200 families. Currently he has one client who admits to having AIDS who he visits regularly; another client died last year. Mostly he teaches people about AIDS. As he sells drugs at the local trading center, he is in a good position to advise people. He has put up his AIDS posters in his shop. Asaba likes being a CCA because people now come to him for advice and while not everyone is grateful for what he is doing, many are.

Asaba would like to have some follow-up training so that he would have new information to share with people. Many people tell him that they have heard enough talk—they want medicine. While he cannot provide them with a cure, at least he could share with them the latest information available about the disease.

AIDS Counselling and Education at Health Centres

In conjunction with the CBC project, a trained counsellor at the Pakanyi health centre is providing HIV/AIDS education once a week to women attending antenatal and maternal and child health (MCH) clinics. These sessions have become very popular; in fact the medical assistant in-charge now refers to the Thursday sessions as “Lady’s Day,” because most of the women are coming for AIDS education rather than for antenatal care.

The sessions appear to be having an impact. One woman, the chairperson of a local women’s club, said that for the first time she personally realizes everyone is at risk. “The counsellor who talks to us at the Thursday clinic has made us realize that even if we are faithful to our husbands and have a trusting relationship, any slight quarrel in the home could open the door for AIDS.” HIV testing, including pre-and post-test counselling, is available at the health centre.
Community Outreach Activities

As part of the CBC project, AIDS education activities are continuously going on throughout the subcounty in public places such as churches and health centres, as well as at home during visits. These activities are carried out by district trainers, CCAs and health care providers. In Pakanyi, a group of 19 women leaders have been trained to carry out similar activities within the town.

In addition, the CCAs, in collaboration with other community leaders and district health committee members, regularly solicit the viewpoints of their clients and the opinions of local MOH staff and collaborating organisations, in order to assess the impact of the CBC project. They seek to examine the appropriateness, efficiency, and effectiveness of specific AIDS prevention and control strategies and to identify opportunities, problems, and unmet needs.

MANAGEMENT

The CBC project operates at three levels: central, district, and community. At the central level, the project coordinator reports to the NACP/IEC coordinator and is responsible for overseeing the functioning of CBC activities in all districts and providing necessary support. At the district level, the district medical officer (DMO) and the district health team supervise the CCAs and district trainers. Operating at the community level are the assistant health educator, the local medical staff, and the sub-county health committee (composed of community opinion leaders, the parish coordinators and the counselling aides). Coordinators follow up and support the work of CCAs in their area and submit written reports to district-level personnel.

The diagram below shows the management structure at both the central and district levels.

At the Central Level:

- MINISTRY OF HEALTH
  - AIDS CONTROL PROGRAMME
  - INFORMATION-EDUCATION-COMMUNICATION UNIT
  - COMMUNITY-BASED COUNSELLING
  - PROJECT COORDINATOR
  - DISTRICT MEDICAL OFFICER
  - SUB-COUNTY HEALTH OFFICER
  - PARISH COORDINATOR

At the District Level:

- DISTRICT HEALTH TEAM & DISTRICT COUNSELLORS
- SUB-COUNTY HEALTH COMMITTEE
  - COMMUNITY LEADERS & SUB-COUNTY COORDINATOR
  - PARISH COORDINATOR & COUNSELLORS
- COMMUNITY COUNSELLING AIDES

RESOURCES

To date the CBC project has been supported with funding provided to the NACP by the World Health Organisation (WHO). However, WHO is reducing its level of support significantly for the coming year. Therefore, the project's continuation will rest on the ability of the MOH to pick up some of the costs using resources available from other donors. The MOH already pays the salaries of the medical staff who provide assistance to the project; personnel drawn from other government agencies are paid through their own ministries. Resistance
Committee officials and CCAs volunteer their services. The NACP provides the project with educational materials and condoms. The CBC project also receives assistance from a variety of other sources; for example, Inter-Aid provides rice and sugar for distribution to people with AIDS. Community members also contribute funds and collect water, firewood, and food for affected families.

Given the funding constraints facing the NACP, project staff believe that the best hope of continuing what appears to be a very successful effort will be to link local activities directly to an NGO working in that area. For example, in another sub-county of Masindi, the international NGO World Vision has incorporated CBC activities as part of its own programme.

EXPERIENCE TO DATE

Probably the most important element of the CBC project has been the tremendous degree of community involvement that has been generated. Community leaders not only select the CCAs, but are involved in mobilizing resources from the community. Their assistance has also been sought in formulating effective strategies to encourage behavioural change among local residents and in suggesting messages to be included in local language IEC materials. Support of community leaders has also been instrumental in establishing an effective referral system between the community and local health units.

In terms of the CCAs themselves, it is a credit to the project that despite working without compensation, not one CCA in Pakanyi has resigned since their original training took place two years ago. District MOH staff believe that this is due to constant supervision in the field, frequent meetings for all CCAs that keep them motivated and involved, and through regular contact between CCAs and district staff when they come in to pick up supplies of condoms and educational materials.

The CBC project seems to be increasing both AIDS awareness and the quality of life for HIV/AIDS patients. In terms of behaviour, CCAs report seeing evidence of change. Asaba Nebba said that he now sees fewer people openly engaging in risky behaviour at the trading center and that it is now common to hear people say, in reference to AIDS: “What they are saying is true, it’s no joke!” Many adolescent boys now come to him for condoms. The district health education officer underscores the increasing demand for condoms: “In the past condoms would expire on the shelf before being distributed. Now we face frequent shortages due to the high demand.” He also notes that more couples are going for HIV screening before getting married.

We are being questioned about what activities we are carrying out on AIDS in the community. In the areas where we are working, people need this knowledge about AIDS. With the introduction of the CBC project, I believe even our donors will be excited when we report back the approach we have incorporated.

Project Manager
for World Vision

Despite already having some impact, the CBC project still faces a number of constraints in trying to effect behaviour change in the community. Misinformation about condom use and safer sexual practices is still common and traditional practices, such as ritual cleansing of widows, persist.

Likewise, despite increased awareness, considerable prejudice against people with AIDS continues to constrain efforts at home care in areas like Masindi.

Hudson Kubalirwa is a peasant farmer in Pakanyi who also works as a CCA. He currently has only one client with AIDS—a man of about 50 who came from southern Uganda seeking work. Shortly after the man arrived in Pakanyi, he married a local woman. But she died of AIDS and now he is in and out of the hospital. The people he worked for let him go and he says he has no family to go home to. Another family in the area has now taken him in, but they are quite concerned about what will happen when he dies—who will pay for the burial costs?
Unlike southern Uganda (districts such as Rakai and Masaka), the full impact of the epidemic has not been felt as yet in this rural area. One CCA noted that he would like to have a video or pictures of people with AIDS so that he could show people what the disease looks like. He said that there are not enough admitted AIDS cases in the area for people to be able to identify with the disease.

There are also several fundamental constraints within the project that are the result of limited resources. CCAs all expressed the need for more and better educational materials (particularly in local languages) and basic teaching aids such as black boards and chalk. One CCA mentioned that just having something that would identify him as a CCA—a T-shirt or badge—would be helpful and would do a lot to boost his morale.

Transport is a major problem facing the project. In Pakanyi sub-district, individual houses within a village are spread out, not clustered together as is the case in some parts of Africa. This means that each CCA puts in a lot of travel time—and on foot if she/he doesn’t own a bicycle. The CCAs must also travel to the district headquarters to pick up additional supplies of condoms and educational materials.

Another complaint commonly expressed by the CCAs is not having anything to bring to clients when they make home visits. They feel that arriving empty-handed is very un-African and limits their effectiveness. If they could provide clients with some food or other basic commodities, such as soap, they feel they would not only be providing a real service but would be perceived as being more helpful by both their clients and their families.

Finally, CCAs frequently refer to the fact that they receive no compensation for their work. They carry on basically out of a sense that they are helping their community and because they receive recognition for this contribution. However, in some parts of Uganda where private organisations are also operating, the CCAs have become aware that their staff are not only being paid to provide similar services, but are being given the use of a project vehicle.

Lastly, while the referral system between the community and the local health infrastructure is functioning, insufficient financial and technical resources hinder the effectiveness of the medical support facet of the project. This is due primarily to the limited number of sites able to provide HIV testing and the lack of adequate drugs within the health units to meet patients’ needs.

LOOKING AHEAD

Future plans for CBC project are to continue training-of-trainers at the district level and to encourage district administrations to solicit support from existing local organisations to develop and maintain these efforts. The NACP would continue to provide technical assistance and educational materials, but would not directly oversee project activities.

The CBC project in Pakanyi has helped to make the community aware that everybody is at risk of contracting HIV/AIDS and that there is a need for continued and concerted effort to combat the disease. It has also demonstrated that community-based HIV/AIDS efforts can help reduce the increasing burden of caring for HIV/AIDS patients within hospitals and health units. In order to improve the effectiveness of efforts such as the CBC project, there is a need to study and understand the causes of the gap between knowledge and behavioural change within specific communities. It would also...
be helpful if a network could be established to help programmes share information and learn from each others' experiences.

Despite its weaknesses, the CBC project offers many lessons for projects seeking to improve home-based education and care efforts. Among the lessons cited by those interviewed for this case study were that:

- Community based efforts at HIV/AIDS control and prevention help to make the community appreciate that the problem is geographically, socially, and economically close to them and to realize that they have the power to act in an effort to cope with it.
- When implementing a community-based project, efforts should be made to incorporate activities within the existing cultural system as well as to find a compromise between traditional beliefs and scientific information.
- Since behaviour modification is a long and continuous process, immediate efforts should be made to induce change while taking into consideration the social and cultural background of the local population.
- Community-based projects require multi-sectoral and inter-agency collaboration in order to broaden the resource base available to the project and to ensure proper coordination of activities.
- In resource poor environments, community-based care and outreach can be a cost-effective alternative to hospital care.
- Community participation in the planning and development of local initiatives, such as the CBC project, encourage a high degree of community participation and support.
- While communities have the potential to help themselves, they require appropriate levels of direction and technical assistance.
- Many local NGOs have some funds available to support AIDS activities at the community level, but they are in need of advice and direction as to how they can best contribute to these efforts.
THE PROBLEM OF HIV INFECTION AND AIDS IN TANZANIA

Since 1983, when the first three cases were reported, AIDS has spread rapidly in Tanzania. According to the Ministry of Health (MOH), 34,140 AIDS cases were reported in 1991, and 38,416 in 1992. But because of the stigma of the disease, official statistics do not accurately reflect its prevalence and probably only about one in five cases is actually reported. Therefore, it was estimated that by 1992, there were as many as 700,000 people infected with HIV, 120,000 cases of AIDS, and that 110,000 children had already been orphaned. Current projections for the year 2000 are for the number of HIV-positive people to increase to 2,400,000, AIDS cases to reach 800,000 and the number of orphaned children to reach between 450,000 and one million.9

The Dar-es-Salaam region, including the capital city and surrounding area, has the highest incidence of AIDS. An HIV seroprevalence study conducted there in 1992 showed that 12.5 percent of family planning clinic clients in three districts (Ilala, Temeke, and Kinondoni) were HIV positive. Generally, urban dwellers, women, and those between the ages of 20 and 29 are most at risk.

In 1984, the first case of AIDS was diagnosed in the Kilimanjaro region of northern Tanzania. Eight years later, the prevalence of HIV infection from area blood donors ranged from 1.6 to 10 percent. In 1992, about 7.5 percent of pregnant women at antenatal clinics in the town of Moshi were HIV-positive.10 However, because of considerable under-reporting in hospitals, actual figures were probably higher.

Since independence, health care had been provided without charge in Tanzania. However, the government has recently introduced a cost sharing plan for recipients of public health services, except for children under five and pregnant women (ante-natal care, deliveries, etc.) who still receive free services. In theory, people who have been diagnosed as having AIDS or tuberculosis also receive free treatment and medications. But because hospitals experience constant shortages of drugs, patients frequently must purchase medication from commercial outlets.

The public health infrastructure consists of hospitals, health centres, and dispensaries, but the quality of services is generally very poor. There is only one doctor per 50,000 Tanzanians. Apart from the government health delivery system, religious and other private institutions offer curative and preventive health services. Some Tanzanians also seek health services from traditional healers and make use of a combination of traditional and modern medicine.

Because AIDS patients often require long hospital stays and recurrent admissions, Tanzania's already overburdened health system cannot cope with the rapidly increasing numbers of people affected by HIV/AIDS. Therefore, families and communities have an important role to play in AIDS prevention and care. Many groups have responded by forming private, voluntary, nongovernmental organisations to cope with the epidemic at the local level.
Recognizing the gravity of the AIDS epidemic, the government has established a National AIDS Control Programme (NACP). While AIDS awareness among Tanzanians is high, there remains insufficient knowledge and understanding about the disease and how it is transmitted, causing continuing stigmatisation of people with AIDS. Mass media efforts to promote awareness (through billboards, posters, etc.) are minimal and Tanzania does not have national television, an important method of disseminating health education information in neighbouring countries.

Several controversial debates are currently underway regarding AIDS policies in Tanzania. For example, physicians rarely list AIDS as a cause of death because it might embarrass surviving family members. This creates a problem for counsellors trying to encourage families of people with AIDS to adopt safer sexual practices. When the patient dies, they point to the death certificate as proof that their relative did not die of AIDS and, therefore, see no reason to modify their behaviour. Another debate concerns whether family members should be informed when someone tests HIV positive. Currently only the person being tested is told and it is up to them whether they want to notify partners or other family members.

THE NATIONAL AIDS CONTROL PROGRAMME

The National AIDS Control Programme was established in Tanzania in 1988 and is located within the Ministry of Health. It has five divisions: information, education and communication, counselling, demography, clinical, and management. NACP staff work within the MOH from the central down to the district level. The main focus of the NACP's current HIV/AIDS prevention and care strategy is:

- Home-based care and community involvement;
- Early detection and treatment of sexually transmitted diseases;
- Behavioural change through education and sensitization;
- Promotion of condom use; and
- Counselling to encourage “positive living.”

The NACP emphasizes home-based care and urges communities to use local resources and initiatives to encourage alternative care strategies. Today, throughout the country, community-based organisations are working to sensitize people, provide information and enlist support in the effort to prevent the spread of AIDS and to care for people affected by the disease.
A CASE STUDY OF THE KILIMANJARO WOMEN'S GROUP IN THE FIGHT AGAINST AIDS IN TANZANIA (KIWAKKUKI)

Consultant: Dr. Hores Isaack-Msaky

Kikundi Cha Wanawake Wa Kilimanjaro Kupambana Na Ukimwi or KIWAKKUKI, as it is commonly known, is the Kiswahili name for the Kilimanjaro Women’s Group in the Fight Against AIDS, a community-based nongovernmental organisation. It was founded in 1990 by a group of women in Moshi Town who felt compelled to join the fight against HIV/AIDS because the negative effects of the epidemic were rapidly increasing in the area.

PROFILE OF THE PROJECT COMMUNITY

The Kilimanjaro region of northern Tanzania has an area of 13,009 square kilometers and a total population of 1,104,068, of which 165,619 reside in urban areas. The annual population growth rate is 2.1 percent, which is lower than the national figure of 3.3 percent.

The KIWAKKUKI project operates in the Kilimanjaro Region, particularly in the town of Moshi (population 96,645) and surrounding areas serving a population of approximately 600,000. The ethnic make-up of the rural area is predominantly Chagga and Pare while Moshi Town is more ethnically mixed with Chagga, Pare, Sambaa, Masai, Arusha, Meru, Asian, Somalis, and a sizable expatriate population.

Outside of Moshi Town, the majority of the population is engaged in farming and marketing. Major crops grown in the area are coffee, bananas, maize, and millet. In the town, the main occupation is trading but there are also stores, markets, industries, transport services and tourism and the offices of parastatal industries (e.g., sugar plantations). Large markets operate, according to weekly cycles, outside the town and are sites for frequent high risk sexual activity. In addition, important transborder (Kenya-Tanzania) trade routes pass through the area.

The entire spectrum of health infrastructure available in Tanzania can be found in the area including both government and private hospitals and occupational health service facilities for inpatients. Below the level of the hospitals, there are a number of health centres and dispensaries run by the government and numerous clinics and dispensaries run by a range of individual and charitable concerns. There is also a new STD clinic in Moshi Town run by the Tanzania-Norway Project (known as MUTAN).

Some people in Kilimanjaro continue to prepare simple home remedies from local plants for self-medication for various ailments. In addition, people frequently consult traditional healers, often in conjunction with the use of the modern health infrastructure, especially in cases of chronic illness. Unfortunately, there have been a number of traditional healers who have advertised that they have a cure for AIDS with the result that many sick people have paid large sums of money—usually beyond their means—for these remedies. Yet traditional healers remain an important source of treatment for STDs, since treatment at the government hospital is widely believed to involve a great deal of personal embarrassment due to the lack of privacy.

Most of the population is literate enough to read a newspaper, and Kiswahili is almost universally understood except by some of the old rural population.

In Tanzania, like many other African countries, the extended family traditionally takes care of the family/clan in case of problems and illnesses. Unfortunately, the HIV/AIDS epidemic has, in many cases, overwhelmed this system. Families are losing their most economically productive members, family caretakers, and those of reproductive age. With the existing low economic status of most Tanzanian families, AIDS is making people in affected communities even poorer.
**PROJECT DESCRIPTION**

The first step in the formation of KIWAKKUKI was taken in December 1990, when a group of women got together informally to organise an AIDS Week in the town of Moshi. The theme for the week's activities was “Women and AIDS,” which was the theme for the World AIDS Day that year. Following the success of the week's activities, a number of these local women decided they would form a women's organisation in Kilimanjaro in response to the HIV/AIDS epidemic. KIWAKKUKI's founders felt that as women were the most vulnerable and affected group within the population, they needed to mobilize to protect themselves, their children, and the whole community from being infected with HIV and to care for those already infected/affected.

Although KIWAKKUKI is a women's organisation, its target group is the entire population in the area: all age groups, sexes and religions. Their objectives include:

- Raising awareness and educating the community, particularly women and young people, about HIV/AIDS;
- Helping restore dignity, self-respect, and purpose to the lives of individuals and families affected by HIV through the formation of a self-help group;
- Promoting understanding and developing a sense of responsibility within communities for HIV prevention;
- Identifying the physical and psychological needs of HIV-infected people and their families and coordinating support for those in need;
- Raising the status of women in family and community life so that women can conduct their lives with dignity and without threat to their physical and mental well-being; and,
- Cooperating with other groups and organisations dealing with HIV/AIDS, including the sharing of information and resources.

**AIDS Education**

KIWAKKUKI's approach to AIDS education is based on the traditional African manner of teaching young people about sex and reproduction—using adult family members, other than parents, to educate young people about topics ranging from family planning and normative behaviour to sexual activities. Traditionally, it is improper for a parent to talk directly to a child about intimate matters, particularly anything to do with sex. This task was generally done by an aunt or uncle, or another family member. However, while modernisation has been breaking down this tradition, parents still feel uncomfortable talking to their children about these matters. Therefore, KIWAKKUKI members have taken the initiative to educate young people about sex and sexuality, including HIV/AIDS prevention and condom use. This approach assumes that the older women's counselling skills can have a significant impact on the younger generation's sexual behaviour.

As some KIWAKKUKI members are teachers, it has been easy for them to arrange meetings in schools. They give talks to both boys and girls. First they divide the young people by sex and then bring both groups together for discussion. They do not provide referrals for family planning because the policy in Tanzania is that such services are for married people only. They do, however, provide individual counselling when requested.

In their work with young people, KIWAKKUKI members have become aware that some youngsters have had sex by age nine or ten. For this reason they have developed a teaching syllabus for use in primary schools. The syllabus has been presented to the Regional Ministry of Education (MOE) for review. For it to be used, teachers would need to be trained so that they would feel comfortable presenting the material. Therefore, the unit is still “under consideration” by the MOE.

KIWAKKUKI members also give classes for church and other youth and women's community groups. Various communication techniques are used including seminars, videos, dramas, puppet shows, songs, and written materials. In addition, all KIWAKKUKI members are invited to regular monthly educational, informational, and strategic
meetings where invited speakers talk on subjects such as women and health, and the relationship of social and cultural issues to AIDS. These seminars also cover modes of HIV transmission, clinical implications, management and care at home and in the hospital, and counselling. In addition, KIWAKKUKI maintains a mobile lending library of AIDS reading materials and video tapes that are available to members at every meeting. To date, KIWAKKUKI’s best known educational mechanism continues to be its public AIDS talks presented during “AIDS Week,” which it has organised annually since 1990. At the 1993 AIDS Day meeting, a comic book, “Dangerous Love,” translated into Swahili and printed by KIWAKKUKI, was launched.

Home Visits and Home Care

Care and support for people living with AIDS and their families is a major problem in the area and thus has become an important component of KIWAKKUKI’s activities. So far, twenty-four members have received training in home-visiting techniques, care of AIDS patients, and counselling. As KIWAKKUKI does not have the resources to provide this training itself, it ran a three-day programme jointly with MUTAN, the joint Tanzania-Norway government programme for STDs/AIDS in the Kilimanjaro and Arusha regions. MUTAN then offered KIWAKKUKI trainees the opportunity to make their initial home visits along with MUTAN staff until they were comfortable making home visits on their own.

KIWAKKUKI identifies its clients through its own members, many of whom are nurses or social workers, via information provided by family members and friends, and through referrals from hospitals and groups such as MUTAN. As many doctors are still uncomfortable talking about AIDS with their patients, people with AIDS or HIV-positive people often receive little or no counselling about their condition. Therefore, KIWAKKUKI’s role is to help them understand and cope with their situation. Members work with AIDS patients, identify their needs, and coordinate psychological, social, material, and financial assistance. All clients must sign an agreement authorizing home visits.

When it is apparent that an AIDS patient has been neglected or discriminated against, with their permission, KIWAKKUKI sometimes takes the responsibility to counsel their family as well in order to encourage them to care for the patient. However, this is a delicate area as there is still considerable stigmatisation of people with AIDS in Tanzania; many families do not want it known that one of their relatives has AIDS. In some cases, people are abandoned and then KIWAKKUKI literally becomes their family, providing resources—even funeral costs in some cases—and caring for those left behind in the wake of the epidemic.
While KIWAKKUKI does not provide medical treatment for HIV/AIDS patients, they do sometimes supply protective materials such as gloves to families caring for AIDS patients at home. They do not provide condoms, but behavioural change is encouraged through AIDS education.

Lillian is eight years old. Her father had worked away from home, keeping one son with him, until he found out he had AIDS. He then came home and began building a new house for his family. However, he died before it was finished. A few days later, his wife gave birth to another child, but within four days of childbirth, she too died of AIDS. The children now live alone, in the unfinished house. In addition to Lillian, there are two boys, 16 and 12, her 11 year old sister and the baby, who is now 8 months old.

Because the father had been away working, his family does not acknowledge the baby as his child. Neighbours provide little help because they know the parents died of AIDS and, although the children's grandparents live nearby, they are not mentally stable and cannot care for them. The 11 year old girl does not go to school at all in order to care for the baby—a task she shares with Lillian. The 12 year old boy does not go because he has no shoes and the other children make fun of him because everyone knows his parents died of AIDS.

The family became known to KIWAKKUKI through a member who is a teacher in the area and the members now visit frequently, bringing basic supplies such as milk, sugar, soap, etc. There is almost nothing in the house and as only half the roof was completed, it floods when it rains. The little girls are doing remarkably well caring for the baby, but he is somewhat malnourished and clearly lacks proper stimulation.

KIWAKKUKI has found employment for the oldest boy so that he has something to do and can contribute to the family. They've also arranged for the baby to be cared for at UPENDO Home (an orphanage) in Moshi, which has enabled Lillian and her sister to go to school.

Mobilizing the Community for the Fight Against AIDS

KIWAKKUKI utilizes various mechanisms to involve the community in the fight against AIDS. For example, youth have been involved in puppet theatre and, in February 1993, KIWAKKUKI held a two-day drama competition on AIDS education. Participants included the church women's groups, youth groups from secondary schools, churches, and police and teachers' colleges. The best plays were recorded on video and are now used as AIDS education materials. KIWAKKUKI also involves people with AIDS as educators and counsellors because they believe they are the most effective in influencing behavioural change.

In early 1994, KIWAKKUKI organised its first Charity Walk for AIDS. Forty-five people participated in the event, marching through the city with banners and wearing KIWAKKUKI T-Shirts. Proceeds from the Walk went to support the work of the organisation.

Support to KIWAKKUKI Members Living with HIV Infection

KIWAKKUKI members range from professionals to housewives and include both HIV-positive and negative women. Members support each other through peer education, advice, and discussions. It is in this spirit that KIWAKKUKI members are both the clients and the staff of the organisation. Members and non-members, both men and women, who are HIV positive meet monthly to discuss their problems, share experiences, and provide one another with moral support. The size of the group fluctuates as there are frequent deaths.

Income-Generating Activities

KIWAKKUKI's charter specifies helping women become self-sufficient. With support from a German organisation, the Friedrich Ebert Stiftung (FES) Foundation, they are creating revolving funds that will benefit women, as well as help them care for community members affected by AIDS. The
organisation has developed an excellent set of guidelines and is unique in that 20 percent of the monthly income earned by each project will go to KIWAKKUKI to be used to care for people with AIDS.

KIWAKKUKI's first income-generating group will be in Kinuweni, a rural area in the foothills about an hour's drive from Moshi. It will involve the purchase of an oil pressing machine for sunflower seeds, a crop that has recently been introduced in the area. The women came together through their local church. The leader is a KIWAKKUKI member; her husband is a veterinarian and has helped facilitate the effort. There are currently six members in this women's group, most of whom have been affected by AIDS: two are widows and two others are caring for orphans. The women first came together this year because they shared common problems and wanted to support one another.

To do this effectively they felt they needed to earn some income. They decided on the press because there is currently none in the area, although more farmers are growing sunflowers. So the project will not only provide income to the group but benefit the community as well. In addition to the press itself, the women will need a donation to construct a building to house it and will also require training in its use and maintenance. These needs will be included in their proposal to KIWAKKUKI. FES will facilitate purchase of the machine and provision of training as well as providing the financial support.

**MANAGEMENT**

KIWAKKUKI is a membership organisation open to all women as well as students in primary and secondary schools who reside in the area. To date, KIWAKKUKI has about 175 members, who pay a modest membership fee and yearly dues. There are also some "honorary" members, mostly men in the community or expatriate women, who support their efforts. KIWAKKUKI is now in the process of registering as an official non-governmental organisation (NGO) in Tanzania. However, until registration is completed, it continues to operate as an affiliate of the Kilimanjaro Women's Information, Economics and Communication Group (KWIECO). It is also a member of the Society for Women and AIDS in Africa-Tanzania branch (SWAAT).

KIWAKKUKI has a governing body, elected annually by the members, consisting of a chairperson, vice-chairperson, secretary general, assistant secretary, and treasurer. They and five members-at-large make up the executive committee that takes responsibility for planning, fundraising, coordination, and execution of the organisation's activities, as well as monitoring expenses.

Most of the organisation's programme decisions are made by the members themselves at regular monthly meetings. But the organisation is still small enough that many of its services continue to be provided on an ad hoc basis. For example, often when they make home visits, and it is evident that a client is in need of food, the members will make a contribution on the spot from their own pockets to purchase the needed supplies.

Major decisions about KIWAKKUKI's activities and future direction are made at its annual meeting. The organisation can also call informally upon a number of advisors for assistance. These include three men from the community: a social scientist, a counsellor/medical assistant, and an anthropologist.

Since 1993, KIWAKKUKI has employed a part-time office helper and, since April 1994, a part-time coordinator. Otherwise, activities are all carried out by part-time volunteer members. They include nurses, teachers, social workers, and housewives. To back up its staff, KIWAKKUKI has been successful in establishing supportive working relationships with other NGOs dealing with AIDS inside and outside the region such as the Society for Women Against AIDS in Tanzania and MUTAN, as well as local hospitals. KIWAKKUKI also maintains positive working relationships with governmental authorities in the area who help with organisation of seminars and workshops on AIDS and provide KIWAKKUKI with reading materials. Members of the business community also offer material support to the project.
RESOURCES

KIWAKKUKI's primary and unique resource is the enthusiastic volunteer services of its 175 members. On its application form, KIWAKKUKI asks each prospective member to identify what she (or he, in the case of honorary members) can contribute to the organisation in terms of time, skills, supplies, or financial assistance. Members pay an initial membership fee of TSh 500 (apx. U.S. $1) and annual dues of TSh 200. KIWAKKUKI receives small donations from church organisations, individuals, MUTAN, and various local charitable organisations for specific activities such as the drama competition. MUTAN provides technical assistance (e.g., resources persons for seminars and booklets) as needed and training of home visitors. Meeting places for the organisation's activities are provided by the Catholic Church's Rainbow Centre or Kahawa House (which is the office of the local coffee exchange) free of charge. Financial support also comes from fundraising activities such as selling T-shirts or the Charity Walk. Whenever professional services are needed, they are available from within its own ranks or from partner organisations, such as MUTAN, the Rainbow Centre, or from the local and regional hospitals.

KIWAKKUKI is currently in the process of making the transition from an ad hoc group of volunteers to a functioning NGO. As a first step in that direction, it has secured support from two German foundations operating in Tanzania to rent and furnish a small office. They have also received assistance from the consultant in developing an organisational plan that will help them to approach donors for support on a more systematic basis. Currently they have seed funding from a Dutch organisation. However, to date the sustainability of the organisation has depended very much on the voluntary spirit of its members and the help of its partner organisations.

EXPERIENCE TO DATE

KIWAKKUKI staff believe that through their mobilisation of women to carry out community-based activities for HIV/AIDS prevention and care they can bring about social change. At the village level, many women have been empowered, especially those who are members of KIWAKKUKI, to talk about AIDS prevention with their husbands and children. Staff believe that their voluntary support to AIDS patients and HIV-affected people helps to give AIDS a face and contributes to reducing the stigma and discrimination surrounding the epidemic.

Since KIWAKKUKI is such a young organisation, it is difficult to comment on its impact in terms of changing the level of knowledge about AIDS or sexual behaviour among community members. In addition, the synergetic effect of a number of programmes operating in the same area are contributing to the increased knowledge about AIDS and its socio-economic impact. Overall, KIWAKKUKI members feel that the community at large is now better informed about AIDS and has been mobilized to carry out prevention efforts. However, while some women now are able to discuss AIDS prevention with their husbands, condom use is still not easily discussed between most husbands and wives. KIWAKKUKI's clients noted that some community members have exhibited behavioural changes as a result of the project. Husbands, they said, stay at home more frequently and are taking more responsibility for family affairs.
Despite these inroads, many people continue to justify their sexual behaviour by saying that AIDS is the result of an accident people have while working or everybody will die one day anyway so why bother taking precautions. A few of KIWAKKUKI's clients interviewed for this study said that the condoms available are not comfortable, cause bruises, and need lubrication. Complaints such as these might be hindering the efforts of KIWAKKUKI specifically, and the NACP, more broadly, to promote condom use.

LOOKING AHEAD

Since KIWAKKUKI does not yet have a systematically organised programme, its activities cannot be easily monitored. At this point the organisation could benefit from development of a short and long-term plan of action in order to make better use of its resources and capabilities. The project could also be strengthened by including condom promotion as a health measure to prevent other STDs, as well as AIDS. As the organisation continues to grow and expand its services, it is now important for KIWAKKUKI to have permanent staff who have managerial and planning skills and can provide support to volunteers and coordinate programme activities.

To strengthen its services, KIWAKKUKI plans to develop a referral system for its clients and members, seek reliable transport for home visits, continue with fundraising activities, and develop teaching materials for AIDS prevention such as video tapes of dramas.

KIWAKKUKI management believe it is essential for them to learn from the experience of other similar programmes in terms of how to strengthen management and develop planning skills. They could benefit from visits to other home-based care programmes, such as the WAMATA-Rubya centre in Bukoba. Exchange of ideas, information, and experiences at national and international levels would also contribute to improving KIWAKKUKI's programme.

KIWAKKUKI has already established good working relationships with a number of NGOs and public institutions in the region. The organisation could benefit from increased collaboration with such groups, particularly within the region, including religious groups which are well organised and include very influential opinion leaders. Greater cooperation with government hospitals and other women's and youth groups in Kilimanjaro, and at the national level, would also enhance the project's visibility. Additionally, since services of traditional healers are widely used in the area, KIWAKKUKI might want to collaborate with them to help incorporate AIDS prevention into their traditional practices.

Specifically, KIWAKKUKI could be strengthened through:

- Improvements in structure and management that would define the roles of members, staff, and clients even though they work on voluntary basis.
- Establishing a planning committee, elected or appointed, and equipping staff with planning skills to enable them to evaluate programme effectiveness. Advisors should include more community elders and non-professional women in the community.
- Promoting better collaboration with hospital-based services in order to facilitate continuity of home-based care and better client follow-up. A systematic work plan for client follow-up should be devised.
- Providing additional training in counselling for all staff and investing in the training of peer educators and counsellors.
- Avoiding heavy dependency on external funding and support, by developing other financial and material resources, including income-generating activities.

The most outstanding lesson to be learned from KIWAKKUKI's experience is how quickly and effectively a group of local women were able to mobilize and form an anti-AIDS group within their own community. The voluntary spirit of its members, who carry out AIDS prevention and care activities during their free time, is the life force of the project. However, KIWAKKUKI members have come to realize that ad hoc activities are difficult to evaluate and that as the organisation expands, there will be a need for a more structured plan of action.
A CASE STUDY OF WALIO KATIKA MAPAMBANO NA AIDS TANZANIA
PEOPLE IN THE FIGHT AGAINST AIDS IN TANZANIA (WAMATA)

Consultant: Dr. Esther Mwaikambo

WAMATA is the acronym for the Swahili name Walio Katika Mapambano na AIDS Tanzania or “People in the Fight against AIDS in Tanzania.” WAMATA is based in Dar-es-Salaam, but operates in two other regions heavily affected by the AIDS epidemic, Kagera and Mwanza. In Dar-es-Salaam, WAMATA carries out activities in the Temeke, Ilala and Kinondoni districts. Each district has a local programme office staffed by a social worker/counsellor. This case study focuses only on the programme of WAMATA, Dar-es-Salaam.

PROFILE OF THE PROJECT COMMUNITY

Dar-es-Salaam, capital city of Tanzania, is one of East Africa’s largest ports, serving not only Tanzania but also the neighbouring countries of Rwanda, Burundi, Malawi, and Zambia. It has an estimated population of two million, 50 percent of which is below 16 years of age. There is a high prevalence of malnutrition (42%) among the population and infant mortality and maternal mortality rates of 107 per thousand and 370 per thousand, respectively.

PROJECT DESCRIPTION

WAMATA was created in June 1989, in Dares-Salaam, when Theresa Kaijaige and a few friends became concerned about the plight of individuals and families facing the stigma of HIV/AIDS infection. Ms. Kaijaige is a social scientist who comes from Bukoba, on the Uganda border, a part of the country that has been hard hit by the AIDS epidemic. Both she and her husband teach at the University of Dar-es-Salaam. The project started informally with visits to AIDS patients in Muhimbili Hospital (Tanzania’s major teaching hospital) and by offering solace to affected families. The families soon responded by participating in the voluntary activities organised by this motivated group.

WAMATA’s overall objectives are consistent with those of Tanzania’s National AIDS Control Programme (NACP): 1) prevention of HIV transmission, 2) amelioration of the social and economic consequences of AIDS, 3) collaboration with national and international organisations, 4) condom promotion, 5) community support, and 6) research on HIV/AIDS related issues. However, WAMATA’s specific objective is to serve HIV-positive individuals, persons with AIDS and their families (especially those who have low incomes), support community groups in the care of those with AIDS, and to assist in the care of orphans.

An unfilled prescription, a hungry or homeless person with AIDS, an orphan suspended from school for lack of a uniform, all turn to WAMATA.

While WAMATA’s services are available to all Tanzanians, most clients are people who are unemployed or engaged in small, often informal businesses, or peasant farmers. Most clients have been brought to the group’s attention by hospital personnel. WAMATA staff visit patients in the hospital and offer bedside counselling. Upon release, patients are followed up at home and have the opportunity to participate in activities offered by the organisation. Others learn about WAMATA by word-of-mouth and come by one of the project’s centres.

Working with the Ministry of Health (MOH), various non-governmental organisations (NGOs) and other institutions sympathetic to its cause, WAMATA undertakes the following activities, to the extent possible depending upon availability of resources:

- Identification of HIV-positive individuals, people with AIDS and their families in need of services;
- Home visits that include counselling and medical care;
• Dissemination of information on the prevention of HIV/AIDS;
• Provision of condoms;
• Educating HIV-positive individuals and people with AIDS as to their rights and responsibilities, both to themselves and to the community;
• Provision of basic necessities to people with AIDS such as medicine, food, clothes, and school supplies for their children; and
• Helping families and communities to care for children orphaned by AIDS.

Education and Counselling

WAMATA endeavors to provide HIV/AIDS education and counselling to the community at large regardless of people's HIV/AIDS status. Counselling is offered to individuals, couples, families, and peer groups by WAMATA staff—social workers (who are permanent staff) and/or volunteers (doctors, nurses, and community health workers). The driver of the programme vehicle has also received training in counselling so that he can interact with potential clients and promote WAMATA's activities. Counselling focuses on partner notification, sex and health education, condom promotion, safer sexual behaviour, women's reproductive health, adolescent sexuality, and the diagnosis and treatment of STDs and reproductive tract infections. The project makes use of flipcharts, information sheets, and videos on AIDS prevention. However, most of its educational materials are in English and thus not appropriate for many clients.

A unique aspect of WAMATA's counselling is its emphasis on clients' rights and responsibilities. People with AIDS are reminded that they too have rights. For example, in Tanzania a person cannot legally be dismissed from a job because he/she is HIV-positive or has AIDS. On the other hand, AIDS patients are made aware that they also have a responsibility to their families and communities to prevent the spread of the disease. It is also the law in Tanzania that if a person is HIV positive, knows it, and does not inform his or her partner or insists on having unprotected sex, that person can be sued by their partner. The work of WAMATA's legal subcommittee in the promotion and defense of the rights of people with AIDS and their families is probably unique in the country.

But education and counselling alone are not enough. As WAMATA staff have noted: "Suffice it to say that without one thing or another to offer to ameliorate the physical and material conditions of a needy client...much of the counselling and sympathetic talk will soon fall on deaf ears and sometimes even be met with a hostile reaction."

Home Visits

The other major component of WAMATA's programme is providing community-based care and treatment for people with AIDS through home visits. Home visiting includes counselling, education about health and positive living, and nursing care. Clients are referred for medical care to appropriate hospitals or clinics. WAMATA staff and volunteers who deliver home care services, particularly nursing care, take reasonable measures to avoid infection such as using gloves when appropriate and observing aseptic measures. However, while they stress the importance of common risk-reducing precautions such as overall cleanliness, the need to wash utensils, and use of aseptic solutions, home visitors seek to make it clear that people with AIDS can be cared
for at home without risk to the health of other family members. Children of AIDS patients are provided with basic supplies: milk and other essential foods for infants; uniforms and payment of school fees for older children.

WAMATA has also assisted a number of women’s self-help groups, affiliated with various religious organizations, that have been formed to take care of people with AIDS and their families, and it encourages the clergy to contribute moral and spiritual counselling. But in some cases, WAMATA becomes the sole source of care and support for some AIDS patients.

A policeman without a family or friends was languishing in the hospital. WAMATA stepped in to ensure that he received counselling, care and moral support. Upon his death, the organization helped to arrange for his body to be sent home for burial.

Centre-based Activities

WAMATA offers people with AIDS the opportunity to participate in a discussion group held at their central headquarters every Saturday. Clients are either provided with or are reimbursed for the cost of transportation. The group gives people with AIDS a chance to meet and share experiences. Staff are available to answer questions and provide assistance. Food, basic supplies, and often medication are made available to those attending these sessions. These commodities are provided by different organizations that support WAMATA (e.g. the Red Cross and African Medical Research Foundation [AMREF]).

Income-generating Activities

WAMATA also operates, to the extent its resources allow, an income-generating programme. People with AIDS are given seed money (usually U.S. $50-100) to start small, simple businesses to help maintain themselves, such as selling charcoal. While in theory, WAMATA’s clients are asked to pay back the money if they can, few if any do. To date, loans are made on an individual basis; there has been no attempt as yet to organize people with AIDS into a larger income-generating effort.

MANAGEMENT

At the national level, WAMATA is governed by an honorary Executive Committee elected annually at its General Meeting. The seven members serve for a two year period. Day-to-day operations are carried out by a national secretariat made up of an executive officer, an accountant, a secretary and the staff at large. Most employees are social workers. Currently, the project has a team of 31 people (22 women and 9 men) of whom eight are permanent/semi-permanent staff. They include an executive officer, a project coordinator, four social workers/counsellors, one secretary, and one driver/office attendant. Doctors, nurses, other social workers, administrators, religious leaders, and various community members volunteer their services. Volunteer staff receive allowances (e.g. reimbursement for travel and per diems) for specific services.

WAMATA personnel participate in management of the project and play an important role in the planning, implementation, and administration of its activities.

RESOURCES

Membership is open to all citizens and residents of Tanzania who pay an entrance fee of TSh. 250 (US $.50) and annual dues of an equal amount. In addition to small but regular grants from the NACP and individual donations, WAMATA has also received support from national and international organizations. A grant from AIDSCOM has enabled WAMATA to:

• Recruit core staff, made-up of a coordinator, accountant, secretary, and four social workers to provide counselling and home-based care;
• Procure office equipment and supplies including a photocopier, typewriter and computer;
• Maintain a vehicle (provided by AIDSCOM). Support from NORAD enabled staff to visit AIDS-related NGOs in Uganda and Zambia, and to rent office space for one year. DANIDA, though the NACP, provides on-going support for counselling and home-care activities in Dar-es-Salaam.

Donations from UNICEF and the Diplomatic Women’s Group have enabled WAMATA to:
• Supply medicines, supplementary foods and clothes to orphaned children; and
• Pay for school fees, uniforms and supplies for 25 orphaned children
The Brothers of Christian Instruction provided WAMATA with a modest office and use of a telephone and post office box before they moved to their current location.

WAMATA maintains collaborative relationships with AMREF and the Society for Women and AIDS in Africa (SWAA). It also depends on the support of individuals, families, and community groups who respond to calls for material, human, and financial resources.

EXPERIENCE TO DATE

WAMATA counsellors face the task of overcoming negative attitudes and considerable misinformation not only within the community but also among people with AIDS themselves. Many AIDS patients interviewed for this study said that they felt angry about their situation, while others considered the disease to be punishment from God for sins committed. Some male clients stated that men never transmit AIDS, only women do. Others stated the belief that people get AIDS in Muhimbili hospital, not in the community, hence there is no need for condom use as it is up to those in the Hospital to protect themselves.

WAMATA staff believe that their most difficult tasks are to counsel women how to inform their partners/husbands that they are HIV-positive and how to suggest that their fiancées get tested for HIV. They also find it difficult to explain to HIV-positive women that if they conceive, their baby may be infected. As a result of counselling, the majority of the clients interviewed for this study (who were mostly women) responded that whenever they have sex, they now use condoms because they are worried about infecting others. However, many women in the community are still afraid to ask their partners to use a condom because they are concerned that he will think they are either concealing the fact that they are positive or that they have been unfaithful.

To date, many more women than men avail themselves of WAMATA’s services. Men appear to be more concerned about being publicly recognized as having HIV or AIDS. Many do not want their wives or partners to know about their HIV status—they say that they want to maintain a normal life in the community.

WAMATA staff have found it difficult to get men who are HIV-positive to accept that they have the disease and that it can be transmitted to their partners/wives.

One of WAMATA’s clients is 48 years old. He has completed primary education and works as a plumber, as does his wife. He lives with his wife and their four children, aged 15, 12, 10, and 8, but does not want her to know he is HIV-positive.

As for practicing safer sex, including condom use
and/or avoiding casual sex, WAMATA staff report that men are more reluctant than women to change their behaviour. Men are also less cooperative about being tested and agreeing not to have more children if they or their partner is HIV positive. To date, no effort has been made to organise separate activities for men.

WAMATA staff interviewed for this case study consider the organisation's greatest strength to be the tremendous participation of its more than 200 members with AIDS in project activities and its collaboration with local organisations. Clients feel that WAMATA has helped them realise that they are not alone in dealing with AIDS and the organisation offers them an opportunity to communicate with one another, to socialize, and to learn to become self-reliant. Because of WAMATA, they feel that when they have problems, there is always help available. Clients expressed gratitude for the help WAMATA has given them to plan ahead, particularly for the future of their children. This has included advice on how to prepare a will.

To date, the community at large is not fully mobilized to participate in the care and treatment of people with AIDS. This is due, in part, to general apathy and poverty, as well as lack of knowledge and understanding. Many people feel they have nothing to offer while others avoid the afflicted because their needs seem overwhelming. WAMATA staff and clients fear that the pace of their activities is too slow and that their work has not made a sufficient impact because many people in the community remain relatively ignorant about HIV/AIDS.

The primary constraints affecting WAMATA are insufficient financial, material, and human resources. Financial resources are needed to cover costs of disease management for AIDS patients, training for staff and volunteers, and client counselling. Home-bound clients need food, medicines, and transport to the hospital; other clients need money for repatriation (returning the deceased to his/her home village) or burial. WAMATA also needs more professionally trained social workers, doctors, nurses, and counsellors. Another constraint is the lack of transport. At the time of the study, the project had only one vehicle to cover all three districts and serve more than 191 clients.

Nonetheless, WAMATA management, staff, and counsellors believe that their project has made an impact. This is based on observations of small changes in individuals' sexual habits and greater use of condoms, as well as by a general improvement in the health of some of their clients.

LOOKING AHEAD

WAMATA's project in Dar-es-Salaam is unique in that it provides education, care, and community support in a holistic manner. However, the organisation could benefit from stronger collaboration with other organisations in order to avoid replication of services and maximise utilisation of scarce resources.

WAMATA's personnel have been catalytic in contributing to social change. Members have not only raised awareness but are also helping people living with HIV infection to consider alternative sexual behaviour and lifestyles. WAMATA's members with AIDS help each other to live more positively and adopt appropriate behaviour that will benefit their health and that of their families. However, to increase the project's effectiveness, staff pointed out the need for:

- More educational materials, especially small booklets, leaflets, and audio visual materials (particularly in Kiswahili and/or local languages);
- More and better training for counsellors and social workers in HIV/AIDS disease management;
- Mobilising and training more community members to do counselling;
- Involving more people with AIDS in counselling of individuals and peer groups;
- Hiring additional full-time professionals, such as nurses, to conduct home visits;
- Being able to offer existing staff better compensation;
- Involving clients more actively in the planning and design of activities;
• Being able to provide adequate facilities and means of transport for counsellors in each district, including sufficient space to ensure privacy;

• Generating sufficient funds to be able to provide credit assistance to people with AIDS for income-generating activities without requiring repayment conditions.

THE PROBLEM OF HIV INFECTION AND AIDS IN KENYA

Like many African countries, Kenya is facing a serious health problem as a result of the AIDS epidemic. AIDS was first diagnosed in Kenya in 1984. By November 1993, 41,175 cases of AIDS had been reported to the Ministry of Health. These statistics, however, represent only a fraction of the epidemic since many cases are not reported.

Data on AIDS in Kenya is derived through two main sources, the sentinel surveillance system (currently operating in thirteen antenatal clinics around the country) and small scale surveys. Using the sentinel surveillance data, the National AIDS Control Programme (NACP) has estimated that there are about 700,000 Kenyans infected with HIV.

Results from the 1992 sentinel survey showed that 20 to 30 percent of pregnant women in areas such as Kitale, Busia, and Kisumu were HIV-positive. In Mombasa, Nairobi, Nakuru, and Kakamega between 10 to 20 percent were infected, while in Kisii, Nyeri, Kitui, and Garissa the rate of infection in pregnant women was between 2 and 10 percent.

According to figures based on population projections of the Long Range Planning Division, deaths from AIDS are expected to rise to an estimated 921,000 by the year 2000. The impact will be most severe among young adults and children under the age of five, resulting in a great loss of both monetary and human resources.

One of the most devastating consequences is an increase in the number of orphans. Using demographic and HIV infection and transmission data, it is calculated that, by 1996, about 300,000 Kenyan children under 15 will be AIDS orphans. With the deteriorating economic situation, already overstretched extended family networks will find it difficult to muster the required resources to meet the basic health, nutritional and educational needs of these children. As a result, many will end up abandoned, leading to an increase in the number of homeless children. There is also growing concern about the effect AIDS will have on child mortality in Kenya, which could rise from the current rate of 115 per 1,000 births to as high as 189 deaths directly or indirectly due to AIDS.

Treatment of people with AIDS places a considerable burden on the health system. The cost of treating a patient with AIDS is estimated to be about KSh 500 (apx. U.S. $7) per day. Assuming that the average length of stay in the hospital is 60 days, the resulting total direct cost will be KShs. 30,000 (apx. U.S. $462) per patient. In 1992, 15 percent of all hospital beds in Kenya were occupied by AIDS patients. By the year 2000, it is estimated that about half of all hospital beds will be required for AIDS patients.
An analysis of available data on the number of AIDS cases reported to the Ministry of Health since 1986 indicates that in Kenya 75 percent are adults between the ages of 20 and 45. Deaths in this age group will have substantial negative impact on the economic development of the country given that people in this age group are the most productive.

THE NATIONAL AIDS CONTROL PROGRAMME

The Kenya National AIDS Control Programme was established in 1986 as a government institution, under the auspices of the Ministry of Health. Its main objectives are to reduce transmission of HIV/AIDS among the Kenyan population and to ease the socio-economic impact of AIDS on local communities. The NACP is charged with keeping government bodies, especially the Ministry of Health, informed about the progression of the HIV/AIDS epidemic through continuous surveillance and monitoring. In addition, the NACP is mandated to coordinate HIV/AIDS activities among government and non-governmental organisations and to ensure that individuals, families, and communities have access to relevant information regarding HIV transmission and AIDS.

The first NACP Medium Term Plan (MTP) (1989-1992) concentrated on controlling the spread of HIV. Information, education and communication activities carried out during the first MTP revealed that about 80 percent of people in Kenya knew something about AIDS. The second Medium Term Plan (1992-1996) proposed a multi-disciplinary, inter-sectoral approach to controlling the rapid spread of the disease. The plan calls for action in preventing infection in three primary areas: sexual transmission of the virus, blood transfusion and unsafe medical practices. The greatest effort is being focused on preventing sexual transmission of HIV. Specific activities outlined in the second MTP include:

- Public sex education;
- Condom promotion and availability;
- Diagnosis and treatment of STDs;
- Promotion of community counselling services;
- Promotion and provision of actions to reduce the social and economic consequences of AIDS; and
- Training of health care workers in counselling and management of AIDS and provision of guidelines and logistic support.

However, the success of this second plan will depend upon the cooperation of health practitioners, the involvement of the media and, most importantly, the participation of every sector of the Kenyan society.
A CASE STUDY OF THE KENYA AIDS SOCIETY (KAS)
Consultant: Ms. Jane Murago-Munene

The Kenya AIDS Society (KAS), formerly known as Know AIDS Society is a nongovernmental organisation (NGO) that operates mainly in urban areas. This case study was conducted in the eastern suburban section of Kenya's capital, Nairobi, and is typical of most of the communities KAS serves.

PROFILE OF THE PROJECT COMMUNITY

The majority of the people in the study area are young to middle-aged with an equal distribution of males and females. Most residents are low income and are employed in the informal sector as part-time workers, vegetable vendors, subsistence farmers, car washers, used clothes dealers, sex workers, or as employees of small businesses. In addition, the study area also includes the unemployed, students, housewives, and some salaried workers.

Although communications, roads, electricity, telephones, and a modern transport system are adequate, poor sanitary conditions prevail. Poverty, ignorance, poor nutrition, and lack of adequate medical facilities and health education contribute to the community's poor health status. The area has four accessible health dispensaries, but they are considered inadequate to meet the needs of the surrounding community. And as government clinics and dispensaries sometimes experience a total lack of drugs and supplies, treatment actually is available more in theory than in fact, and ambulance services are unreliable. Traditional health systems operate alongside modern medicine and play an important role in the community. Many residents rely upon traditional healers to treat sexually transmitted diseases (STDs) and AIDS-related ailments such as tuberculosis and skin diseases.

PROJECT DESCRIPTION

The Kenya AIDS Society was founded in 1989 when a group of HIV-positive Kenyans came together to discuss their situation. They quickly realized that while individually they could not do much to address the problem of AIDS, as a group they could be much more effective. They could have an identity and encourage more people with HIV/AIDS, and other concerned individuals, to come forward and help prevent further transmission of the disease and to provide assistance to those already affected. The founders of KAS were among the first people with AIDS in Kenya to speak publicly about their condition. They agreed that they would make themselves available to talk to any individual or group that wanted to know about HIV and AIDS.

KAS was registered with the Registrar of Societies and the Ministry of Health in February 1990 as a non-sectarian, non-political, non-profit NGO. KAS offices, including a drop-in centre for people with AIDS, are located in Pangani, not far from downtown Nairobi.

The primary goal of KAS is to reduce the disabilities and stigma associated with HIV infection. To realize this goal, KAS tries to mobilize people with AIDS to respond to their own health problems in a positive way and to use its own members to inform the community about AIDS prevention and care of those affected by the disease. Specifically, KAS aims to:

- Mobilise people with HIV/AIDS for counselling, outreach, education, and advocacy, thus giving people with AIDS an alternative to the passive hopelessness which often overwhelms them;
- Unite persons with or affected by HIV/AIDS so that they can benefit by sharing experiences and learning from each other about how to live positively with HIV/AIDS;
- Establish means of collaboration with and encourage support from the community-at-large; and
- Develop and maintain supportive relationships with other community organisations.
However, first and foremost the organisation is OF and FOR people with HIV and people with AIDS. The need for advocacy in support of the rights of AIDS patients and the desire to assist AIDS orphans have also become significant concerns for the organisation.

The KAS Centre

KAS operates a drop-in Centre for HIV-positive people at its office in Pangani. The Centre is a place where people with AIDS can meet and seek comfort in an emotionally supportive atmosphere. The nurturing environment allows for both social contact and relaxation. It also provides an open forum in which people feel free to confide the difficulties and psychological pressures they face in dealing with the disease.

At the Centre, clients can take advantage of a variety of resources including a library with a modest amount of reference materials, a television and VCR, and recreational equipment. The Centre is available on a walk-in basis. KAS clients can come anytime to receive counselling, enjoy the welcoming surroundings, watch television or talk with others. Additionally, both morning and afternoon tea, as well as lunch, are available at no cost to clients every day.

Public Education

KAS has created an outreach programme for dissemination and exchange of information about AIDS. It regularly conducts seminars designed to create AIDS awareness in schools, colleges, churches, and other institutions. KAS believes that having HIV-positive people serve as educators has helped to humanize the illness. Presentations are tailored to each group’s needs and may include information on safer sex, condom use, adolescent sexuality, diagnosis and treatment of STDs and reproductive tract infections, and women’s health. In addition, the project’s administrators, counsellors, and registered volunteers use pamphlets, video cassettes, posters, and TV and radio messages to spread the word.

KAS also has a performance troupe, the KAS Players. These young actors—not all of whom are HIV-positive—use drama, poems, skits, puppet shows, and songs as AIDS awareness tools. So far, they have produced two music cassettes (available for sale) that highlight the socio-economic impact of AIDS.

KAS also has a twenty-four hour hotline. The hotline, operated by four trained counsellors, serves the entire country. It is currently the only means KAS has of responding to people concerned about HIV/AIDS outside of Nairobi. Most callers request information about AIDS or express concern that they themselves or their partner may be infected, or they ask about the services that KAS provides.

HIV/AIDS Counselling

A primary activity of KAS is providing counselling about HIV infection and AIDS. The organisation has established counselling outlets in a number of dispensaries and hospitals in Nairobi, including the Kenyatta National Hospital, the Infectious Disease Hospital, Langata Health Centre, STD clinics, and skin clinics. KAS counsellors work at these sites daily to recruit clients for its counselling services and group therapy sessions, to publicise its Centre, and to identify individuals in need of services.

Whenever possible, staff counsel individuals, couples, families, and peer groups in private rooms...
at the KAS Centre or in clinics—or they arrange to meet them in their homes. KAS counsellors also make home visits and provide health education/counselling to people with AIDS and their families on "positive living." People with AIDS are encouraged to take care of themselves, eat well, engage in risk reducing behaviour, and maintain a positive attitude. Families are provided with information about the disease and how it is transmitted so that any fears they have about caring for an afflicted member will be alleviated.

Mr. O. was diagnosed as HIV-positive in 1991. Omari Nyantika, a KAS counsellor based at the CPK Kibera Clinic (operated by the Anglican Church), visits Mr. O. regularly at his home to see how he is doing and provide whatever support he can. This is because Mr. O. will not come to the Centre to attend the group counselling sessions—he doesn't want his HIV status to be known. Not only is he concerned about what his neighbours will think, he still has not told his wife about his condition. She is currently staying in her village following the delivery of their fourth child, a boy. He says that when she returns, he will tell her he has AIDS.

Mr. O. then asks if there is a possibility that the baby could also be HIV-positive. He is saddened by the news that it is possible that the child is infected. This is going to make talking to his wife even harder. Omari Nyantika tells Mr. O. that when his wife returns, he will come back to help him explain the situation and to provide additional counselling if needed.

Mr. O. says that his main concern right now is school fees for his children. He used to be a construction worker, but since becoming ill he is now employed as a night watchman, which means he is making less money. His youngest daughter has been attending a pre-school but he doesn't have the money to enroll her in primary school next term. Omari Nyantika says that he will put him in touch with a group that is trying to help children affected by AIDS to stay in school.

Group therapy and other group activities are carried out at the Centre and other sites where KAS staff are posted. Counsellors run sessions for about 10 to 12 persons for a six week period in order to build a supportive network among the participants. Clients use the open forum to discuss their problems and enlist support from others. They also have the opportunity to learn more about HIV infection, its transmission and prevention, and about issues of personal hygiene and health.

### Home Visits

KAS has established a special home visiting programme carried out by former/practising sex workers. These women are paid to help home-bound people with AIDS with their daily household chores (such as shopping, preparing food, cleaning, and laundry). In addition to acquiring an alternative source of income, these women gain a sense of empowerment through their participation in the programme, helping them to reduce their dependency on prostitution as a source of income and providing the information and support they need to be better able to negotiate safer sexual practices with their clients.

### Supporting Activities

KAS also provides support to orphans by providing children with blankets, soap, eggs, and powdered milk and offering counselling to their guardians. Because orphaned children are a rapidly growing phenomenon, and care of their children a major concern facing AIDS patients, KAS has established a subsidiary organisation, the AIDS Orphan Support Organisation to develop programmes and enlist community and donor support to assist children orphaned by AIDS.

In the past, KAS tried to help clients sustain income-generating activities, such as knitting and kitchen gardening, but has had little success. The organisation quickly realized that such enterprises require considerable research, planning, training and technical assistance—in addition to funding. KAS currently does not have the resources to make
income-generating efforts by clients a priority. KAS is also involved in advocacy on behalf of people with AIDS. To date there is no legislation in Kenya to protect HIV-infected individuals from losing their jobs or having their rights violated in other ways. KAS is trying to address some of these issues, but has not yet been very successful because there are no clear-cut government policies to protect people with AIDS.

MANAGEMENT

KAS is a membership organisation and all its clients are eligible to become members. If they can afford it, they pay a small fee. However, membership is never denied due to the inability to pay.

A Board of Management, composed of ten individuals from different professional backgrounds with experience in the field of HIV/AIDS, meets quarterly. It makes major management decisions which are passed on to the Secretariat for implementation. All members of the Board serve on a voluntary basis.

Daily operations are overseen by an Executive Committee, elected by KAS members at an annual general meeting. The Executive Committee meets monthly and informs the Secretariat, via the director, of its decisions. The Secretariat is responsible for actually carrying out the KAS programme. A Planning Committee—composed of six board members and four advisors from other organisations—takes responsibility for programme development, implementation, administration, monitoring, and evaluation. KAS' senior staff meet every Monday morning with the Director to review activities from the previous week and to plan future events.

KAS relies heavily upon volunteers, who offer their services on a regular basis, to conduct home visits, answer the hotline, prepare publications, and assist in training activities. There are currently around 60 volunteers; about half are people with AIDS who are given allowances for food and transport. The remainder are professionals from other organisations who donate their time as needed.

RESOURCES

KAS has 25 paid staff, including a director, accountant, information officer, field officers, public relations/fundraising officer, counsellors, and a cleaner/messenger. In addition, there are 60 registered volunteers.

Until recently, KAS has relied on the African Medical Research Foundation (AMREF) and the Red Cross to provide staff development and training. However, the Society has begun to develop its
own in-house training programme due to the need to provide on-going staff training. Collaboration between KAS and the National AIDS Control Programme (NACP) is important in terms of coordinating its efforts with those of other organisations, and for dissemination and exchange of current information on AIDS. The NACP also provides educational materials and condoms to the project. KAS coordinates and facilitates treatment for HIV/AIDS patients through referrals to KEMRI or government hospitals.

KAS has received funding from the Ford Foundation, the World Health Organisation (through a grant to AMREF), Lutheran World Federation, UNICEF, various churches, local organisations, and individuals. For example, the Society has just received two new vehicles, a minibus from PLAN in Kiambu and a Suzuki from UNICEF. The minibus will be used for field work, the Suzuki for administrative matters.

While the community itself bears the largest portion of the responsibility for home-based treatment and care, support for HIV-positive individuals and people with AIDS in Kenya is still lacking. There is still considerable stigmatisation against people who are HIV-positive or have AIDS. Thus, those infected with HIV often seek to conceal their condition in order to avoid ostracism or discrimination from both families and neighbours. KAS staff commented that one helpful strategy that not only maximises the project’s human resources but also helps to reduce such stigmatisation has been the use of people with AIDS and HIV-positive people as counsellors.

**EXPERIENCE TO DATE**

An underlying principle of KAS is that it is of paramount importance for the community to be involved in coordinated activities to prevent the spread of HIV and in the treatment and care of HIV/AIDS infected people. HIV/AIDS is far different from anything the community has ever experienced. While some community members appear to be sympathetic, due to general apathy, fear, or feeling overwhelmed by the needs of the afflicted, many avoid any contact with people with AIDS.

Violet Thika is the KAS counsellor at the Infectious Disease Hospital, a branch of Kenyatta National Hospital. She works with TB patients with AIDS—which is about 80% of those with tuberculosis—providing counseling to about 20-25 patients per day. Mr. M. is one of Violet’s clients. His family deserted him after they found out he had AIDS. When he was released after his first stay in the hospital, he had no place to live and often had to sleep out on the street. He would often visit the KAS Centre during this time for support and assistance. Finally a friend, who he calls a “good samaritan,” offered him a place to stay. However, by that time his condition had deteriorated. He is now back in the hospital where he has had to have fluid removed from his lungs. Violet hopes that when he is again released, he will be able to return to the house of his friend.

In traditional circles—where myths, beliefs, and taboos frequently take precedence over factual information—some people still consider HIV/AIDS to be a curse. Yet, despite such beliefs, widows of people with AIDS continue to be “inherited” or made to yield to social and sexual practices with deceased husband’s relatives. This continues to happen in spite of the fact that their husbands died of AIDS or that they themselves could be HIV-positive or even have full blown AIDS.

However, there is evidence that with appropriate education and information on AIDS, people can begin to change their behaviour. A case in point is one KAS client, a widow, who refused to be inherited. Her refusal signified that she was not willing to participate in traditional practices for fear of transmitting HIV/AIDS to others. As a result, she was disowned by her husband’s family and lost all claim to her rightful inheritance and that of her children. This woman subsequently died of AIDS.
In addition to the strain of dealing with family and community attitudes, staff continually must deal with clients' problems in securing adequate food, lodging, and medical care. For this they maintain liaisons with numerous other organisations so that they can refer clients for help. But often the need far exceeds supply. Further, clients are faced with concerns about maintaining their families, such as paying school fees for their children.

But on the positive side, more and more people are obtaining information from educational materials, using the KAS hotline and, according to KAS counsellors, engaging in safer sex by using condoms and having fewer partners. It is unfortunate, however, that most of the educational materials currently available to KAS are in English and therefore of limited use to non-English speakers (the majority of KAS clients), not to mention low-literate or illiterate audiences.

KAS clients report that "people feel free at heart" to talk openly about HIV/AIDS in the group therapy sessions. They say that some people have changed by becoming spiritually committed and that many have started to take measures to avoid the spread of AIDS by using condoms. Sex workers are also trying to find alternative means of earning a living. From the administrators' viewpoint, change in sexual behaviour has been most notable among sex workers. According to KAS, more and more people are using condoms to protect themselves from infection, although some people still continue to spread HIV due to ignorance.

Both staff and clients believe that men are the main problem in preventing the reduction of the spread of the disease because they are reluctant to use condoms—"it's like eating a sweet with the wrapper on"—and because they continue to visit prostitutes. Some women interviewed said that condoms break or that men tear them deliberately. Staff feel that the group currently at greatest risk of contracting HIV/AIDS infection is female adolescents, aged 10-19 years old, due to the dogo-dogo syndrome: older men or "sugar daddies" who provide material and financial support to young girls for school fees, clothes or food in exchange for sexual favours.

### LOOKING AHEAD

After this case study was carried out in 1993, KAS revised its management structure to be more responsive to the needs of its growing staff and clientele. This has resulted in greater involvement of staff in management decisions as emphasised by the institutionalisation of the Monday meeting of senior staff. They have also been working to improve accountability—a recent audit found their accounts to be in good order. However, there still appear to be some problems to be resolved, including maintaining a sufficient cash flow to allow prompt response to immediate needs.

KAS is currently in the process of preparing a proposal to ACTION AID that will include support for a newsletter to keep all KAS staff, volunteers and collaborating organisations updated on activities. The newsletter will also serve as a venue for other features such as a question and answer column. They have also completed a new brochure that describes the organisation and the services it offers. The brochure will be placed in health clinics and distributed by field workers.

KAS encourages staff members to take advantage of opportunities to obtain additional training. For example, staff are being encouraged to nominate someone to attend a course on Sex Education, HIV/AIDS Prevention and Reproductive Health being offered by the Margaret Sanger Center in New York. KAS will then seek funding to support that individual's participation. A representative of KAS also attended the annual meeting of the Society for Women Against AIDS in Africa (SWAA) in Zambia, with support from the Lutheran Church.

There are currently a number of areas where KAS would like to strengthen its activities in order to better meet the needs of its clients. Joe Muriuki, founder and director of KAS, says that one of the major burdens the organisation currently faces is the growing number of groups requesting training and orientation from KAS. While the Society is more than willing to respond to these requests, this does put a strain on the organisation's resources. By next year, the director would like KAS to be in a position...
to develop a specific programme to meet such requests. In the meantime, they will continue to respond on an ad hoc basis as best as they can.

Another problem that is more difficult to address is how to respond to the plight of the most needy cases among their clients who require food, medicine and other necessities. The need for such basic resources is growing, but most of the organisations they now turn to for such assistance are already stretched to the limit.

KAS has already used forums such as National AIDS Day to advocate for policies that support people with AIDS. However, more needs to be done to bring about sympathetic and supportive government policies to protect the rights of AIDS patients. And people with AIDS could also benefit from education and counselling about their legal rights.

When looking at the issue of replicability, certain factors must be considered. For example, it is important that services such as those provided by KAS be geographically accessible to those who need them. The availability of funds and a functioning health infrastructure are crucial for project expansion. Community acceptance and participation in project activities is also vital for sustainability.

The KAS case study demonstrates that people with AIDS can be effective counsellors. However, for an organisation such as KAS to operate in areas where literacy is low, appropriate information, education and communication materials in local languages need to be developed.
The Voluntary Women Rehabilitation Institute (VOWRI) is a project that is helping sex workers in Kenya protect themselves from sexually transmitted diseases (STDs), including AIDS, and involving them in the effort to reduce HIV transmission. The project is also assisting these women develop alternative sources of income to help them reduce or eliminate their financial dependence on prostitution.

The majority of VOWRI's clients come from areas such as Pumwani-Majengo, Kariobangi, Korosho, Huruma, and City Center “brothels” such as Aden and Sagana, all of which are within Nairobi. VOWRI also operates from several sites in Machakos town, which is located about 30 km east of Nairobi.

PROFILE OF THE PROJECT COMMUNITY

The sections of Nairobi where VOWRI operates are poor and densely populated and the physical infrastructure has been stretched to the breaking point. The few schools that exist suffer from neglect and overcrowding and are unevenly distributed throughout the community, while roads, communication channels and sewage and water systems, are insufficiently developed.

A majority of residents are poor and few can afford even two meals a day. Most are unemployed or under-employed and make their living in the informal sector, selling items such as kerosene, firewood, and a variety of small goods. Others engage in illicit trades, such as brewing and selling alcoholic beverages and peddling drugs. Those who do manage to obtain gainful employment—as construction workers, warehouse or factory employees, night watchmen, security guards, or as other types of unskilled workers—generally work outside the area. However, even these jobs pay poorly.

Due to the current economic situation, more and more women are resorting to working in the sex trade to support their families. Some survive solely on earnings from prostitution while others establish sexual alliances in exchange for favours. Not surprisingly, given the current economic difficulties and high levels of illicit sexual activity, there is a high incidence of STDs and AIDS in these areas.

Health facilities, both public and private, are located in the area and are within walking distance for most residents. There are also some traditional healers who treat many common illnesses. People with AIDS frequently seek the services of healers for moral and spiritual support.

PROJECT DESCRIPTION

In 1984, studies of sex workers in urban Nairobi showed that 30-88 percent of the women surveyed were HIV positive. Data from these studies also revealed a high prevalence of other sexually transmitted diseases. In response, the Departments of Microbiology and Community Health at the University of Nairobi set up an STD clinic in Pumwani specifically to meet the needs of prostitutes. However, the women did not like being labeled as sex workers through use of this facility. So, when five other service delivery points were integrated within the existing primary health care centres about three years ago, STD services were made available at each unit. While such integrated services were able to meet broader health care needs, the sex workers clearly had special needs and were particularly vulnerable to HIV infection.

To better meet the needs of these women, Dr. Elizabeth Ngugi from the Department of Community Health, University of Nairobi, and some of her associates, formed an organisation called the Voluntary Women Rehabilitation Institute (VOWRI) to specifically address the problems that were facing prostitutes and to engage them in STD and HIV/AIDS prevention activities as well as socio-economic development. The project has been fully operational since 1990.
VOWRI attempts to combat HIV transmission through behavioural modification, empower sex workers to negotiate for safer sexual practices and assist these women in developing alternative or supplementary means of earning income. Most of VOWRI's clients are drawn from among the approximately 3000 prostitutes in the areas served by the STD clinics. The women either come to VOWRI on their own or are referred by clinic staff.

VOWRI has no official membership system. Anyone can come and join in the activities. The women band together into support groups according to their location and interests (there are about 30 members in a group). Each group has a peer leader and maintains its own bank account; members are accountable to each other in terms of regularly making contributions and properly maintaining the account. Some women come once, others infrequently; however, there are 97 women who come regularly and have received training and/or material assistance from VOWRI. VOWRI members range in age from 15 to 50 and almost all have children that they are supporting, usually on their own. Many have migrated from rural areas to Nairobi in search of work, some are from other East African countries. They have few, if any, marketable skills. More than one third of the regular members are HIV-positive.

Each group of women meets weekly to: 1) share experiences and participate in group counselling sessions; 2) participate in a "merry-go-round" savings strategy which provides each woman with a small sum of money on a rotating basis; 3) maintain a joint savings account which can be used to support group projects; and 4) encourage members to maintain their own individual bank accounts. Transport is not provided for the women to come to these meetings—they come because it is important to them.

Counselling

Counselling is a major component of the VOWRI project and a trained counsellor is part of the staff. While individual counselling is provided on an as-needed basis, group counselling is a regular feature of weekly meetings. At these sessions the women share knowledge and sympathy and also work on income-generating activities.

VOWRI has found that it is these counselling opportunities—both for individuals and within groups—that provide sex workers with the emotional support they need to begin changing their sexual behaviour. Having such a support network also helps members cope with the news when they learn that they are HIV positive.

Negotiating Safer Sex

During group counselling sessions, health topics selected by the women are discussed; VOWRI staff or invited guests provide the necessary expertise. The women are particularly interested in learning how to negotiate for safer sexual practices with clients. This is accomplished by strengthening their human relations and communications skills. The women learn to try and convince clients that condom use is in the client's own best interest. They also learn how to put on a condom thus making condom use part of the sexual act.

The women regularly discuss their experiences negotiating safer sex—affirming those who have taken action and encouraging those who have not. This is not a simple task because there is a lot of competition for clients and some men will actually pay more for sex without a condom. However, because of the knowledge and support they have gained through participation in these groups, VOWRI members have been able to convince many of their clients to use condoms—and even to take some home.

VOWRI clients have found that such negotiation can be carried out most effectively when groups of women work together in a particular setting—such as a bar—and agree among themselves not to accept clients who will not use condoms. As long as everyone sticks together, this approach can be very effective. For women working on their own, it is
much harder. Additionally, there is more and more competition—because more women are in need of money and some men are becoming more careful about going with prostitutes.

VOWRI also encourages prostitutes to use another form of contraception, besides condoms, to protect themselves from unwanted pregnancy. All modern methods of contraceptives for women (pills, IUDs, injectables, female sterilization, and Norplant) are discussed. Dr. Ngugi estimates that almost half of the women now use either the pill on a regular basis or have been sterilized. Many of the women have come to understand that, given their HIV status or high risk of infection, it is important that they don’t get pregnant.

VOWRI refers sex workers to appropriate health services for family planning. Unfortunately in Kenya, as in many African countries, government policy restricts provision of family planning information and services to women who are unmarried or under 20 years of age.

Income-Generating Activities

Because most of VOWRI’s clients are the sole support for their families, from its inception the organisation has maintained that if their clients are to reduce their dependency on prostitution, they must have other means of earning income. Given the poverty in which they live, this is not an easy task. Most of the women are unskilled and the alternatives to sex work possible for them generally pay poorly and require many more hours of hard work.

In its effort to help prostitutes find other sources of income generation, VOWRI has tried several different approaches. In one case, individual women were given small amounts of money to start their own business. The money was a gift, not a loan. Typically, businesses the women operate include: very small hotels (known locally as “kiosks”), vegetable vending, selling old clothes, water kiosks (a very profitable system by which water is distributed from community spigots), charcoal and fuel selling, basket weaving, hair dressing, and washing/ironing clothes. Because most of the women are unskilled, they had to be taught business management and, in some cases, given skills training. VOWRI has been able to provide support to some young girls to take tailoring courses so that they could learn a trade.

Currently, VOWRI lacks the funds needed to

Asha is 38 years old and has been a sex worker for the past eight years. She was once married but she and her three children were chased out of her marital home. Soon after, she started selling mboga (green vegetables) for survival but the money was not enough to feed, clothe, and educate her children. Hence, she gave up the vegetable business and resorted to prostitution which was more profitable.

Asha heard about VOWRI through one of the group’s peer educators who encouraged her to become a member. As a VOWRI member, she received a loan of Ksh. 7,000 which she used to re-start her vegetable business. She was able to give up prostitution briefly as the vegetable business was performing well. With initial profits, she bought a small plot of land and paid school fees for her children. But after a while, the business collapsed due to the recent drought and she was driven back to sex work.

Now, she needs another loan from VOWRI in order to build a house on her plot. She intends to rent out the premises for income because she doesn’t want to work as a prostitute anymore.
continue helping individual women start businesses. In its place, a “merry-go-round” savings plan has been initiated. Within each group, members contribute weekly and then each in turn receives the entire amount collected. The recipient is supposed to be able to use the money for her business or any other expense, however, the amount available is very small.

Another approach is for the various groups to undertake specific projects. For this purpose, each group maintains its own bank account and the women decide how much to contribute per week. To date, most of these efforts have been craft projects carried out during weekly meetings. As yet, there has not been any skills training involved; the women draw on the abilities they already have, such as basket weaving. The major constraint these efforts face is effective marketing of the goods produced. At the time this case study was conducted, VOWRI did not have an international outlet and the local market is saturated with similar items. To date, their best market has been international meetings; for example, they sold items at the Berlin AIDS conference in 1993.

Trying a different approach, the group in Karogosho recently saved KSh 40,000 (apx. U.S. $615) and bought a plot of land. They plan to put up a building and will use one room as their own meeting place and then rent out the remaining space as an income-earning project. Dr. Ngugi has promised to rent one of the rooms to store project materials (including condoms) for the women and their clients.

Educating the Community

In Kenya today, HIV-positive people are still severely marginalised in their communities, often forced to live with other AIDS patients or treated like pariahs. Not surprisingly, fear of stigmatisation has made many who are infected reluctant to make their status known. VOWRI members, with the help of trained community health workers, have been able to help reduce ostracism and bring about increased community support by sharing information on HIV transmission and the care of people with AIDS. Supplies of condoms are kept at VOWRI centres and are always available. Members usually take up to 100 at a time—both for personal use and to distribute in the community. Many VOWRI members have become known in their communities as peer educators/counsellors and their neighbours now come to them for information about HIV/AIDS. Being recognised in this way has boosted their self-esteem and many who were initially too shy to speak out have now become active agents of change both among their peers and in the community at large.

VOWRI also contributes to greater public awareness by participating in and/or organising events such as the AIDS Awareness Exhibition at the Museum of Nairobi in 1993. At this exhibition, a quilt was made bearing the name of women from Pumwani whom have died of AIDS. VOWRI members have also composed a number of songs which they have performed for a variety of local organisations. In its educational activities, VOWRI makes use of information, education and communication materials provided by the National AIDS...
Control Programme (NACP) and other non governmental organisations (NGOs).

Home-based Care and Orphans

VOWRI members are also involved in home-based care of people with AIDS. Within each larger group, subgroups of women who live in the same area look after one another, visiting anyone who might be sick to make sure they have food, water and other supplies. When someone is seriously ill and in need of assistance, caregivers alert nearby clinics to request needed services.

A major problem VOWRI is now facing is how to care for the orphans left behind when one of the women dies. As most of the women are not from Nairobi, they usually do not live near their families. Also, in some cases, the stigma of AIDS or knowledge of the mother’s profession causes their families to reject them and their children. Dr. Ngugi noted that two members had recently died, one leaving two children and another, three. In one case, VOWRI was instrumental in convincing an aunt to care for the children; in the other instance the grandmother was persuaded to take in her grandchildren. Both families now receive support from VOWRI.

MANAGEMENT

VOWRI’s activities are carried out by the director, who reports to a board of directors, and manages the staff and the occasional volunteers who assist the project. VOWRI’s work is closely affiliated with the STD programme of the Departments of Community Health and Microbiology of the University of Nairobi. The staff consists of Dr. Ngugi, a nurse/counsellor (who is also trained in small business management), and an accounts clerk (who performs a variety of functions for the organisation). There was a second counsellor who left, but she has not been replaced due to lack of funds. All the members carry out peer education, as do volunteers.

VOWRI collaborates with the Ministry of Health (MOH), through the NACP, as well as with professional organisations, family planning institu-

ions, religious groups, and other NGOs. Local authorities, such as city health officials and the Nairobi City Commission have been very supportive and provide referral services to members in need of health care or other social services.

RESOURCES

While VOWRI is closely affiliated with the STD project of the Departments of Community Health and Microbiology, University of Nairobi, the University does not directly support the organisation. Establishment of VOWRI was made possible by funding from the Royal Netherlands Embassy and the Danish government. Other donors have provided support for specific activities. The Belgian embassy in Kenya has recently donated a large loom to VOWRI, along with a supply of yarn. The organisation now must raise the funds to hire a trainer who will teach the women to use the loom. Private donations and support of individuals in the community also help keep the project going. Condoms are provided by the Ministry of Health.

EXPERIENCE TO DATE

The fact that many HIV-positive men are still reluctant to refrain from casual sex or to use condoms underscores the importance of increasing women’s assertiveness in sexual negotiation. VOWRI members’ increased knowledge about the
Jane was born in Nyeri district. She received formal education only up to standard two in primary school. Shortly after the birth of her first child in 1967, Jane moved to Nairobi because her parents were unable to support her. Subsequently, she had three other children but they all died in childhood due to illness. She has one living son, Mwangi, who is now 28 years old and married with a child. Jane was 25 when she entered the sex trade.

She first learned about VOWRI at the Pumwani-Majengo STD clinic two years ago. Jane was determined to give up prostitution if offered an alternative. Therefore, when she was told that VOWRI could assist her in starting her own business, she decided to become a member. She first attended a three day skills training course at the VOWRI centre in Pangani on small business management. Then she was given some seed money by VOWRI to start a business of her choice.

Jane decided to begin by selling fruits. Later she switched to selling green vegetables which proved to be more profitable. During this time, she managed to save some money which she used to open a food kiosk in a low-income residential area in Nairobi. The kiosk is operating well at the moment.

Since her association with VOWRI, Jane has never returned to sex work. She says VOWRI has helped to raise her self esteem and gain respect among her peers. She is now referred to as "Mama Mwangi" (i.e. mother of Mwangi), a term that is commonly used to refer to respectable women in Kenyan society.

LOOKING AHEAD

Despite its achievements, VOWRI's current financial situation is precarious. At this time they are able to provide training in income-generation skills only to new members and have no funds to help them actually start businesses. Dr. Ngugi described VOWRI's immediate needs as:

- Money to continue operating. When interviewed prior to publication of this report, she said that she had not been able to pay her staff for three months and is concerned about being able to pay the rent on their centre in Pangani.
- The ability to help arrange care for the orphaned children of VOWRI members.
- Additional support in the care of women with AIDS.
- Funds to help more members start businesses and to provide some additional support to women whose existing income-generating activities have suffered as a result of the recent drought—particularly, vegetable and grain vendors.
- Resources to increase the number of women VOWRI is able to help.
- A telephone and computer.

As lack of funding is the key issue facing VOWRI, the organisation could benefit from a concerted fundraising effort backed by a well-defined project plan. However, project staff are few and Dr. Ngugi—
who devotes an amazing amount of time, energy and personal resources to the project—is involved in many other activities at the University of Nairobi and is also the director of the Kenya branch of the Society of Women and AIDS in Africa (SWAA). While VOWRI has received some support from international donors (Belgium, Denmark and the Netherlands), the awards have generally been small and have come from local mission budgets. VOWRI is now in the process of preparing a proposal for broader support to be submitted to DANIDA.

In addition to needing money to fund members' individual businesses as part of its income-generating programme, VOWRI has recognised the need for establishing an outlet where members can sell the items they produce. A showroom where their products could be displayed and sold would be very helpful. Many of the women have been easily discouraged when their business efforts have not proven nearly as financially rewarding as prostitution. There is also a need to conduct a study to identify other, non-traditional methods of income-generating activity. This will help VOWRI create products that are not currently available and, therefore, more profitable.

VOWRI's main centre in Pangani is small and cramped—especially now that the loom occupies an entire room. Right now an adjacent office is vacant. If funds were available, VOWRI would take over this space to provide more room for meetings, training and income-generating activities.

Lastly, there remains a real need to provide material and financial assistance to help orphaned children of VOWRI members. For the seropositive women participating in the VOWRI project, anxiety for their children's future is a major concern. As Dr. Ngugi said: “Sex workers are human beings with human feelings. HIV-positive sex workers need counselling to prepare their children for when they are gone.” VOWRI needs to increase and diversify its fundraising capability and strengthen its collaboration with other NGOs, as well as government institutions, in order to get the assistance it needs to continue its work and fulfill its goals.

ENDNOTES

Publication of this case study report is the culmination of the first phase of the Community-Based AIDS Prevention and Care in Africa: Building on Local Initiatives project. In this phase, we have attempted to learn from the experience of the organisations surveyed—and, most particularly, from the eight local organisations that participated in the case studies—in order to better understand how they have been able to mobilize support at the community level to establish, expand and continue their activities. The experience has made it clear that local people—including people living with AIDS—can become active and, in many cases, dynamic agents for changing attitudes and providing support to those in need within their communities.

As noted in the introduction, the eight cases profiled include not only projects that began as grassroots initiatives, but also efforts by established national organisations that recognized that if they were going to bring about change, they would need to work at the community level. Through an examination of their experiences, we seek to identify some of the advantages of working at the local level, common elements of successful project implementation and, of equal importance, challenges and constraints that such efforts face.

ADVANTAGES OF COMMUNITY-BASED INITIATIVES

One of the goals of the community-based AIDS project was to assess the effectiveness of integrating prevention and care activities within the same project—a topic of considerable debate, particularly in developed country settings. However, it quickly became apparent that, in the context of the five African countries where these studies took place, there is no dichotomy at the community level between working towards stemming the tide of the epidemic and caring for those already affected. At the local level, where people are living with AIDS on a daily basis, artificial distinctions between prevention and care are revealed to be more the result of top-down programme strategies than a realistic response to people's needs.

Another clear advantage of organisations working at the community level is their ability to encourage not only the support but the participation of local leaders in AIDS prevention and care activities. In Africa, the role of the elders cannot be underestimated. Enlisting their support, as well as the involvement of local government officials, is an important first step in sanctioning the participation of the community and enlisting the support of prominent individuals and other local organisations.

In addition, local leaders can be an important source of information about the design of effective strategies within a particular community. For example, in Zimbabwe the traditional healers' association is working to get the cooperation of local chiefs and opinion leaders in establishing alternative rituals that will satisfy local traditions but not put people at risk of HIV transmission. In Uganda, community leaders have been actively involved in the design of the project's information, education and communication (IE&C) strategy. In Tanzania, local women are building on the tradition that family members other than parents educate young people about sexuality in order to teach children and adolescents about AIDS.

Having the focus of a project at the community level also builds in an accountability factor. Unlike donor-driven initiatives conceived, executed and fully funded from above, if a community-based project is not perceived as useful by local people, they simply will not participate in the effort or provide the support needed for the project to continue operating.

Local initiatives also seem to be particularly effective in mitigating some of the effects of the epidemic on those who are HIV positive or have AIDS. Although in varying degrees, in all of the five countries where case studies took place there still remains
considerable stigmatisation of people with AIDS. The projects studied appear to be far more effective than mass media or national education campaigns in addressing this problem because they are actually putting a human face on the epidemic.

In particular, efforts such as WAMATA in Tanzania and KAS in Kenya, that actively involve people with AIDS in their projects, have been very effective in influencing greater concern for and support by families and within the community for those who have been infected. And through their participation, people with AIDS feel they are making a contribution, that they have something positive to offer their community. In the case of the VOWRI project, engaging sex workers in community education and home care has been instrumental in increasing their self-esteem and helping them gain respect in their communities as a source of knowledge about AIDS prevention. Furthermore, all the projects are providing community members—whether HIV positive or not—with a sense that there is something they can do in the face of a situation that might otherwise leave them feeling helpless.

In addition, all of the projects are helping those who are HIV positive or who have AIDS to live more positively with the disease. For example, by carrying out home visits, the projects are making the lives of AIDS patients easier and are demonstrating to their families and neighbours that there is nothing to fear from relating to them in a normal way.

The last advantage is one that is almost impossible to measure: behaviour change. All of the projects report some degree of behaviour modification on the part of their clients in terms of increased condom use and greater avoidance of risky sexual activity. There is also some evidence that with increased knowledge, some people are able to avoid participating in traditional practices such as circumcision or widow inheritance/ritual cleansing that involve the risk of HIV transmission. However, it must be remembered that none of these projects operates in a vacuum. Their clients are also affected by mass media campaigns and the work of other programmes in the community. So while the extent of their influence on behaviour change cannot be accurately gauged, the projects do appear to be making some difference in this critical area.

ELEMENTS OF SUCCESSFUL PROJECTS AND RELATED CHALLENGES

In reviewing their experiences, the eight projects studied seem to share a number of common elements of success. However, in almost every instance where we can identify what works, we can also point to challenges that must be overcome.

Strong Foundations

Foremost among the elements of success is the role of strong and determined people in getting things off the ground. Even in developed countries—particularly the United States—the response of governments to AIDS has often been criticized as too slow and too little. In these situations too, it was the efforts of concerned individuals and private organisations that spearheaded the response to the epidemic. In resource-poor environments such as sub-Saharan Africa, the situation has not only been similar but even more pronounced. It is, therefore, not surprising that in the Africa context, recognition of the need to take action by one or more highly committed, resourceful and energetic people appears to be a critical element of success.

For example, at the grassroots level, women in Kilimanjaro, Tanzania and Lusaka, Zambia looked around and saw friends and family members dying and children being left to fend for themselves. So they got their friends together, thought about what they could do, and went to work. Starting at the other end of the spectrum, thoughtful staff within the NACP in Uganda and ZINATHA in Zimbabwe involved in trying to educate people about HIV transmission and encourage the care of people with AIDS realized that without involving people where they live, very little was going to change—so they rethought their approach.
Exceptional people such as these can be found at all levels of society. The challenge is to provide them with the recognition, resources and encouragement they need to get on with it.

Reaching Out

But no matter how tireless or committed such individuals may be, the experiences of the projects studied also make clear that these efforts are surviving and growing because they have been successful in initiating linkages with a range of other institutions. Most projects have by now established liaisons with the National Aids Control Programme in their country as well as a variety of supportive relationships with both governmental and non-governmental organisations and the private sector. These institutions are a major source of information, educational materials, commodities, expertise and, in some cases, financial support.

While an important element in sustainability is the involvement of the local community—either in terms of time volunteered, contribution of food, clothing or other basic items, or financial donations—all of the projects studied rely on outside assistance. In the case of those originating at the grassroots level, there appears to be an incremental expansion of the resource base as projects grow and gain recognition and sophistication. While some of the projects have been able to earn income through the staging of special events or the sale of items such as T-shirts, to date only Kwasha Mukwenu in Zambia makes income-generation a major component of its programme.

Several projects have attempted to help their clients establish small-scale enterprises to support themselves and their families, but these efforts have experienced limited success. In most cases, this is because development of successful income-generating activities requires considerable staff expertise in market analysis as well as the ability to provide training and seed capital. Efforts of those projects seeking to assist clients in this manner could be bolstered through provision of appropriate technical assistance and financial support. However, to what degree projects themselves will be able to generate their own support remains in question given the growing demand for their services and limited financial resources of most of the communities they serve.

One of the challenges these groups continually face is how to broaden their base of support without neglecting the needs of an expanding client base.

The Role of Volunteers

While some organisations do operate with the assistance of paid staff, in almost every case the work of volunteers is, if not their primary resource, then an invaluable support in carrying out project activities. These efforts demonstrate that when provided with appropriate training, supervision and support, community members can play a vital role in educating their peers and caring for people with AIDS.

However, for even committed volunteers to continue as active participants they need to receive some form of incentive. In Uganda, providing bicycles to some of the community counselling aides (CCAs) was a tremendous boost to their spirits—a reward for good work and an answer to the perpetual problem of insufficient transport—but the number of bicycles available were few. The women of Kwasha Mukwenu have good ideas for generating more income to support orphans, but right now they have only 35 active members. This is because few women can afford to give up a significant part of each day for volunteer activities unless there is some form of compensation involved. The challenge projects face, therefore, is not just how to provide salaries to paid employees, but how to offer volunteers a sufficient incentive for them to stay involved.

Access to Health Care

People with AIDS have intensified health care needs and the population at large needs to know where they can go for HIV testing and counselling. By establishing links with local health facilities, projects are offering an important service to their
clients by providing access to services and medication that might not otherwise be available to them. However, in situations where the health care infrastructure is already overstretched and suffering from shortages of staff and commodities, the projects are faced with an almost perpetual need to find new and varied sources of care for their clients. And people with AIDS have other needs as well, including food and basic commodities such as soap, fuel oil and the like, that projects also must address.

Training and Support

One important element present in varying degrees in all the projects studied is counselling. By providing clients with opportunities to participate in individual and, more importantly, group counselling sessions, projects are helping to dispel a sense of isolation and frustration often experienced by those affected by AIDS. And in some cases, such as the VOWRI project in Kenya, the process is helping clients establish their own mutual assistance networks. But while provision of counselling to those who have been infected with HIV and their family members is an important element of all the projects studied, it also requires special skills. When people learn they are HIV positive or have AIDS, they often react with anger or despair. Even health and social workers who already have training in basic counselling skills need special resources in order to help clients deal with a life-threatening situation such as AIDS. At the INDENI Petroleum Refinery, where medical services are of unusually high quality, clinic staff identified lack the skills needed to effectively counsel those who are HIV positive as a major concern. In addition, projects face the challenge of finding ways to help their staff deal with the problem of "burnout" that often affects those who work in such an emotionally charged environment.

COMMON CONSTRAINTS

All of the projects studied are operating under significant constraints in terms of resources. Not only is funding often insufficient, sporadic or at times absent, but projects also face perpetual shortages of materials and commodities. Those that support home-based care lack medicines and supplies to give to patients, while those carrying out information programmes lack educational materials—especially materials that are culturally appropriate and in local languages and simple formats that can be easily understood by their clients. And project staff consistently face the problem of insufficient transport to enable them to effectively carry out their work. Besides trying to meet the immediate needs of their clients, all the projects are grappling with the growing phenomena of orphaned children. In addition to the many young people already at risk, the fear of who will care for their children when they die and how they will be able to stay in school haunts parents already affected by the disease. The traditional resilience of the extended family is hard pressed to meet the need—especially in urban areas where people often live far from their kin. Beyond supporting family networks so they can increase their capacity to care for children in need, one of the greatest challenges these organisations face is how to establish substitute mechanisms that can provide children not only with physical care, but with the emotional, psychological, and social support they need.

FUTURE ACTIVITIES

The next phase of the Community-Based AIDS Prevention and Care in Africa project will attempt to help projects address some of these issues. A starting point will be to convene workshops in each participating country to disseminate the case studies report and review what has been learned to date. It is envisioned that this effort will help to facilitate broader and stronger networking among groups carrying out community-based prevention and care efforts in each country and between them and organisations able to provide financial support and technical assistance. Particular attention will be given to the identification and assessment of effec-
tive information materials and to seeking ways of making these materials more accessible to local populations.

To the extent possible, the Population Council will also seek to provide access to technical assistance designed to meet the specific needs of individual projects in areas such as management, evaluation, counselling and IE&C. The Council will then assess the utility of these interventions in strengthening the effectiveness of these projects in meeting their clients needs. These experiences will ultimately be documented so that those seeking to assist community-based initiatives, not just in Africa but in other parts of the world as well, can benefit by what is being learned.
 LIST OF CONSULTANTS
The following consultants were involved in carrying out the initial survey of community-based organisations and/or in preparation of the case studies.

KENYA
Ms. Jane Murago-Munene  
Cine Arts Production  
Ms. Jane Muriithi  
AIDS Orphans Support Organisation of Kenya  
Ms. Lucy Muthuni  
Kenya AIDS Society  
TANZANIA  
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Muhimbili Medical Centre  
Dr. Esther Mwaikambo  
Medical Women Association of Tanzania (MEWATA)  
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Population Council  
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Ms. Patricia Kamanga  
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 LIST OF ORGANISATIONS/INDIVIDUALS PARTICIPATING IN SURVEY OF COMMUNITY-BASED ORGANISATIONS

KENYA:
Undugu Society of Kenya  
Nairobi  
Kenya National Council of Social Services (KNCSS)  
Nairobi  
World Vision International  
Nairobi  
Amani Counselling Society  
Nairobi  
Provide International  
Nairobi  
Crescent Medical Aid Kenya  
Nairobi  
Ministry of Health - National AIDS Control Programme  
Nairobi  
Makini Herbal Remedies  
Nairobi  
Kenya AIDS Society  
Nairobi  
Voluntary Women Rehabilitation Institute (VOWRI)  
Nairobi  
The Children of God Relief Institute  
Nairobi  
Kenya Medical Women’s Association  
Nairobi  
Christian Health Association of Kenya  
Nairobi  
TANZANIA:  
Family Planning Association of Tanzania  
Dar-es-Salaam  
The Christian Medical Board of Tanzania (CMBT)  
Dar-es-Salaam  
EMAU - Responsible Parenthood Education for Youth Project  
Dar-es-Salaam  
The African Medical and Research Foundation (AMREF-Tanzania)  
Dar-es-Salaam  
The Organisation of Tanzania Trade Unions (OTTU)  
Dar-es-Salaam  
The Tanzania Council for Social Development (TACOSODE)  
Dar-es-Salaam  
The Tanzania Episcopal Council (TEC)  
Dar-es-Salaam  
Walio Katika Mapambanona Ukimwi Tanzania (WAMATA)  
Dar-es-Salaam  
The Tanzania Danish Red Cross Society  
Dar-es-Salaam
Tanzania Media Women's Association (TAMWA)
Dar-es-Salaam

Ministry of Health National AIDS Control Programme
Dar-es-Salaam

The Society for Women and AIDS in Africa (Tanzania Branch-SWAAT)
Dar-es-Salaam

Medical Women Association of Tanzania (MEWATA)
Dar-es-Salaam

UGANDA:
Good Samaritan Clinic
Mengo Hospital
Kampala

AIDS Information Centre (AIC)
Kampala

Uganda Virus Research Institute
Entebbe

Namirembe Diocese Day Care Centre
Kampala

The AIDS Support Organisation (TASO)
Kampala

Church Human Services
Kampala

World Learning Inc.
Kampala

Nsambya Mission Hospital
Kampala, Uganda

Rakai Project
Entebbe

Makerere University Students AIDS Control Association (MUSACA)
Kampala

Ministry of Health - National AIDS Control Programme
Entebbe

ZAMBIA:
Ministry of Labour and Social Security (MLSS)
Lusaka

Traditional Health Practitioners Association of Zambia (THPAAZ)
Lusaka

Family Life Movement of Zambia
Lusaka

The Zambia Nurses Association
Lusaka

Society of Women and AIDS in Africa-Zambia Branch
Lusaka

Children in Distress (CINDI)
Kwasha Mukwenu Mukuyanda
Lusaka

Young Women's Christian Association (YWCA-Zambia)
Lusaka

Churches Medical Association of Zambia
Lusaka

Kara Counselling and Training Trust
Lusaka

Family Health Trust
Lusaka

Ministry of Health National AIDS Control Project
Lusaka

Planned Parenthood Association of Zambia (PPAZ)
Lusaka

University of Zambia
Institute for African Studies
Lusaka

Supa Baking Company Ltd.
Lusaka

ZIMBABWE:
Zimbabwe National Family Planning Council
Harare

Zimbabwe Red Cross Society
Harare

National Council of Samaritans in Zimbabwe
Harare

Mshambanzou Drop-in Centre
Harare

Island Hospice Service
Harare

Women's Action Group (WAG)
Harare

Zimbabwe Congress of Trade Unions (ZTCU)
Harare

Zimbabwe National Traditional Healers Association (ZINATHA)
Harare

Zimbabwe AIDS Network (ZAN)
Harare

Ministry of Health - National AIDS Control Programme
Harare

Child Protection Society
Chinyradzo Children's Home
Harare

University of Zimbabwe
Department of Student Health Affairs
Harare
For more information about the Community-Based AIDS Prevention and Care in Africa: Building on Local Initiatives project or to request copies of the case studies, please contact:

The Population Council
P.O. Box 17643
Nairobi, Kenya

Publications can also be requested from:
The Robert H. Ebert Program on Critical Issues in Reproductive Health and Population

The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017

For more information about the Positive Action programmes, write to:

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